PUBLIC

HUTT VALLEY DHB / Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**AGENDA** Held on Wednesday 1 December 2021 Time: 9:00am Location: Zoom Zoom Meeting ID: 876 5068 1844

2DHB CONCURRENT BOARD MEETING

	Item	Action	Presenter	Pg
1.	**PROCEDURAL BUSINESS**			
1.1.	Karakia		All members	2
1.2.	Apologies	**NOTE**	Chair	
1.3.	Public Participation	**NOTE**	Chair	
1.4.	Continuous Disclosure 1.4.1 Board Interest Register 1.4.2 ELT Interest Register	**NOTE**	Chair	3 8
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1.6.	Matters Arising	**NOTE**	Chair	18
1.7.	Chair's Report and Correspondence	**NOTE**	Chair	
1.8.	Chief Executive's Report	**NOTE**	Chief Executive	19
1.9.	Board Work Plan 2022	**NOTE**	Chair	35
2.	**DHB PERFORMANCE AND ACCOUNTABILITY**			
2.1.	HVDHB Financial and Operational Performance Report – September 2021 2.1.1. Report	**NOTE**	Chief Financial Officer Director Provider Services Director Strategy, Planning and Performance	38 42
2.2.	CCDHB Financial and Operational Performance Report – September 2021 2.2.1. Report	**NOTE**	Chief Financial Officer Director Provider Services Director Strategy, Planning and Performance	90 93
3.	**STRATEGIC PRIORITIES**			
3.1.	Strategic Priorities update	**NOTE**	Chief Executive	136
4.	**DECISIONS**			
4.1.	HSC update and items for approval from meeting dated 24/11/21 4.1.1. Appendix 1 4.1.2. Appendix 2	**NOTE**	Chair of HSC	140 142 193
4.2.	Delegations for the 2021/22 summer break in Board schedule	**NOTE**	Chief Executive	206
5.	**UPDATES**			
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6.	**Other**			
6.1.	2DHB Covid Planning	**NOTE**	Chief Executive	209
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6.3.	Resolution to Exclude the Public	**APROVE**	Chair	216

Next concurrent Board meeting:
Date: Wednesday 16 February 2022, **Location:** Hutt Hospital **Time:** 9.00am

Karakia

Kia hora te marino

Kia whakapapa pounamu te moana

Hei huarahi mā tātou i te rangi nei

Aroha atu, aroha mai

Tātou i a tātou katoa

Hui e! Tāiki e!

Translation

May peace be wide spread

May the sea be like greenstone

A pathway for us all this day

Let us show respect for each other

For one another

Bind us all together!

CAPITAL & COAST AND HUTT VALLEY DISTRICT HEALTH BOARDS

Interest Register

01/12/2021

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, Greater Wellington Rail Ltd • Councillor, Greater Wellington Regional Council • Chair, Transport Committee, Greater Wellington Regional Council • Associate Portfolio Leader, Sustainable Development • Member of Capital & Coast District Health Board • Member, Harkness Fellowships Trust Board • Member of the Wesley Community Action Board • Independent Consultant

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

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

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

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

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

	• Medical Reviewer for the Health and Disability Commissioner

HUTT VALLEY AND CAPITAL & COAST DISTRICT HEALTH BOARDS

Interest Register

EXECUTIVE LEADERSHIP TEAM

1 DECEMBER 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
John Tait *Chief Medical Officer 2DHB*	• Vice President RANZCOG • Ex-offico member, National Maternity Monitoring Group • Member, ACC taskforce neonatal encephalopathy • Trustee, Wellington Hospitals Foundation • Board member Asia Oceanic Federation of Obstetrician and Gynaecology • Chair, PMMRC • Director, Istar • Member, Health Practitioners Disciplinary Tribunal
Christine King *Chief Allied Health Professions Officer 2DHB*	• Brother works for Medical Assurance Society (MAS) • Sister is a Nurse for Southern Cross
Sarah Jackson *2DHB Acting Director Clinical Excellence*	• Nil
Rachel Gully *Director People, Culture & Capability 2DHB*	• NIL
Chris Kerr *Chief Nursing Officer 2DHB*	• Member and secretary of Nurse Executives New Zealand (NENZ) • Relative is HVDHB Human resources team leader • Relative is a senior registered nurse in SCBU • Relative is HVDHB Bowel Screening Programme Manager • Adjunct Teaching Fellow, School of Nursing, Midwifery and • Health Practice, Victoria University of Wellington

Wednesday, 24 November 2021

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
Sue Gordon *Transformation Director*	• Board Member, Netball New Zealand
Martin Catterall *Chief Digital Officer 3DHB*	• NIL
Mathew Parr *Acting Chief Financial Officer 2DHB*	• Substantially employed by PWC • Partner's father works in the printing team at CCDHB

PUBLIC

	MINUTES Held on Wednesday 3 November 2021 Location: Zoom Zoom: 876 5068 1844 Time: 9:30am
2DHB CONCURRENT BOARD MEETING	**PUBLIC**

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

PRESENT

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

APOLOGIES

Yvette Grace
'Ana Coffey
Stacey Shortall (left at 11.40am)
Haimora Bowkett (left at 10.40)
Wayne Guppy for lateness (logged on 9.40am)
Ria Earp for lateness (logged on 9.40am)

IN ATTENDANCE

Hutt Valley and Capital & Coast DHB

*Rosalie Percival	Acting Chief Executive Chief Financial Officer
*John Tait	Chief Medical Officer
*Karla Bergquist	Executive Director Mental Health, Addictions and Intellectual Disability Service
*Paul Oxnam	Executive Clinical Director Mental Health, Addictions and Intellectual Disability Services
Arawhetu Gray	Director Māori Health
Junior Ulu	Director Pacific People's Health
Rachel Haggerty	Director Strategy, Planning and Performance (zoom)
*Sarah Jackson	Director of Clinical Excellence
*Joy Farley	Director Provider Services
*Rachel Gully	Director People and Culture
Martin Catterall	Chief Digital Officer
Sue Gordon	Director Transformation (zoom)
*Helen Mexted	Director of Communication and Engagement
*Sally Dossor	Director Office of the Chief Executive and Board Secretary
*Meila Wilkins	Board Liaison Officer

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1 PROCEDURAL BUSINESS

1.1 KARAKIA

The Board opened the meeting with a karakia.

1.2 APOLOGIES

As noted above.

1.3 PUBLIC PARTICIPATION

1.4 INTEREST REGISTER

1.4.1 COMBINED BOARD INTEREST REGISTER

The Boards **noted** the updates to the interest register for Hamiora Bowkett:

- Chair, Eastern bay of plenty primary health alliance
- Chair, Māori Communities COVID-19 Fund

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

1.4.2 COMBINED EXECUTIVE LEADERSHIP TEAM INTEREST REGISTER

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

1.5 MINUTES OF PREVIOUS CONCURRENT MEETING

The Boards **approved** the minutes of the concurrent Board Meeting held on 1 September 2021 (public).

	Moved	**Seconded**	
HVDHB	Prue Lamason	Josh Briggs	**CARRIED**
CCDHB	Kathryn Adams	Chris Kalderimis	**CARRIED**

1.6 MATTERS ARISING FROM PREVIOUS CONCURRENT MEETINGS

There were no updates or comments on the matters arising from previous meetings.

1.7 CHAIR'S REPORT AND CORRESPONDENCE

Nil.

1.8 CHIEF EXECUTIVE'S REPORT

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

Notes:

- Updated the vaccination statistics as at 31 October 2021.
- Discussion on whether we can project the date for reaching 90% fully vaccination.
- Our closure rate is at 98% (1st dose to 2nd dose).
- We are now in the hard graft of getting to the 'hard to reach' groups.
- We are working on principle and driver to be 90% fully vaccination by Christmas.
- Noted the 90% target still leaves a significant number unvaccinated and the question asked if we will apply the 90% to all populations. The 90% target is set by the Ministry of Health so we apply as per that directive – but that does not change the focus and the drive to reach all priority populations.

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- Discussion on how we have worked with Māori and Pacific to increase vaccination rates and how we have used data and analytics to assist with the programme to achieve as have to date.

1.9 BOARD WORK PLAN 2021/2022

The Board **noted** the work plan for 2021/2022.

2 DHB PERFORMANCE AND ACCOUNTABILITY

2.1 HVDHB AUGUST 2021 FINANCIAL AND OPERATIONAL PERFORMANCE REPORTREPORTS

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

The HVDHB Board notes:

(a) the DHB had a ($0.4m) deficit for the month of August 2021, being $2.5m favourable to budget;

(b) the DHB year to date deficit excluding $0.1m net COVID-19 costs was ($3.7m);

(c) the Funder result for August was $2.6m favourable, Governance $0.1m favourable and Provider ($0.2m) unfavourable to budget;

(d) total Case Weighted Discharge (CWD) Activity was 1% ahead of plan.

	Moved	**Seconded**	
HVDHB	Prue Lamason	Wayne Guppy	**CARRIED**

2.2 CCDHB AUGUST 2021 FINANCIAL AND OPERATIONAL PERFORMANCE REPORTS

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

The CCDHB Board notes:

(a) The DHB had a ($5.7m) deficit for the month of August 2021, being ($1.2m) unfavourable to budget before excluding COVID-19;

(b) The DHB year to date had a deficit of ($8.3m), being ($1.2m) unfavourable to budget before excluding COVID-19;

(c) In the two month we have incurred $3.0m additional net expenditure for COVID-19;

(d) The DHB has an overall YTD deficit of ($5.3m) from normal operations (excluding COVID-19) being $1.2m favourable to the underlying budget.

	Moved	**Seconded**	
CCDHB	Roger Blakeley	Brendan Boyle	**CARRIED**

Notes:

- Request for the record of the YTD deficit and the Ministry level of comfort with the deficit. The current numbers being reported is to the revised budget deficit (which the Ministry has

recommended to the Minister for approval). The impact of Covid was prevalent in August given lockdown. Genuine Covid costs will be funded retrospectively.

- Practical ability to catch up planned care waiting lists is difficult as the system was at capacity pre-Covid. There is careful management of the waiting lists.

3 UPDATES

3.1 2DHB MĀORI HEALTH STRATEGIES (TAURITE ORA & TE PAE AMORANGI), PROGRESS & PERFORMANCE REPORT – QUARTER 1

The Director Māori Health presented and answered questions.

The Boards noted:

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

(b) the update on the Iwi Māori Partnerhsip Boards (IMPBs)

(c) the developments in the Whānau Care (CCDHB) and Manaaki Whānau (HVDHB) teams

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

	Moved	**Seconded**	
HVDHB	Prue Lamason	Ria Earp	**CARRIED**
CCDHB	Sue Kedgley	Kathryn Adams	**CARRIED**

Notes:

- Very positive comments on the report and the work being undertaken by the team.
- We have commissioned resource to work with TUI MC to be ready for the Māori Health Authority – previously that work was done within DHBs.
- In order to engage with the MHA they are re-looking at their membership so that as a Board they have the skills that are fit for purpose on 1 July 2021.
- Not yet aware of what role the MHA will have in taking over this post on 1 July.
- Noted the 5 new Māori leadership roles across the DHBs.
- Noted the work of whanau care services and how it works.

3.2 2DHB PACIFIC HEALTH AND WELLBEING STRATEGIC PLAN FOR THE GREATER WELLINGTON REGION 2020 - 2025: PROGRESS & PERFORMANCE REPORT APRIL – NOVEMBER 2021

The Director Pacific People's Health.

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 a progress report from April – November 2021.

(b) There are a number of initiatives that have occurred during the period to deliver on the actions outlined in the Strategic Plan.

(c) The Covid-19 response for Pacific.

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	Moved	**Seconded**	
HVDHB	Ken Laban	Naomi Shaw	**CARRIED**
CCDHB	Chris Kalderimis	Roger Blakeley	**CARRIED**

Notes:

- The Board thanked staff for their work on the Covid response for Pacific people and no questions were asked.

3.3 3DHB DATA AND DIGITAL UPDATE – QUARTER 1

The Chief Digital Officer presented.

The Boards noted:

(a) The content of the attached Data and Digital update report for Quarter 1 2021/2022.

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

(c) The core clinical work programmes – single clinical portal and regional radiology information system are progressing on track.

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

	Moved	**Seconded**	
HVDHB	Prue Lamason	Ria Earp	**CARRIED**
CCDHB	Sue Kedgley	Brendan Boyle	**CARRIED**

Notes:

- Progress noted on the implementation of the programme, and engagement regionally as we focus on the transition to Health NZ.
- Work is continuing on managing vacancies and actively recruiting in a difficult environment – but to a realigned and refocused work programme.
- How we work will be enhanced by the roll out of Microsoft Teams an important step for the way we work.

3.4 SUICIDE PREVENTION AND POSTVENTION – STATISTICS ON SUICIDE AND SELF-HARM, AND THE 3DHB ACTION PLAN UPDATE

The Director Planning Performance and Strategy Presented

The Boards noted:

(a) The release of the 2020/2021 national annual provisional suicide statistics and the launch of an interactive web reporting tool that provides a single source of information on deaths by suicide in Aotearoa

(b) Current national and regional suspected suicides and self-harm data sourced from the web-tool, the 3DHB Suicide Notifications Database and 2DHB self-harm statistics.

(c) The National Suicide Prevention Office (SPO) now requires all District Health Boards to develop 12 month regional suicide prevention action plans that implement actions from He Tapu te Oranga o ia Tangata: Every Life Matters – Suicide Prevention Strategy 2019–2029

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(d) The 3DHB Suicide Prevention and Postvention Action Plan (presented to the 3DHB Disability Advisory Committee in July 2021) is a living document and has been revised to update the new national and 3DHB information

(e) While many other DHBs will need to develop a plan, the 3DHB are well ahead as the Action Plan has already been endorsed and is being implemented. The plan only requires refinement to ensure it aligns with current data and the focus areas outlined by the SPO.

	Moved	**Seconded**	
HVDHB	Wayne Guppy	Ken Laban	**CARRIED**
CCDHB	Roger Blakeley	Sue Kedgley	**CARRIED**

Notes:

- Noted that a very small proportion of people who die by suicide have engaged with our clinical services – which demonstrates how important it is to have points of contact in the community.
- The need for support services and our ability to provide support is high.
- The report provides very good information and demonstrates the significance of the issues.
- Impact of Covid on mental health noted
- Noted the interagency approach and involvement with other agencies such as Te Puni Kōkiri and MSD.

3.5 HUTT VALLEY MATERNITY PROGRESS UPDATE

The Director Provider Services presented and Rhondda Knox (Service group manager- Surgical Women's and Children) and Wendy Castle (interim Director Midwifery HVDHB) presented to the Boards.

The HVDHB Board noted:

(a) **A** review of the women's health service was commissioned in 2018 which identified areas of risk and made 67 recommendations for improvement in a report released in mid-2019.

(b) The Women's Health Service Clinical Governance Group are accountable for monitoring and reporting on progress against the review recommendations, and report through to the Clinical Governance Board and Chief Executive.

(c) All recommendations from the 2018 women's health service review have been implemented or are in progress.

(d) A $1.9 million plus investment made by the DHB has supported enhanced leadership, safer clinical practice and a greater focus on quality.

(e) The $9.53 million maternity facility redevelopment at Hutt Hospital is on track to be completed in October 2023.

(f) Optimising birth and reducing caesarean sections is a current area of focus with analysis of a retrospective clinical audit and project information to be released in December 2021.

(g) Maternity is a highly regulated and monitored sector and based on this we can assure safe clinical practice standards.

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Powerpoint Board presentation - Optir

	Moved	Seconded	
HVDHB	Ken Laban	Josh Briggs	**CARRIED**

Notes:

- Not seeing an impact from the closure of the Te Awakairangi Birthing Centre on numbers and capacity at Hutt Hospital as only 1 birth at the Birthing Centre every 3 days. This is also seen in the context of declining births at Hutt (and numbers are forecast to decrease from around 1500 to 1250)
- Discussion on the number of LMCs and whether there will be an impact of Covid on the number of LMCs.
- Noted that significant work is yet to be done to improve the facilities at Hut Valley.
- Some members expressed concern that at the current time the only choice is between the hospital or a home birth, and that the hospital in effect does not operate as a primary space. Further concerns that it will be 2 years before the current issues are addressed. The members raising the issue want to assure consumers that they can have a primary birth if they wish.
- The C-section rate at Hutt is an outlier, and is not acceptable, and the approach that we are taking is designed to reduce it in a sustainable way. Robust data is needed, that looks at our whole community. 3-6 months of data is required under the approach before seeking opportunities to influence and change.
- Explanation for the CCDHB C-section figures and that they are consistent with the Tertiary services provided at Wellington Regional Hospital (e.g. complexity of care required).
- The HVDHB Maternity Project is being monitored by MCPAC, however the difficult contracting environment has added time to the approach.

ACTION

- Staff to report back on provision for primary birthing (as part of the report to HSC and the Boards on 24 November 2021 and March 2022).

4 OTHER

4.1 GENERAL BUSINESS

Nil.

4.2 RESOLUTION TO EXCLUDE THE PUBLIC

	Moved	Seconded	
HVDHB	Ken Laban	Prue Lamason	**CARRIED**
CCDHB	Roger Blakeley	Kathryn Adam	**CARRIED**

5 NEXT MEETING

Date: 1 December 2021, **Location:** Level 11 Boardroom Grace Neill Block, Wellington Regional Hospital **Time:** 9am

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

DATED this day of 2021

David Smol
BOARD CHAIR

MATTERS ARISING LOG AS AT 1 DECEMBER 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 oral update at 7 July 2021 Board meeting at item 6.3 of the minutes.
21-P09	3-Nov-21	Director Strategy Planning and Performance. Director Provider Services	In progress		Board - Public	3.5	Hutt Valley Maternity Progress Update	Staff to report back on provision for Primary Birthing (as part of the reports to HSC and the Boards in November 2021 and March 2022).	Refer implementation plan for the 2DHB Maternity and Neonatal System Plan on work programme (March 2022).

Chief Executive's Report

Prepared by: Fionnagh Dougan, Chief Executive

1 Introduction

This report covers the period from 22 October to 17 November 2021.

2 COVID-19 Update

2.1 Current cases (as at 22/11/2021)

	2DHB	HVDHB	CCDHB
Number of active cases	1	0	1
Number of recovered cases	135	24	111
Number of cases deceased	2	0	2
Total number of cases	138	24	114

2.2 Testing – total tests and people served (from 18/08/2021 to end 22/11/2021)

	2DHB			HVDHB			CCDHB		
	Māori	Pacific	Other	Māori	Pacific	Other	Māori	Pacific	Other
Total tests processed	9,762	6,345	60,029	2,624	1,468	11,692	7,138	4,877	48,337
Total people tested	8,232	5,298	51,203	2,389	1,330	10,815	5,886	3,986	40,548

2.3 Testing – 2DHB people served (from 18/08/2021 to end 22/11/2021)

	2DHB			HVDHB			CCDHB		
	Māori	Pacific	Other	Māori	Pacific	Other	Māori	Pacific	Other
Est. domiciled population tested	11%	14%	12%	8%	10%	9%	13%	16%	13%

2.4 Vaccination –2DHB providers delivery (from 22/02/2021 to end 21/11/2021)

	2DHB	HVDHB	CCDHB
Total doses administered	722,998	219,672	503,308
Total people served	380,726	119,261	268,916

2.5 Vaccination – 2DHB people coverage (from 22/02/2021 to end 21/11/2021)

	2DHB		HVDHB		CCDHB	
	1st Dose Coverage	Completed Course Coverage	1st Dose Coverage	Completed Course Coverage	1st Dose Coverage	Completed Course Coverage
Māori	84%	71%	81%	67%	86%	74%
Pacific	86%	75%	86%	76%	87%	75%
65+	97%	95%	97%	94%	97%	95%
Other	95%	90%	94%	88%	96%	91%
Total	93%	87%	91%	84%	94%	88%

2.6 Vaccination coverage of DHB workforce (from 22/02/2021 to end 21/11/2021)

	CCDHB	HVDHB
1st Dose	97%	97%
Complete course	94%	94%

3 Communications and Engagement

3.1 External engagement with partners and stakeholders

The main focus has been on ongoing engagement with community organisations and partners on the vaccination campaign, particularly as we endeavour to vaccinate harder to reach groups. We have also commenced engagement with primary health, community partners, councils, WREMO, and government agencies around our plans to manage COVID-19 in the community using the Ministry of Health's national framework.

3.2 External communications and engagement – press releases and pitches

DHB	Subject	Outlet / Channel
2DHB	Travel action plan and car parking	PR / Social media
2DHB	update on development of the 2DHB Maternal and Neonatal System Strategy.	Web article / social media

p

3.3 Health promotion campaigns

COVID-19 vaccination programme

As at 15 November, the 2DHBs have now reached significant milestones with 92% of people in the greater Wellington region having received at least their first dose of the vaccine, and at least 85% of people fully vaccinated.

Wellington City has achieved the milestone of 90% fully vaccinated against COVID-19. This has been a group effort and is a testament to the hard work from Tū Ora Compass Health, the local pharmacy network and community providers along with many vaccinating general practices.

We know there is a lot more work to do. Our measure of success is getting at least 90% of our Māori and Pacific people vaccinated as well, and we continue to focus on achieving that.

With the goal of reaching 90% fully vaccinated in our region, we are focused on providing information to those who have questions and offering a variety of vaccination options including mobile clinics, and pop up events including an all-nighter event tailored to shift workers.

There are around 60 clinics operating in the Wellington region - a mix of GP, Pharmacy, community vaccination centres, and outreach/pop up sites.

We are now focusing on areas with higher numbers of people who are unvaccinated, taking both the vaccine and vaccinators to where people live and work to make it easier for them to be vaccinated and to answer their questions.

Supporting our equity populations

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. As at 15 November 2021, at least 81% of Māori in the greater Wellington region have received their first dose, while 67% are fully vaccinated.

Māori health partners and providers continue to operate community clinics across the region and are mobile initiatives to target specific communities with large numbers of unvaccinated people. They are also running a series of hui focused on sharing accurate and persuasive information about COVID-19 and the vaccine.

The Pacific Health team working alongside Pacific providers and PHOs are focusing on reaching young people. The first Tongan community event was held on Saturday 13 November at the Lower Hutt Vaccination Centre, while the DoIt4DaEast Vaccination Festival is rescheduled for Saturday 20 November in Porirua. As at 15 November, 84 per cent of Pacific people in our region have received at least one dose of the vaccine and 72 per cent are fully vaccinated.

Following a successful Halloween event for the Rainbow Community on Saturday 30 October in Lower Hutt, further events are scheduled for 21 November in Paekakariki and 27 November in Lower Hutt. We continue to receive positive feedback about the pronoun cards which help to help foster more comfortable conversations when confirming their identity and working with organisations that are trusted within their communities.

Information sessions encourage kōrero for Māori

Many people want to kōrero about the COVID-19 vaccine in a safe environment where they can ask questions of clinical experts. Information session evenings held in Wainuiomata and Waiwhetū, Lower Hutt, were tailored for key influencers from whānau, who have expressed hesitancy or had questions of a clinical nature.

Del Carlini, Māori Equity Lead Programme Manager – COVID-19 Response, says initial feedback has been positive and we are now working with PHOs and sports clubs to run further information sessions.

"*Our most effective line of questioning was when we had the Malaghan scientist reveal that she had had COVID herself so she was able to describe what that was like and the long ongoing impacts. It was a compelling story. We know that some people who attended the information sessions are now vaccinated and in one case, they have become vocally supportive of vaccination. We just need to do a lot more of these sessions. The information given out is one part of the process, more important is giving people an opportunity to ask questions face to face and to test their thinking. Often their questions are about specific health conditions and the vaccine*," says Del Carlini.

Rugby league clubs also requested support. An information session was held on Thursday 28 October for rugby league players and whānau in Waitangirua, and more sessions at sports clubs are planned.

Recognition for accessibility leadership

In recognition of our 2DHB leadership in improving accessibility in health care for disabled people, Prime minister, Jacinda Adern visited our Lower Hutt Vaccination Centre, a "Super Accessible" site.

The Disability Equity team and PHOs have worked closely together since the start of the 2DHB Covid-19 vaccination programme to lead the way in ensuring our COVID-19 vaccination sites and processes are as accessible as possible for everyone.

This includes staff training, building audits and resource packs including communication cards for Deaf and hard of hearing people, Easy Read information, sensory tools and NZSL signage.

Feedback from the disability community has shown that accessible and low sensory events have encouraged many people who would otherwise not have been vaccinated to do so. Four disability events are planned to the end of November.

Harnessing data for vaccination success

The reasons people are not yet vaccinated are many and varied, and often very personal. Taking the vaccine, and the conversation about vaccination, to places where people live and work is key to addressing some of these challenges, and accurate data plays a crucial role in supporting this.

With support from Capital & Coast and Hutt Valley DHBs, Māori and Pacific providers and PHOs have access to a variety of data that is regularly updated. This includes heat maps that identify groups of streets with higher numbers of unvaccinated people and numbers of unvaccinated people in particular suburbs.

The locations that the Hutt Valley's Delta Buster visits each week, for example, are based on this data. It is also used for targeted text blasts promoting individual events as it enables us to send the messaging to people in specific suburbs and age groups, people who are eligible for their second dose or are unvaccinated.

By youth for youth

As part of our youth campaign and countdown to summer, we are providing COVID-19 vaccine information sessions and events across the region tailored to young people. The aim is to create some urgency with summer coming up and counting down to festivals and summer activities.

We are reaching out to young people via social media, youth organisations and through information sessions at schools or sports clubs, where people can kōrero about the COVID-19 vaccine and have their questions answered.

"I found the educational information easy to understand and it was more related to me. I could easily ask questions and I found the session very helpful. I was originally unsure but this information helped me to decide to get my vaccine."

In some schools, we are working closely with school nurses and the Board of Trustees to provide information sessions and vaccination clinics. Around 80 students were recently vaccinated at Mana College.

RPH Activity update

RPH created videos and content on youth Pacific vaccination and Maori vaccination

- Interview with Pacific youth – Ezra and Bella
- Interview with kaumatua from Maraeroa Marae – Koro Waata and Kui Diane
- RPH supported a community run LGBTQI+ Halloween vaccination event at the Hutt vaccation centre

Super Saturday

RPH staff and friends were out in force on Super Saturday to tautoko Super Saturday events.

RPH Health promotion staff – Sisi Tuala-Le'afa, Ateliana Amato; engaged with the community alongside board members Ken Laban, Roger Blakeley; former All Black Piri Weepu and our RPH public health advocates – the Wainuiomata Kotiro under-14 league team.

COVID Posts for Porirua and Wairarapa

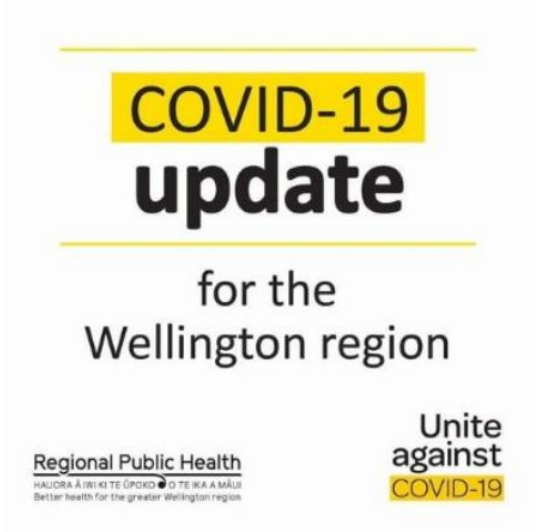
Posts on locations of interest and testing information cases in our RPH region which includes Wairarapa are seeing high levels of engagement. With shares across WREMO and local council channels. Across four of these posts reach has been over 80,000 people along with 10,000 active post engagements and over 200 shares. Partner agencies such as WREMO and local councils have helped with sharing these posts to get greater reach.

Key messaging covered:

- New cases in Wairarapa

- Updates to locations of interest in Wairarapa
- Encouragement for people who attended a specific tangi at Whenua Tapu Cemetery, Porirua, to get tested for COVID
- Testing locations
- Vaccination locations

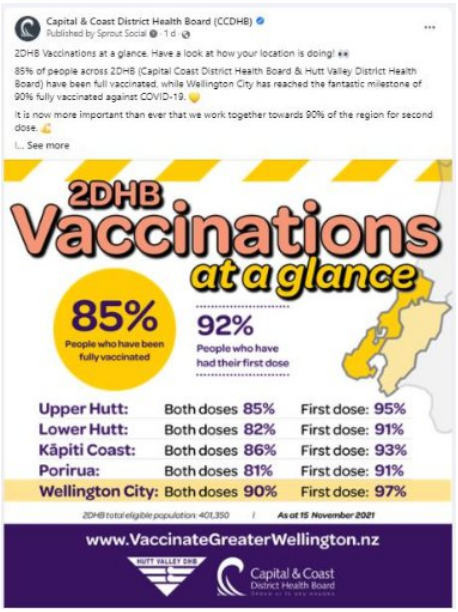
3.4 Social media views and stories




Regional Public Health
Published by Sprout Social · 26 October at 13:54 ·
"Get your vaaacccinnneeeeee on Haaaaallloowweeeeeeen!"
Dress-up in your best scary Halloween get-up and get vaccinated at our Halloween vaccination event on Saturday! Come along for an afternoon and evening of frighteningly great entertainment, spooky spot prizes and treats!
Youth (12+): 11am - 3pm. Adults (20+): 5.30pm - 8.30.
Get your vaccine on
HALLOWEEN
LGBTQIA+ friendly event
First dose: Saturday 30 October
Second dose: Saturday 27 November
218 High Street, Lower Hutt
Youth (12+): 11am – 3pm
Adults (20+): 5.30pm – 8.30pm
Book an appointment or just drop in!
Transport available, call 0800 829 935
Entertainment // Spot prizes // Health promotion // Food


Regional Public Health is with Ngaire Va'a and 16 others.
Published by Sprout Social · 18 October at 20:49 ·
Kia ora e te whānau– what a weekend! Huge shout-out to Kokiri Marae Health & Social Services. for organising the launch and blessing of the Delta BUSter! If you haven't been vaccinated yet – keep an eye out on Kokiri's page for the Delta BUSter locations – as it makes its way to a spot near you soon!
Overall Super Saturday saw over 130,000 vaccinations delivered across Aotearoa.
Sisi and Ateliana from our RPH team were joined by our health ambassadors – Nga Hau E Wha O ... See more
+3
1,578
People reached
131
Engagements
Boost post

3.2.1 Top social media posts



CCDHB impressions	HVDHB impressions	RPH impressions
Facebook: 632,317 Twitter: 154,653 LinkedIn: 11,739	Facebook: 86,822 Hutt Maternity Facebook: 1,612 Twitter: 13,565 Instagram: 738 LinkedIn: 17,644	Facebook: 108,749

3.3 Website page views and stories

CCDHB	HVDHB	RPH	MHAIDS
page views 81,000	page views 19,000	page views 21,000	page views 7,100

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

Top five webpages CCDHB

1. Disability and deaf vaccination exemption cards
2. Working with us
3. COVID-19 community based assessment centres
4. COVID-19 changes to our services
5. After hours and emergency care

Top five webpages HVDHB

1. COVID-19 community based assessment centres
2. Working with us
3. COVID-19 information for visitors
4. Contact us
5. Hutt hospital campus map

Top five webpages RPH

1. Getting vaccinated in the Wellington region
2. COVID-19 FAQs
3. Vaccinate Greater Wellington latest updates
4. Vaccinate Greater Wellington pop-up events
5. Vaccinate Greater Wellington vaccine rollout plan

Top five webpages MHAIDS

1. Te Haika phone – does someone you know need help?
2. Child and adolescent mental health services
3. Adult mental health services
4. Contact our services
5. Central Region Eating Disorder Services (CREDS)

Website stories and releases

Transport and Parking at Wellington Regional Hospital

A multi-million dollar investment is set to make it easier and more encouraging for staff, patients, visitors, and others to make more sustainable choices about how they get to and from Wellington Regional Hospital.

Over the next 10 years Capital & Coast DHB will invest $3.3 million to improve access for people walking or cycling to Wellington Regional Hospital, including new end of trip facilities for staff – such as bike storage, lockers, showers and changing rooms – a carpooling app for staff, improvements to the Kenepuru Community Hospital shuttle, and personalised travel planning support.

“We know that staff, patients, and visitors currently face challenges around accessing our hospitals for work or to receive care,” said chief financial officer Mathew Parr.

“Among these challenges is transport – people who drive currently struggle to find onsite car parks, while some may not have access to a vehicle at all. Investing in improvements that provide safe and easy access to our hospital for our staff and communities is a vital part of being able to care for patients and help ensure the health and wellbeing of our region’s whānau and communities.”

The work to improve accessibility is part of the Wellington Regional Hospital Travel Action Plan – a $7.5 million collaboration between Greater Wellington Regional Council (GWRC), Waka Kotahi, Wellington City Council (WCC), and CCDHB.

Positive progress on 2DHB Maternal and Neonatal System Strategy

We are pleased to provide an update on the development of the 2DHB Maternal and Neonatal System Strategy and action plan for our region, ahead of Board review in December and its rollout from 2022.

He aha te mea nui o te ao? He tāngata, he tāngata, he tāngata.

What is the most important thing in the world? It is the people, it is the people, it is the people.

This strategy seeks to deliver a whole-of-system approach to improving maternal and neonatal care for all families in our region, with a pro-equity focus on actions to improve outcomes for Māori and Pacific whānau & families, and disabled women and babies with impairments.

Across our rohe (2DHB) a significant amount of work and engagement has taken place to review our maternal health service, with a particular focus on service delivery for maternity and neonatal care that will support mothers, families and babies in their first 1,000 days. Over 5,000 babies were born in 2020 across our region and we know that the first 1000 days of a child's life are the most crucial for their development.

As we work towards a future system, we remain focused on providing excellent care to mothers, babies and whānau as well as enhancements to our current services, including our Hutt Maternity redevelopment programme.

CCDM at the 2DHBs in our region reach key milestone

Ceremonies were recently held celebrating our DHBs being assessed as having fully implemented the Care Capacity Demand Management (CCDM) programme with an overall percentage of 93% at CCDHB and 97% at HVDHB.

The CCDM programme is a set of tools and processes that help DHBs better match the capacity to care with patient demand. Getting the balance right between patient demand and staff capacity means DHBs can improve the quality of care for patients, the staff working environment, and use health resources in the best possible way. Full implementation relates to all the tools and processes having been implemented.

The tools help us identify the nursing and midwifery FTE required to meet demand, monitor aspects of safe staffing through the core data set and enable variance response management reporting.

The celebrations at each DHB were held with Chris Kerr (Chief Nursing Officer, Hutt Valley and Capital & Coast DHBs), our CCDM teams, SSHW and a few other key invited people. Certificates were presented by Bridget Smith (Director of the Safe Staffing Healthy Workplace Unit at TAS) at our COVID-19 safe ceremonies.

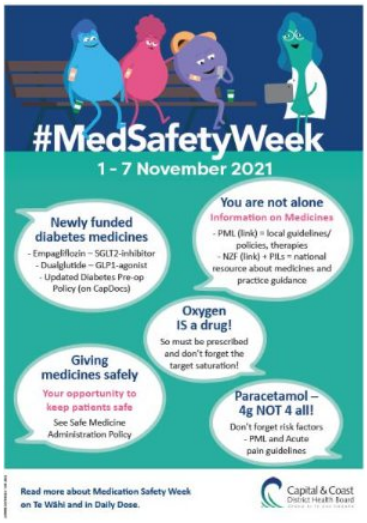
3.4 Internal Engagement and Communication

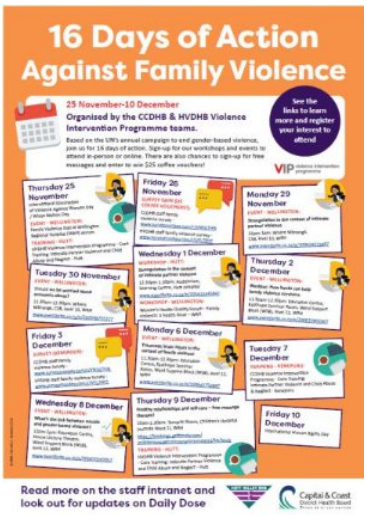
3.4.1 Intranet page views and stories

CCDHB	HVDHB
page views 224,623	page views 154,310

3.4.2 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.





3.4.3 Top intranet stories

Nine Maternity Support Workers join Hutt Maternity whānau

We are delighted to welcome nine Maternity Support Workers (MSWs) to the Hutt Maternity whānau today.

This is a significant milestone for the service and is an integral part of future workforce planning.

These roles are current student midwives and join us as support workers to provide invaluable support for our new mothers, parents, pēpē and their whānau.

“Our new maternity support workers will provide important care for our women and parents at Hutt Maternity. From providing a listening ear, to parentcraft support, their role supports the delivery of care on our wards and supports the students’ journey towards a rewarding career in midwifery,” says Clinical Midwife Manager Elaine Newman.

“This programme is a great way to support our student midwives through their studies, enabling them to learn new skills while supporting our current workforce”.

The MSWs are employed by Hutt Valley DHB and work alongside our midwives, nurses, medical staff, HCAs, administrators and LMCs.

CCDHB registrar awarded funding for research

New Zealand's most promising emerging researchers have been awarded $11.3 million to undertake high-quality research and develop the skills to address current and future health challenges.

Associate research, science and innovation minister, Hon Dr Ayesha Verrall, today announced the results of the Health Research Council of New Zealand's annual Career Development Awards.

This year's funded researchers and projects include Dr Alice Rogan, emergency medicine registrar at Wellington Regional Hospital and research fellow at the University of Otago (Wellington), who has been awarded a Clinical Research Training Fellowship to investigate the use of blood biomarkers to improve the clinical pathways for patients who present to ED with traumatic brain injuries (TBI).

Traumatic brain injuries can span from mild (concussion) to severe (brain bleeding or swelling), and doctors must decide who is at risk of more severe injuries and warrants a CT head scan. This can be difficult, particularly in people with severe concussion or intoxication. Demand for CT head scans is also increasing due to an increasing population, says Dr Rogan. This can lead to patients waiting longer for results or facing treatment delays which can lead to poorer patient outcomes.

This project proposes that blood biomarkers could be used as a screening tool to exclude more severe injuries and support doctor's decision-making. This could reduce the rates of head scans performed, improve quality of care, and reduce a patient's length of stay in ED.

Dr Rogan says certain blood biomarkers are being used in a few hospitals in Europe, but there isn't evidence to support their wider use in Emergency Departments internationally, particularly in New Zealand where we have a different healthcare model and different clinical pathways. New Zealand also has significant population differences compared to countries that have so far tested these biomarkers. "We're looking to see if these blood proteins have a beneficial health impact for Kiwis as a rule-out test in TBI, so that people without severe injuries can be quickly identified as not requiring a CT scan. If found to be reliable, the impact for future clinical practice is expansive."

2DHB BOARD WORK PLAN 2021/2022 – 1 December 2021

	Wed 16 Feb 2022	Wed 30 Mar 2022	Fri 13 May 2022	Wed 22 Jun 2022
	Hutt Hospital	WLG Hospital	Hutt Hospital	WLG Hospital
Service Spotlight	**Community Dental Service**	**Anaesthesia**	**Rheumatology**	**Cardiology**
Quality and Safety/Health and Safety				
2DHB Quality and Safety	2DHB Quality and Safety (and selected focus area)	2DHB Quality and Safety Report	2DHB Quality and Safety Report	2DHB Quality and Safety Report (and selected focus area)
MHAIDS Quality and Safety	MHAIDS Quality and Safety Report	MHAIDS Quality and Safety Report	MHAIDS Quality and Safety Report	MHAIDS Quality and Safety Report
2DHB Health and Safety	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 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 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 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
3DHB Digital Report	Q2 Report		Q3 Report	
Māori Strategy (Te Pae Amorangi and Taurite Ora)	Q2 Report		Q3 Report	
Pacific Health and Wellbeing Strategic Plan	Q2 Report and selected focus area (To be advised)		Q3 Report and selected focus area (To be advised)	
Strategic Priorities				
Pro-Equity				
Strategic Priorities Overview	Reporting on implementation and engagement on next steps. *The papers marked * are on the HSC work plan – and will be reported to the Boards via HSC or DSAC.*			
Our Hospitals				Our Hospitals and the 2DHB Hospital Network (incl. Master Site Plan)
Commissioning and Community		*Commissioning and Community (Locality / Placed-Based Healthcare) – incl. Investment Cases *Implementation plan for aged care.		
Mental Health and Addiction Services		*Mental Health and Addictions Commissioning (incl. Kaupapa Māori Services).		
Maternity & Women's Health		*Implementation Plan for the 2DHB Maternal and Neonatal Health System Plan		
Enablers				

	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 03/03/22	FRAC items for Board Approval from meeting dated 27/04/22	FRAC items for Board Approval from meeting dated 01/06/22
MCPAC update		MCPAC update and items for approval from meeting dated 3/03/2022	MCPAC update and items for approval from meeting dated 27/04/2022	MCPAC items for Board Approval from meeting dated 01/06/22
HSC update and items for Board Approval		HSC update and items for approval from meeting dated 16/03/22		
DSAC update and items for Board Approval		DSAC items for Board Approval from meeting dated 16/03/22		
Engagement				
Te Upoko o te Ika Māori Council (TUI MC)		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			
Annual Report	N/A			
Other items				
Environmental Sustainability Strategy		Sustainability Strategy update		
Procedural and Board process issues	Ratification of any decisions made under summer delegation			
Action log items				
Other				
Workshops/Training/Site Visit at conclusion of Board meeting (where time allows)				
Site Visit				

Board Information – Public

1 December 2021

HVDHB Financial and Operational Performance Report – September 2021

Action Required

The Boards note:

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

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

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

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

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 DHB
Contributors	Finance Team, Health Intelligence and Decision Support, 2DHB Hospital Services.

Executive Summary

1. The COVID-19 response costs for the 21/22 financial year are expected to be fully funded by the Ministry of Health, revenue has been accrued to cover the costs reported to the Ministry. The net impact to September is additional revenue of $0.2m in relation to Regional Public health.
2. The Ministry have confirmed that holidays Act remediation costs and costs to calculate the remediation and rectify the systems will be funded via additional deficit support not operating income. The remediation costs have been included in the 2021/22 expenditure budget but no revenue has been budgeted.
3. Excluding the net COVID-19 costs the DHB's result for the three months to 31 September 2021 is a ($4.8m) deficit, versus a budget deficit of ($7.9m).
   3.1. For the three months to 30 September 2021 the overall DHB result, including COVID-19 and Holidays Act costs is a ($4.6m) deficit compared to a budget deficit of ($7.9m). This includes a reduction in community pharmaceuticals costs.
4. Key underspends in the provider include; Allied Health personnel, outsourced services and depreciation. In the funder underspends in demand driven costs including; Community Pharmaceuticals, Other Health of Older People (Other HoP) and other external provider payments.

5. Agreed budget changes of $14m will be adjusted in the October results. The budget changes impact the funder by $13m reducing community pharmaceuticals and IDF outflow. The provider arm will be reduced by $1m for anticipated reduction in depreciation for the current year.
6. Capital Expenditure to 31 September was $1.9m with $37.4m remaining including projects that were delayed and funding which has been transferred into this financial year.
7. The DHB has a positive cash balance at month-end of $18.8 million which is better than budget due to delayed capital spend. We are expecting an equity injection for capital in relation to two capital projects approved for MoH funding (Maternity upgrade projects and the procedure suit). The equity injections are expected in 2021/22 and 2022/23 to line up with forecast expenditure.

Hospital:

8. The impact of COVID-19 lockdown was felt across all specialties and services with a total of 1719 cancellations across planned care, inpatient, outpatient, radiology, and endoscopy in particular. This is on top of underlying disruptions created by acute demand, RSV outbreaks, and industrial action.
9. Last month we highlighted the service delivery and financial risk that in the constrained environment the DHBs will not be able to deliver the full planned care funding schedule nor reduce waiting list size so that people are treated within 120 days; this is now a given. To mitigate the impacts both DHBs are maximising utilisation of current theatre and bed capacity as well as private hospital outsourcing capacity. Investment in innovation will help to provide alternative solutions for people to access and reduce the number of people requiring treatment, these will take time to implement. SMOs continue to lead planning surgery based on those with greatest clinical urgency and long waiting times.
10. Work continues with the Front of Whare, 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) – in respect of the former, this work is supported by expertise from the MOH and is inextricably linked to other ongoing work to assess and address overall hospital capacity.
11. With the closure of Te Awakairangi Birthing Centre and upcoming Xmas period plans have been developed for managing the impact of increased births between October to February. A paper is in development for the next board meeting outlining the quality improvements undertaken over the past two years since the external review
12. Ongoing and intractable workforce shortages across midwifery and nursing, allied health in particular sonographer social work and radiographers which remain 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.
13. A cautious start at the end of the first quarter– meeting budget.

Funder

14. In this report we have highlighted key areas of performance with a focus on our core services and achieving equity. We have developed and implemented initiatives with Māori and community providers but they are stymied by a lack of scaled investment to support all of those who need these response to have a significant impact:

15. HVDHB is progressing a range of initiatives that provide more choice and options for young people to engage in primary care. Vibe continues to reach young people in need of youth appropriate access to primary care services. The four YOSS providers across the 2DHBs were successful in a Youth Mental Health RFP for 12-18 year olds.

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

17. 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 also implementing a mental health model of care in ED, and enhancing the support to mental health and addiction patients who present to ED.

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 64 below plan year to date.
Financial	Planned deficit for HVDHB is $30.8 million with no COVID-19 impacts included. The Planned deficit will be updated for October reporting and reduced to $16.8 million as approved by the Board.
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

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

Monthly Financial and Operational Performance Report

For period ending
30 September 2021

Contents

Section 1

Financial and Performance Overview and Executive Summary

Executive Summary

- The COVID-19 response costs for the 21/22 financial year are expected to be fully funded by the Ministry of Health, revenue has been accrued to cover the costs reported to the Ministry. The net impact to September is additional revenue of $0.2m in relation to Regional Public health.
- The Ministry have confirmed that holidays Act remediation costs and costs to calculate the remediation and rectify the systems will be funded via additional deficit support not operating income. The remediation costs have been included in the 2021/22 expenditure budget but no revenue has been budgeted.
- Excluding the net COVID-19 costs the DHB's result for the three months to 31 September 2021 is a ($4.8m) deficit, versus a budget deficit of ($7.9m).
  - For the three months to 30 September 2021 the overall DHB result, including COVID-19 and Holidays Act costs is a ($4.6m) deficit compared to a budget deficit of ($7.9m). This includes a reduction in community pharmaceuticals costs.
- Key underspends in the provider include; Allied Health personnel, outsourced services and depreciation. In the funder underspends in demand driven costs including; Community Pharmaceuticals, Other Health of Older People (Other HoP) and other external provider payments.
- Agreed budget changes of $14m will be adjusted in the October results. The budget changes impact The funder by $13m reducing community pharmaceuticals and IDF outflow. The provider arm will be reduced by $1m for anticipated reduction in depreciation for the current year.
- Capital Expenditure to 31 September was $1.9m with $37.4m remaining including projects that were delayed and funding which has been transferred into this financial year.
- The DHB has a positive cash balance at month-end of $18.8 million which is better than budget due to delayed capital spend. We are expecting an equity injection for capital in relation to two capital projects approved for MoH funding (Maternity upgrade projects and the procedure suit). The equity injections are expected in 2021/22 and 2022/23 to line up with forecast expenditure.

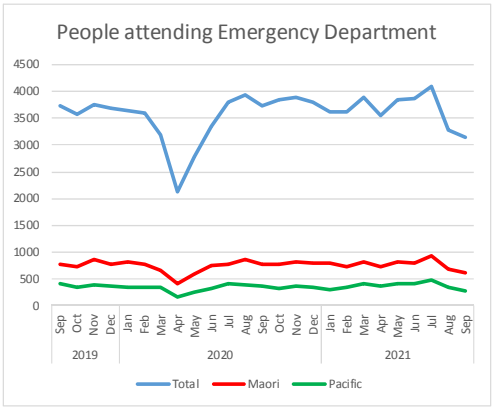
Executive Summary (continued)

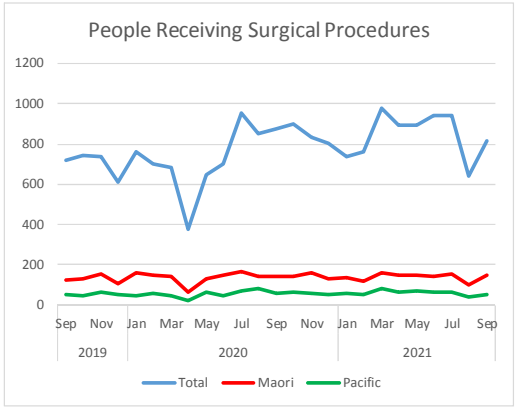
- **Hospital:** The impact of COVID-19 lockdown was felt across all specialities and services with a total of 1719 cancellations across planned care, inpatient, outpatient, radiology, and endoscopy in particular. This is on top of underlying disruptions created by acute demand, RSV outbreaks, and industrial action.
- Last month we highlighted the service delivery and financial risk that in the constrained environment the DHBs will not be able to deliver the full planned care funding schedule nor reduce waiting list size so that people are treated within 120 days; this is now a given. To mitigate the impacts both DHBs are maximising utilisation of current theatre and bed capacity as well as private hospital outsourcing capacity. Investment in innovation will help to provide alternative solutions for people to access and reduce the number of people requiring treatment, these will take time to implement. SMOs continue to lead planning surgery based on those with greatest clinical urgency and long waiting times.
- Work continues with the Front of Whare, 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) – in respect of the former, this work is supported by expertise from the MOH and is inextricably linked to other ongoing work to assess and address overall hospital capacity.
- With the closure of Te Awakairangi Birthing Centre and upcoming Xmas period plans have been developed for managing the impact of increased births between October to February. A paper is in development for the next board meeting outlining the quality improvements undertaken over the past two years since the external review
- Ongoing and intractable workforce shortages across midwifery and nursing, allied health in particular sonographer social work and radiographers which remain 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.
- A cautious start at the end of the first quarter– meeting budget.
- **Funder:** In this report we have highlighted key areas of performance with a focus on our core services and achieving equity. We have developed and implemented initiatives with Māori and community providers but they are stymied by a lack of scaled investment to support all of those who need these response to have a significant impact:
- HVDHB is progressing a range of initiatives that provide more choice and options for young people to engage in primary care. Vibe continues to reach young people in need of youth appropriate access to primary care services. The four YOSS providers across the 2DHBs were successful in a Youth Mental Health RFP for 12-18 year olds.
- Our main lever to reduce demand is to invest in community services to support frail elderly at home for longer. Investment in a whole of system approach to managing frailty will assist older people to live longer in independence. This will also support improved coordination of services across the region. Hutt Hospital ED has introduced an electronic screening tool to identify frail patients early and provide them with appropriate care and support, including activities to reduce deconditioning (loss in muscle strength).
- 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 also implementing a mental health model of care in ED, and enhancing the support to mental health and addiction patients who present to ED.

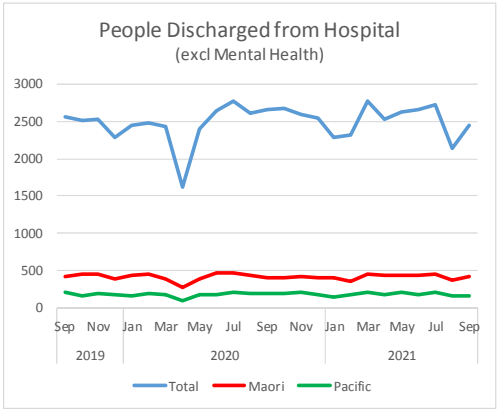
Performance Overview: Activity Context (People Served)

The numbers below count individuals once and are based on Hutt Valley DHB being the DHB of Service. The start of the August was busy but was impacted by the Covid-19 Level 4 lockdown from 18th August. Note Mental Health now reported by CCDHB as they are the DHB of service for MHAIDS

People attending ED	**3,145**	624 Maori, 272 Pacific
People receiving Surgical Procedures	**818**	150 Maori, 52 Pacific
People discharged from Hospital (excl Mental Health)	**2,444**	413 Maori, 152 Pacific







Performance Overview: Activity Context (People Served)

People seen in Outpatient & Community

9,162

1,399 Maori, 651 Pacific

Primary Care Contacts

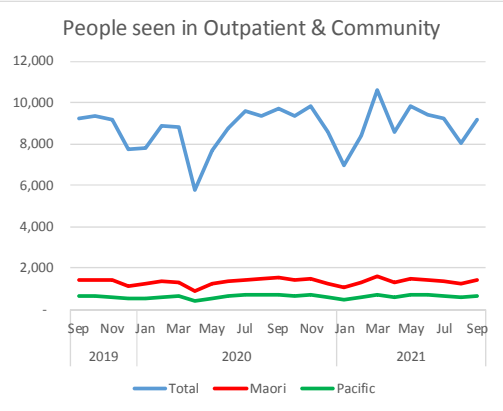
34,774

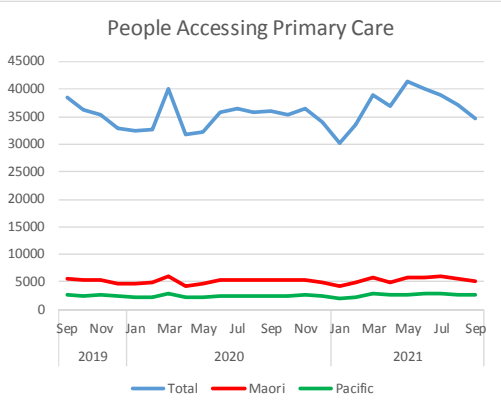
5,178 Maori, 2,637 Pacific

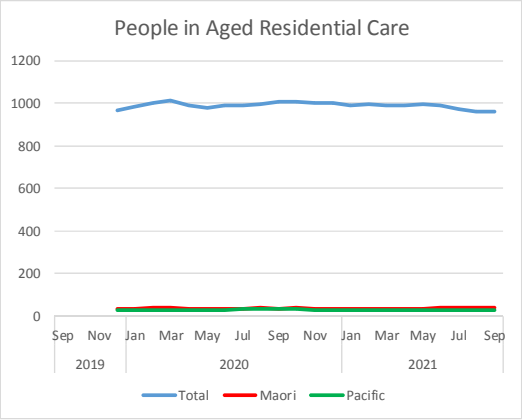
People in Aged Residential Care

959

38 Maori, 28 Pacific







Financial Overview – September 2021

YTD Operating Position	YTD Provider Position	YTD Funder Position	YTD Capital Exp
$4.6m deficit	$0.1m deficit	$4.8m deficit	$1.9m
Against the budgeted deficit of $8.0m.	Against the budget deficit of $1.0m.	Against the budget deficit of $7.0m.	Compared to a maximum budgeted spend of $36.1m

YTD Activity vs Plan (CWDs)	YTD Paid FTE	Annual Leave Accrual
On target	1,837	$22.3m
2 CWDs over PVS plan at end of Sept. IDFs were 100 CWD below budget at the end of the month	YTD 86 FTE below annual budget of 1,924 FTE.	This is an decrease of $0.1m on prior period.

Hospital Performance Overview – September 2021

YTD Shorter stays in ED	People waiting >120 days for treatment (ESPI5)	People waiting >120 days for 1st Specialist Assmt (ESPI2)	Faster Cancer Treatment
82%	1,118	821	87%
13% below the ED target of 95%, and below September 20 87%.	Against a target of zero long waits a monthly increase of 97.	Against a target of zero long waits a monthly increase of 104	We were below the 62 day target this month. The 31 day target was achieved at 89%

YTD Activity vs Plan (CWD)	YTD Standard FTE	Serious Safety Events
On target	1,844	1
2 CWDs over PVS plan at end of Sept. IDFs were 100 CWD below budget at the end of the month	71 below YTD budget of 1,915 FTE. Month FTE was 85 under budget an downwards movement from August of 10 FTE.	An expectation is for nil SSEs at any point.

Section 2

FUNDER PERFORMANCE

Executive Summary – Funder

- Overall the funder has a favourable variance of $1.3m for the month, which includes reduced community pharmaceuticals in line with the proposed budget change and prior year spend.
- Aged residential care costs and Other Health of Older People costs are unfavourable ($65k) for the month it is anticipated these costs may continue to rise during the year and put pressure on the total budget.
- Mental Health costs are favourable $52k for the month reflecting timing of contracts which will be rectified with the acute care continuum investments come on stream.
- In this report we have also highlighted key areas of performance with a focus on our core services and achieving equity. It is recognised that these highlight significant need for improved service delivery and a pro-equity commissioning approach. We have developed and implemented initiatives with Māori and community providers but they are stymied by a lack of scaled investment to support all of those who need these response to have a significant impact:
  - HVDHB is progressing a range of initiatives that provide more choice and options for young people to engage in primary care. Vibe continues to reach young people in need of youth appropriate access to primary care services. The four YOSS providers across the 2DHBs were successful in a Youth Mental Health RFP for 12-18 year olds.
  - Our main lever to reduce demand is to invest in community services to support frail elderly at home for longer. Investment in a whole of system approach to managing frailty will assist older people to live longer in independence. This will also support improved coordination of services across the region. Hutt Hospital ED has introduced an electronic screening tool to identify frail patients early and provide them with appropriate care and support, including activities to reduce deconditioning (loss in muscle strength).
  - 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 also 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 – September 2021

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

Month					$000s	Year to Date					Annual				
Actual	Budget	Variance	Last Year	Variance		Actual	Budget	Variance	Last Year	Variance	Forecast	Budget	Variance	Last Year	Variance
					Revenue										
39,259	39,837	(578)	37,970	1,289	Base Funding	118,922	119,510	(587)	113,909	5,013	477,408	478,038	(630)	455,083	22,326
2,901	2,411	490	2,770	131	Other MOH Revenue	8,853	7,233	1,620	8,118	735	33,170	28,932	4,238	34,030	(860)
19	26	(6)	67	(48)	Other Revenue	71	77	(6)	347	(276)	282	307	(24)	733	(450)
9,680	9,557	124	10,049	(369)	IDF Inflows	28,278	28,670	(391)	28,514	(235)	114,671	114,678	(7)	111,945	2,726
51,860	**51,830**	**30**	**50,856**	**1,004**	**Total Revenue**	**156,124**	**155,489**	**636**	**150,888**	**5,237**	**625,532**	**621,955**	**3,577**	**601,791**	**23,741**
					Expenditure										
349	349	0	416	67	DHB Governance & Administration	1,046	1,046	0	1,247	201	4,183	4,183	0	4,652	469
21,712	21,391	(321)	21,201	(511)	DHB Provider Arm	64,161	64,172	11	63,094	(1,066)	257,147	256,689	(458)	252,732	(4,414)
					External Provider Payments										
2,790	4,169	1,379	4,219	1,430	Pharmaceuticals	10,709	12,745	2,037	10,566	(143)	37,399	50,057	12,658	37,162	(237)
4,401	4,448	47	4,593	192	Laboratory	13,163	13,345	182	13,445	283	53,067	53,169	102	52,577	(491)
2,644	2,684	41	2,705	61	Capitation	8,043	8,053	10	7,944	(99)	32,204	32,214	10	31,021	(1,183)
1,196	1,219	23	1,193	(3)	ARC-Rest Home Level	3,731	3,748	17	3,680	(51)	15,084	14,858	(226)	13,871	(1,213)
1,844	1,936	92	1,634	(210)	ARC-Hospital Level	5,788	5,954	166	5,445	(342)	23,701	23,599	(102)	21,724	(1,977)
2,983	2,803	(180)	2,089	(895)	Other HoP & Pay Equity	8,381	8,409	28	7,115	(1,265)	33,607	33,635	28	30,335	(3,272)
970	1,022	52	392	(578)	Mental Health	3,004	3,066	62	2,275	(729)	12,363	12,265	(98)	11,898	(465)
2,004	1,947	(57)	1,925	(79)	Other External Provider Payments	6,511	5,936	(575)	6,575	64	27,783	24,403	(3,380)	25,067	(2,716)
11,831	11,991	160	9,798	(2,033)	IDF Outflows	36,369	35,974	(396)	27,542	(8,828)	142,894	143,894	1,000	108,813	(34,082)
52,723	**53,960**	**1,237**	**50,164**	**(2,559)**	**Total Expenditure**	**160,905**	**162,448**	**1,543**	**148,928**	**(11,977)**	**639,432**	**648,967**	**9,535**	**589,851**	**(49,580)**
(863)	**(2,131)**	**1,267**	**692**	**(1,556)**	**Net Result**	**(4,781)**	**(6,960)**	**2,179**	**1,960**	**(6,741)**	**(13,900)**	**(27,012)**	**13,112**	**11,939**	**(25,839)**

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 ($578k) to budget for the month.
- Other MoH revenue is favourable $490k for September.
- IDF inflows $124k favourable based on information available.

Other MOH Revenue Variance	MTH $000's	YTD $000's
Capitation Funding	(22)	113
2021/22 Planned Care	-	-
COVID-19 Funding	500	1,557
2020/21 Planned Care	-	55
Crown funding agreements		
B4 School Check Funding	34	(39)
Additional Immunisation funding	-	-
More Heart and diabetes checks	(5)	(16)
Additional School Based MH Services	(10)	(29)
Maternity Quality and Safety Programme	(0)	100
Rheumatic Fever Prevention Services	(137)	(236)
Midwifery Clinical Coaches and Return to Practice Pro	25	25
Pilot Alert Programme	(22)	(22)
Healthy Homes Initiative Expansion	91	91
VIP Programme Coordination in DHB's	(30)	(30)
Well Child/Tamariki Ora Services	45	45
Other CFA contracts	(67)	(52)
Year to date Variance $000's	**490**	**1,620**

Expenditure:

Governance and Administration is on target for August. Provider Arm payments variance includes IDF Inflows passed through to the Provider.

External Provider Payments:

Pharmaceutical costs are favourable $1,379k for September.

Capitation expenses are $41k favourable for the month, partially offset by changes to revenue.

Aged residential care costs are $116k favourable for the month.

Other Health of Older People costs are unfavourable by ($180k) for the month and favourable $28k YTD.

Mental Health costs are favourable $52k for the month, reversing the trend over the prior two months.

Other External Provider Payments are ($57k) unfavourable for the month, driven by COVID-19 related payments of $303k offset by revenue.

IDF Outflows are favourable $160k for the month based on available information and impacted by COVID-19 lockdown.

Inter District Flows (IDF)

IDF Wash-ups and Service Changes September 2021		
IDF Outflows $000s	Variance to budget	
	Month	YTD
Base	0	0
	-	-
	-	-
Wash-ups		
2021/22 Outflows - inpatient	310	(351)
	-	-
2020/21 Outflows - inpatient	58	58
2020/21 Outflows - outpatient	(63)	(63)
2020/21 Outflows - PCT	-	(10)
2020/21 Outflows ATR	(162)	(162)
2020/21 PHO	-	-
2020/21 FFS	-	21
2020/21 Community Pharmacy	17	111
Rounding (timing) differences	-	-
IDF Outflow variance	**160**	**(396)**

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 $124k favourable for the month.

IDF Outflow (expense):

- Based on the data available, overall IDF outflows are favourable for the month $160k due to COVID-19 lockdown, unfavourable YTD ($396k) which includes the impact of a high cost patient.

Commissioning: Families & Wellbeing

What is this measure?

Youth health and wellbeing

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

Why is this important?

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

How are we performing?

- The proportion of HVDHB-domiciled 10-24 year olds enrolled in a PHO is 81% for Māori, 89% for Pacific, and 104% for non-Māori, non-Pacific.
- The proportion of 10-24 year olds accessing primary care in the last month is 16% for Māori, 14% for Pacific, and 18% for non-Māori, non-Pacific.
- The rate of presentation to ED per 1,000 10-24 year olds is 86 for Māori, 102 for Pacific, and 83 for non-Māori, non-Pacific.

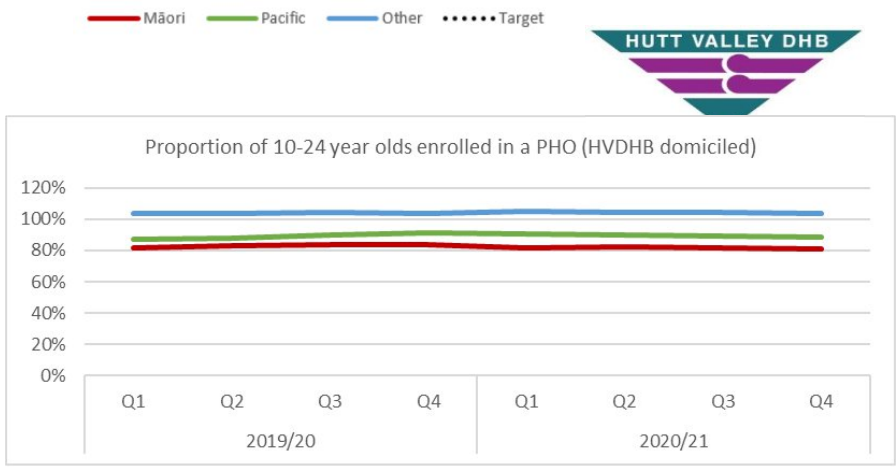
What is driving performance?

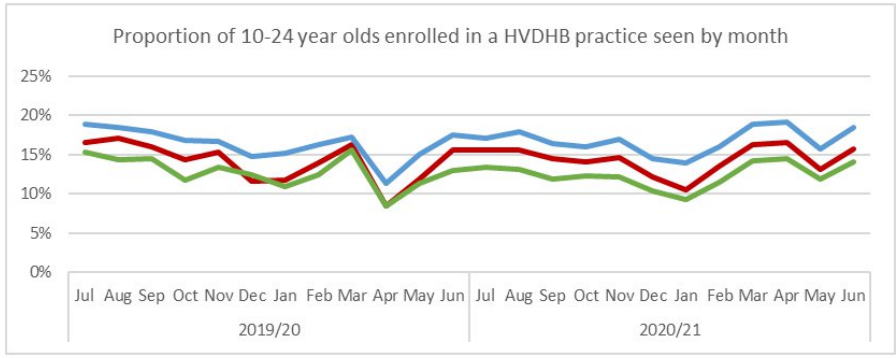
- Young people require a unique mix of social and health services which traditional and mainstream primary care services are not always best equipped to respond to.

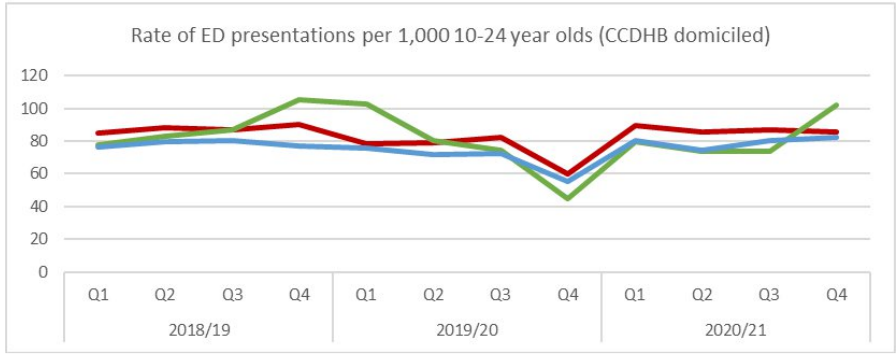
Management comment

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

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







Commissioning: Primary & Complex Care

What is this measure?

Older People and Frailty

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

Why is this important?

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

How are we performing?

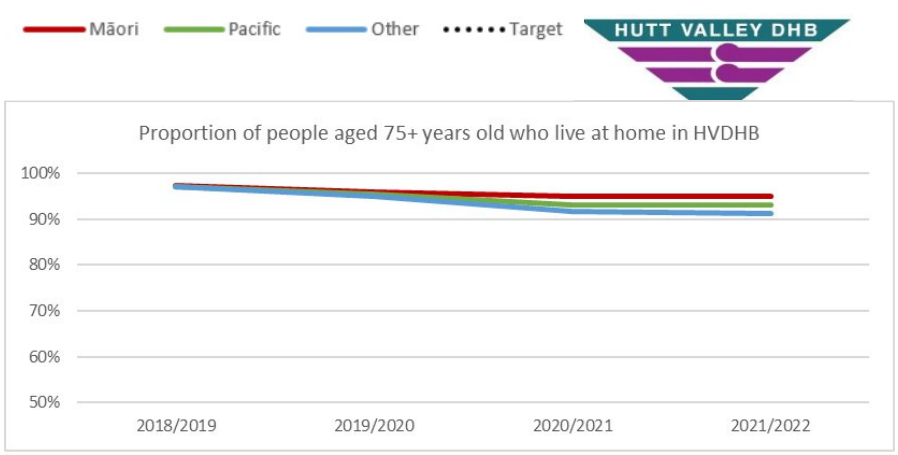
- The proportion of 75+ year olds living at home is 95% for Māori, 93% for Pacific, and 91% for non-Māori, non-Pacific.
- The acute bed day rate for 75+ year olds is 2,103 for Māori, 1,802 for Pacific, and 1,668 for non-Māori, non-Pacific.
- The 0-28 day acute readmission rate for 75+ year olds is 14% for Māori, 134% for Pacific, 12% for non-Māori, non-Pacific.

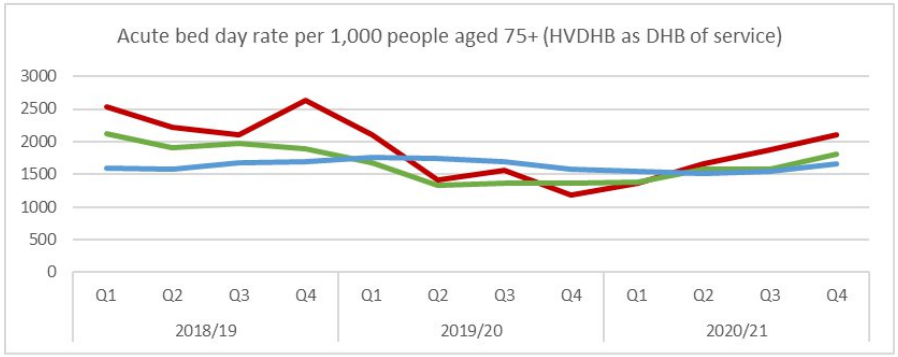
What is driving performance?

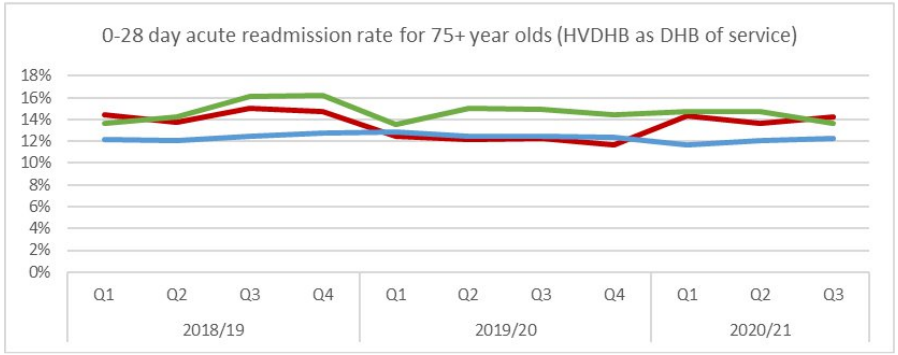
- Frail older people contribute to a significant volume of hospital bed occupancy due to their complex health and social circumstances. We have invested to support frailty across our health system to reduce their length of stay in hospital and decrease risk of further functional decline.

Management Comment

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







Commissioning: Hospital & Speciality Services

What is this measure?

- 95% of people presenting to ED seen with 6hrs (admitted and non-admitted)
- ED Occupancy above 90%
- General Adult Hospital Occupancy

Why is this important?

- **Acute flow** at an individual level describes the journey a person takes through our health system to receive care for urgent or unplanned events. **Acute flow** at a system level describes the flow of all acute patients through our system. **Acute demand** measures how many people require acute care in a period of time.
- Recently, there has been increased discussion about acute demand and presentations to EDs across New Zealand. Addressing capacity constraints and mitigating acute demand is important for ensuring that people receive appropriate and timely access to acute care with equitable outcomes.

How are we performing?

- The proportion of people presenting to ED and seen in under 6 hours was 89%
- ED occupancy was over 90% in the week ending 19 Sep 10% of the time.
- Hospital occupancy was over 90% in the week ending 19 Sep 0% of the time.

What is driving performance?

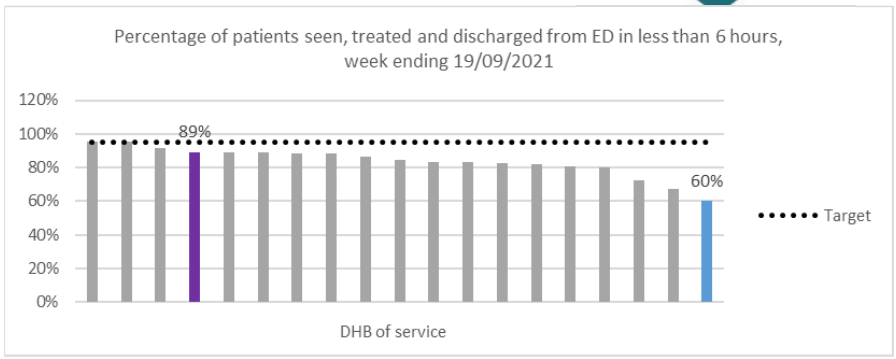
- The average general adult bed deficit is 8 at Hutt Hospital in 2020/21.
- COVID-19 disruption to care delivery heightens system stress in the medium to long term.
- Quality of care is hindered when occupancy of general adults beds is higher 90%
- Significant workforce vulnerabilities and stresses impact delivery and safety.
- We have analysed data across our 2DHB Hospital Network and identified a number of demographic and clinical drivers that are impacting acute flow and acute demand across our health system.

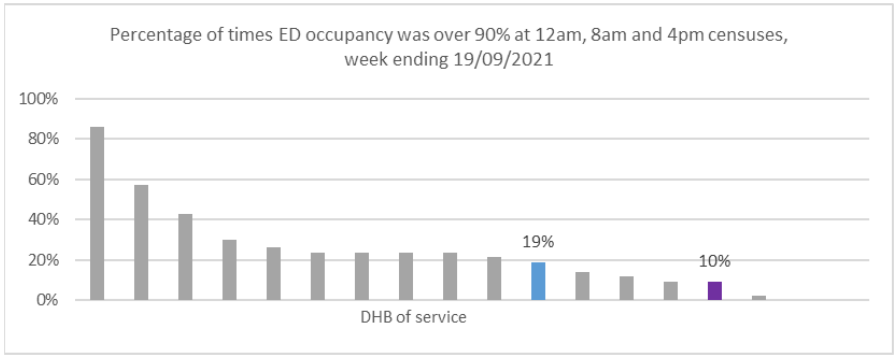
Management comment:

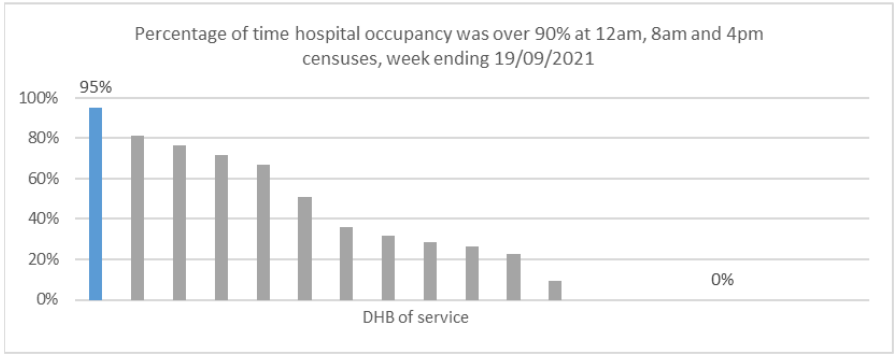
- Destravis has been engaged to provide options on the best use of facilities across HVDHB and CCDHB in the 2DHB Hospital Network in the medium to long term.
- In response to capacity constraints we are undertaking the following projects identifying options for increasing **Bed and Theatre Capacity** across our three hospitals within the next two years while optimising use of current capacity. We are identifying options for increasing capacity and flow through Wellington ED and acute assessment areas as part of the **Front of Whare** project.
- These are part of the Hospitals strategic work programme for 2021/22.

CCDHB HVDHB

HUTT VALLEY DHB







Commissioning: Mental Health & Addictions

What is this measure?

- ≥80% of non-urgent referrals seen within 3 weeks
- Number of patients discharged from TWA 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.

What is driving performance?

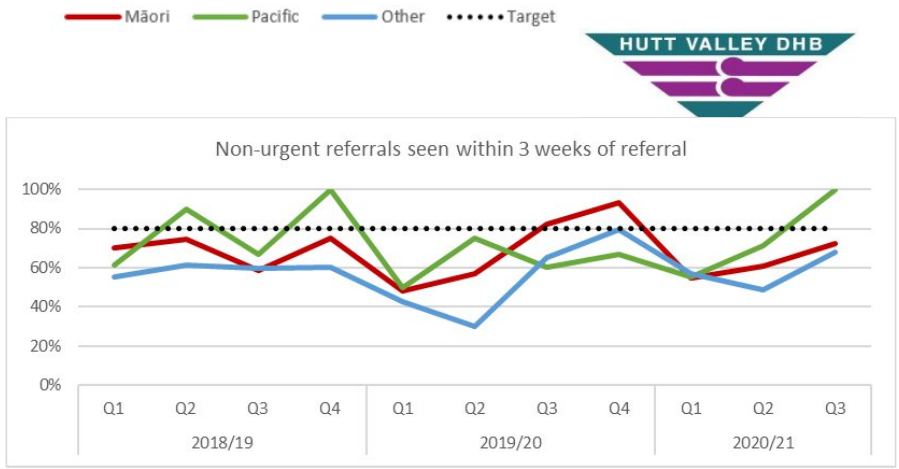
- Performance is above the 80% target for non-urgent referrals seen within 3 weeks for Pacific (100%), and below target for Māori (72%) and non-Māori, non-Pacific (68%).
- The number of patients admitted to TWA for more than 14 days was 12 for Māori, 2 for Pacific, and 15 for non-Māori, non-Pacific.
- The number of people aged 0-19 years old referred to AOD services were 9 for Māori, 3 for Pacific, and 22 for non-Māori, non-Pacific.

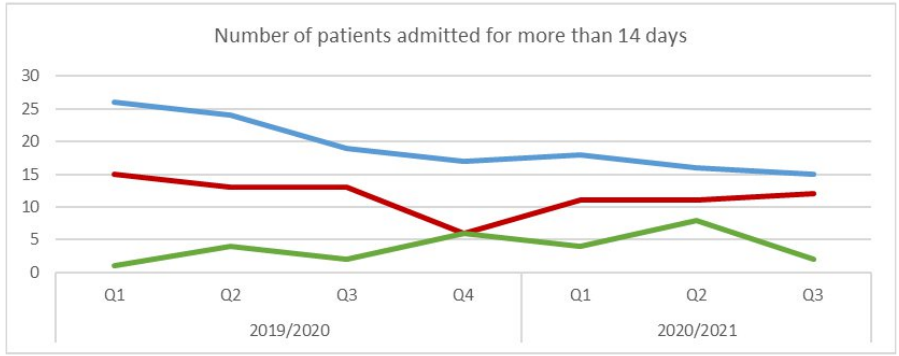
What is driving performance?

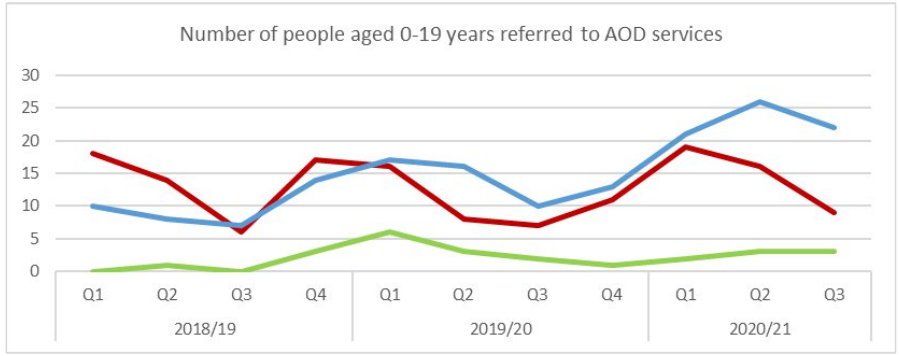
- MHAIDS are developing smart systems as a key enabler of service delivery, including the Te Haika upgrade.
- The 3DHB Acute Care Continuum project is developing increased access to Crisis Respite services as an alternative to acute inpatient care or earlier discharge pathways.
- The 3DHB Model of Care 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?

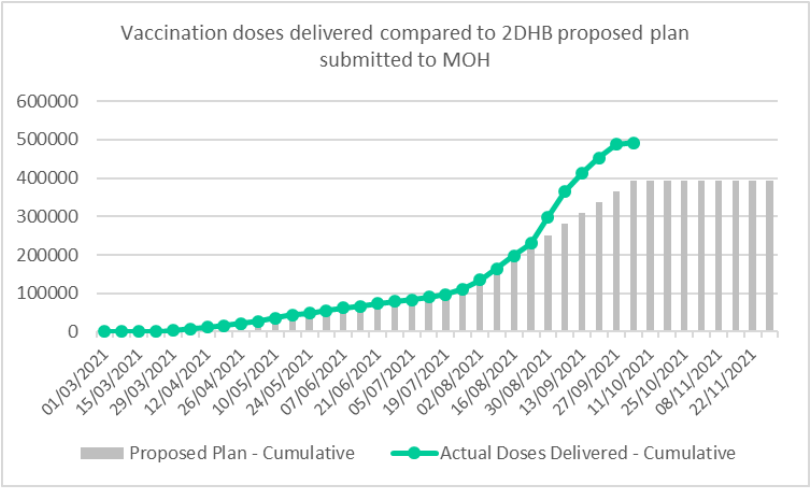
- The COVID-19 vaccine rollout aims to protect Aotearoa by ensuring that everyone over 16 years old receives the two doses. Ensuring equitable access to free COVID-19 vaccines is a priority for New Zealand.
- First we are protecting those most at risk of COVID-19.

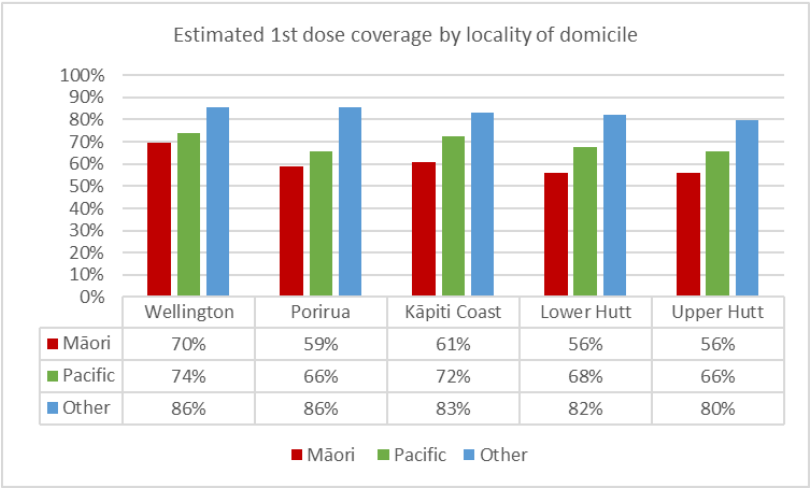
How are we performing?

- **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 27/08/2021
Data current at: 28/08/2021 @9.35am





	Wellington	Porirua	Kāpiti Coast	Lower Hutt	Upper Hutt
Māori	70%	59%	61%	56%	56%
Pacific	74%	66%	72%	68%	66%
Other	86%	86%	83%	82%	80%

Section 3

Hospital Performance

Executive Summary – Hospital Performance

- The impact of COVID-19 lockdown was felt across all specialities and services – with a total of 1719 cancellations across planned care, inpatient, outpatient, radiology, and endoscopy in particular. This is on top of underlying disruptions created by acute demand, RSV outbreaks, and industrial action.
- Last month we highlighted the service delivery and financial risk that in the constrained environment the DHBs will not be able to deliver the full planned care funding schedule nor reduce waiting list size so that people are treated within 120 days; this is now a given. To mitigate the impacts both DHBs are maximising utilisation of current theatre and bed capacity as well as private hospital outsourcing capacity. Investment in innovation will help to provide alternative solutions for people to access and reduce the number of people requiring treatment, these will take time to implement. SMOs continue to lead planning surgery based on those with greatest clinical urgency and long waiting times.
- Work continues with the Front of Whare, 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) – in respect of the former, this work is supported by expertise from the MOH and is inextricably linked to other ongoing work to assess and address overall hospital capacity.
- With the closure of Te Awakairangi Birthing Centre and upcoming Xmas period plans have been developed for managing the impact of increased births between October to February. A paper is in development for the next board meeting outlining the quality improvements undertaken over the past two years since the external review
- Ongoing and intractable workforce shortages across midwifery and nursing, allied health in particular sonographer social work and radiographers which remain 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.
- A cautious start at the end of the first quarter– meeting budget.

Hospital Throughput

Completed for period					Hutt Valley DHB Hospital Throughput YTD Sep-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							
1,041	1,221	180	1,197	156	Surgical	3,146	3,649	503	3,642	496	14,143	13,880
1,792	1,755	(37)	2,008	216	Medical	5,657	5,332	(325)	5,837	180	20,853	22,570
385	370	(15)	459	74	Other	1,126	1,111	(15)	1,337	211	4,464	5,221
3,218	**3,345**	**127**	**3,664**	**446**	**Total**	**9,929**	**10,092**	**163**	**10,816**	**887**	**39,461**	**41,671**
					CWD							
1,106	1,298	192	1,318	212	Surgical	3,551	3,805	254	3,867	316	14,879	13,880
931	999	68	1,024	94	Medical	3,076	2,952	(124)	2,979	(97)	11,317	22,570
432	418	(14)	399	(33)	Other	1,273	1,321	48	1,237	(35)	5,146	5,087
2,468	**2,715**	**247**	**2,741**	**273**	**Total**	**7,899**	**8,078**	**179**	**8,083**	**184**	**31,342**	**41,537**
					Other							
3,483	4,021	538	3,997	514	Total ED Attendances	11,786	12,346	560	12,317	531	49,261	50,206
890	950	60	973	83	ED Admissions	2,811	2,975	164	3,059	248	11,294	12,086
741	887	146	805	64	Theatre Visits	2,208	2,628	420	2,465	257	10,232	9,587
135	142	7	138	3	Non- theatre Proc	371	425	54	440	69	1,638	1,631
6,601	7,141	540	7,461	860	Bed Days	22,141	22,034	(107)	22,925	784	84,357	89,609
4.84	4.55	(0.29)	4.44	(0.40)	ALOS Inpatient	4.52	4.55	0.03	4.50	(0.02)	4.55	4.55
2.07	2.08	0.01	1.97	(0.09)	ALOS Total	2.03	2.08	0.05	2.03	(0.00)	2.08	2.08
7.80%	8.02%	0.21%	7.93%	0.13%	Acute Readmission	7.72%	8.02%	0.29%	7.40%	-0.32%	7.31%	7.80%

Reduced services and lower acute demand under the national COVID-19 level 3-4 restrictions during August 18- Sept 7 has affected volumes for the month and year to date. Surgical discharges and caseweights are under budget for the month and year to date. Medical discharges were slightly over lower than budget for the month but 11% lower than the same time last year. Year to date, Medical caseweights are higher than budget mainly due to high discharges in July under Emergency (treated over 3 hours and discharged) during the RSV outbreak. Other services are close to budget for discharges and caseweights for the month and year to date.

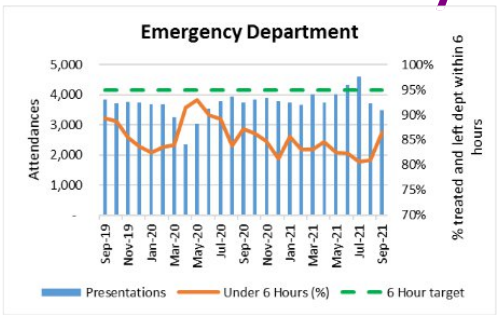
Total ED visits were 13% lower than last year. Patients admitted to inpatient wards from ED was 9% lower than the same time last year. Theatre visits were 16% lower than budget year to date and 10% lower than last year. Bed days were lower than budget for the month and 12% lower than last year. Inpatient ALOS in September was longer than budget and the same time last year. The acute readmission rate was lower than budget and lower than the same time last year.

Operational Performance Scorecard – 13 mths

Domain	Indicator (MoH KPIs highlighted yellow)	2019/20 Target	13 Months Performance Trend												
			Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Safe	Serious Safety Events[1] confirmed	Zero	1	2	3	0	1	3	3	3	0	2	0	3	1
	SABSI Cases [2]	Zero	1	2	1	1	1	0	1	0	0	1	3	2	0
	C. difficile infected diarrhoea cases	Zero	1	1	4	0	1	0	1	2	1	1	2	5	1
	Hand Hygiene compliance (quarterly)	≥ 80%	82%	79%			79%			80%			TBC		
	Seclusion Hours- average per event (MH Inpatient ward TWA)[3]		11.4	13.3	1.4	43.6	7.6	22.4	39.8	13.6	21.0	21.4	16.9	22.4	14.7
Timely	Emergency Presentations	49,056	3,997	4,273	4,328	4,259	4,059	4,026	4,315	3,982	4,315	4,331	4,593	3,711	3,482
	Shorter Stays in ED (SSiED) % within 6hrs	≥95%	87.2%	86.3%	84.8%	81.3%	85.8%	83.1%	83.1%	84.6%	82.6%	81.5%	79.0%	80.0%	86.1%
	SSiED % within 6hrs - non admitted	≥95%	91.5%	91.0%	89.8%	86.9%	90.7%	89.9%	89.5%	89.7%	89.6%	89.2%	86.5%	87.0%	91.6%
	SSiED % within 6hrs - admitted	≥95%	75.1%	73.2%	71.8%	66.3%	72.0%	62.8%	65.3%	70.3%	61.3%	56.8%	55.5%	60.2%	71.2%
	Total Elective Surgery Long Waits -ESPI 5	Zero Long Waits	915	992	1,002	1,115	1,251	1,328	1,238	1,177	1,020	904	930	1,021	1,118
	No. Theater surgeries cancelled (OP 1-8)		154	142	128	138	87	139	198	124	127	186	153	206	150
	Total Elective & Acute Operations in MainTheatres 1-8[6]		805	824	775	744	664	712	898	816	843	856	867	600	741
	Specialist Outpatient Long Waits- ESPI 2	Zero Long Waits	674	723	704	758	1,016	1,124	1,093	1,015	808	625	624	717	812
	Outpatient Failure to Attend %	≤6.3%	5.4%	5.6%	6.0%	6.2%	7.7%	5.6%	5.5%	6.2%	6.4%	6.6%	6.5%	6.5%	7.8%
	Full Year Forecast surplus / (deficit) $m - Provider (1) (2)	($2.03)	($15.38)	($12.54)	($14.33)	($14.64)	($14.29)	($16.06)	($19.72)	($20.40)	($25.09)	($25.43)	($3.94)	($3.94)	TBC
	Full Year Forecast surplus / (deficit) $m - DHB (1) (2)	($8.14)	($13.37)	($12.31)	($12.87)	($14.54)	($14.33)	($14.24)	($14.25)	($14.01)	($16.93)	($12.23)	($30.84)	($30.84)	TBC
	% Theatre utilisation (Elective Sessions only)[7]	≤90%	90.4%	86.2%	88.1%	87.2%	86.4%	87.2%	87.8%	88.4%	87.8%	87.3%	87.1%	86.0%	85.9%
	Overnight Patients - Average Length of Stay (days)	≤4.3	4.52	4.26	4.72	4.79	4.50	4.37	4.89	4.35	4.69	4.80	4.64	4.92	5.28
	Long Stay Patients Not Yet Discharged (>14 days)	≤5	17	15	19	24	21	34	20	23	29	22	25	35	16
	Overnight Beds (General Occupancy) - Average Occupied	≤130	144	130	138	144	130	149	146	143	148	152	153	144	130
	Overnight Beds (General Occupancy) - % Funded Beds Occupied	≤85%	88.8%	80.4%	85.1%	93.4%	84.7%	96.5%	94.8%	92.9%	96.2%	98.5%	94.3%	89.1%	80.2%
	All Beds - ave. beds occupied[8]	≤250	249	231	240	240	229	253	253	243	255	256	260	241	220
	% sick Leave v standard	≤3.5%	4.0%	3.4%	3.4%	3.1%	2.0%	2.5%	3.5%	3.1%	3.2%	3.8%	4.1%	4.4%	2.7%
	% Nursing agency v employee (10)	≤1.49%	2.2%	26.2%	12.7%	12.7%	12.8%	12.4%	13.0%	11.8%	0.4%	14.5%	0.0%	0.5%	TBC
	% overtime v standard (medical) (10)	≤9.22%	8.1%	9.2%	10.7%	6.9%	11.9%	9.6%	7.9%	8.3%	10.1%	8.7%	11.2%	7.4%	TBC
	% overtime v standard (nursing)	≤5.47%	12.3%	12.3%	14.4%	11.6%	23.7%	14.2%	11.2%	15.7%	13.2%	15.9%	12.5%	13.1%	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)



Arrivals -
Month - 3,483 (3,997)
YTD - 11,786 (12,317)

Self Referred
Month - 2,139 (2,550)
YTD - 7,623 (7,999)

GP Referred
Month - 345 (426)
YTD - 1,061 (1,310)

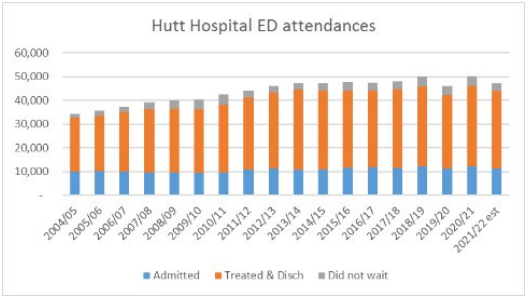
Other
Month - 999 (1,021)
YTD - 3,102 (3,008)
Current (Last Year)

Category	Volume	% Seen in time
1	34 (103)	100% (100%)
2	682 (2,241)	40% (36%)
3	1,436 (4,810)	36% (27%)
4	1,080 (3,715)	47% (41%)
5	251 (918)	78% (72%)
	Mth (YTD)	Mth (YTD)

Did Not Wait
Month - 155 (264) 4%
YTD - 832 (848) 7%

Treated & Disch
Month - 2,438 (2,760) 91% <6hr
YTD - 8,143 (8,410) 88%

Admitted
Month - 890 (973) 71% <6hr
YTD - 2,811 (3,059) 62%



- **What is this Measure**
  - The percentage of patients admitted, discharged and transferred from an Emergency Department within 6 hours.
- **Why is it important**
  - This indicator measures flow through the whole system it is impacted by the number of people arriving at ED, how fast ED treats them, availability of beds in the hospital and community service availability.
- **How are we performing**
  - Due to the Covid-19 lock down August 17 to September 7 volumes were lower than 2020. This led to a small improvement in the shorter stays target 82.46% YTD
- **What is driving Performance**
  - Available inpatient capacity (between 25-35% most days) certainly supported flow out of ED for those requiring an inpatient stay.
- **Management Comment**
  - Although ED continues to see lower presentations numbers, our admission rate remains stable.
  - High acuity and high occupancy in the hospital has continued to put pressure on this target.
  - We continue to explore options for managing the average general adult bed deficit of 8 at Hutt Hospital around new initiatives such as early supported discharge and more virtual ED options.

Planned Care Funding & Service delivery

Figure one: Planned care funding sources

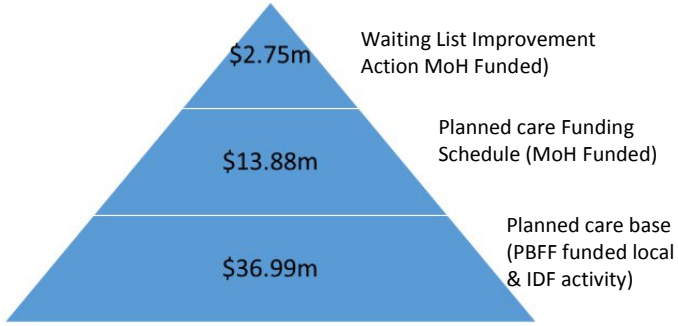
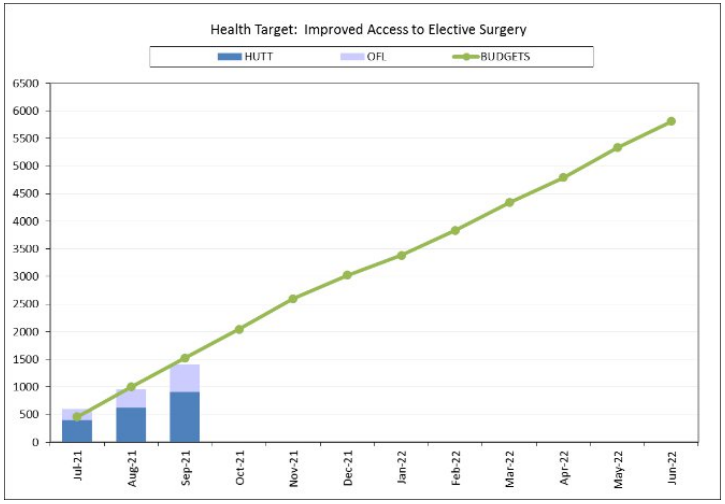
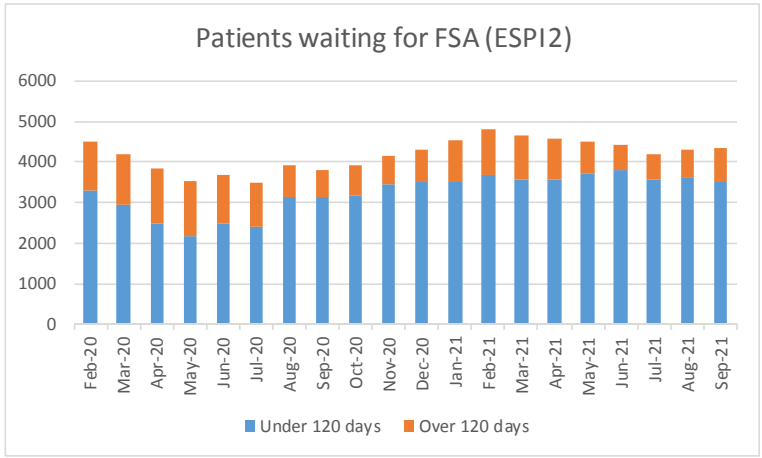


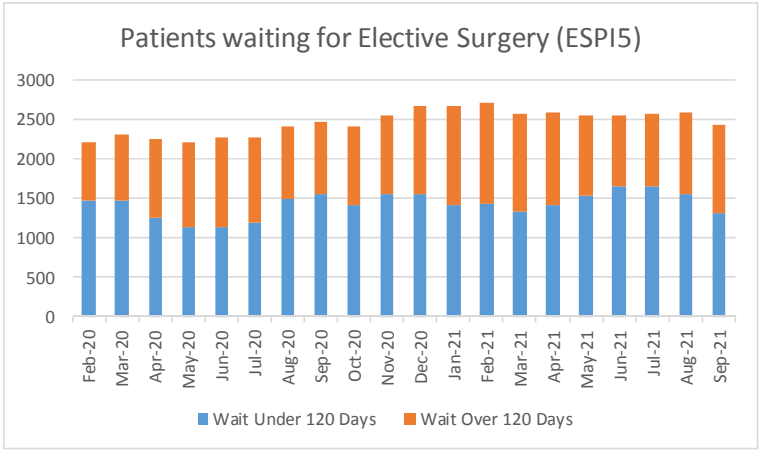
Figure two: Discharge trajectory for Planned care base and Planned care funding schedule – 97%



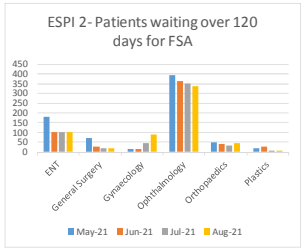
- **What is this measure?**
  - The delivery of an agreed number of inpatient surgical discharges and minor procedures to the Hutt Valley Population
  - The are three funding sources as per figure one – this is important as each has measures and deliverables required to access the funding which is paid after delivery .
- **How are we performing?**
  - Discharges are 117 behind plan for the Planned care base and Planned Care Funding Schedule (figure one) – this equates to 92% as per figure 2.
  - YTD results are impacted by the Covid-19 lock down and preparations for the NZNO and MERAS strikes (which were cancelled).
  - The increase in acute surgical presentations displaces planned surgeries as the theatres and beds are required for acute cases.
- **What is driving performance?**
  - Discussion will take place with the Ministry of Health at a national level on how best post Covid-19 to manage Planned Care delivery for 2021-2022 and the trajectory approach.
  - The orthopaedic initiative to reduce ESPI 2 $275k in 2020-2021 is continuing in the new financial year with funding carried over. This model is significantly assisting in reduction of the orthopaedic ESPI 2 waitlist.
  - Work on the 2 DHB closed RFP for outsourcing progressed in September and a recommendation on providers is now with ELT. It is anticipated that outsourcing will commence in Quarter 2 at the latest post some pricing and volume negotiation.
  - Commenced on project design of the Optometrists in cataract First Specialist Assessment and surgical follow which will reduce the ESPI 2 waitlist by 200 patients in 2021-2022
  - Capital investment of $3,647k to establish a 5 room procedure suite. The Minister of Health approved funding for the build and concept plans have been finalised. Building work has commenced on 11 October with a 9 month timeframe.

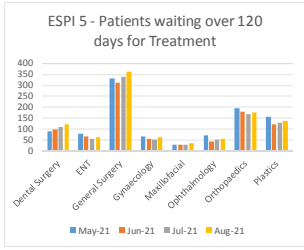
Planned Care – waiting times-

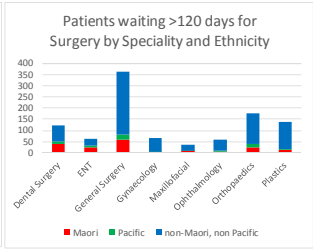




- **What is this measure?**
  - The delivery of Specialist assessments or Treatment within 120 days
- **Why is it important?**
  - It is important to ensure patients receive care at the most appropriate time to support improved health.
- **How are we performing?**
  - The total waiting for an FSA increased by 2.7% (115) this month. The number waiting over 120 days rose by 12% (75)
  - The number waiting for elective surgery rose by 4 to 2,583 and the number waiting over 120 days by 91 to 1,021
  - However the numbers of patients waiting longer than 120 days for both assessment and treatment remains high.

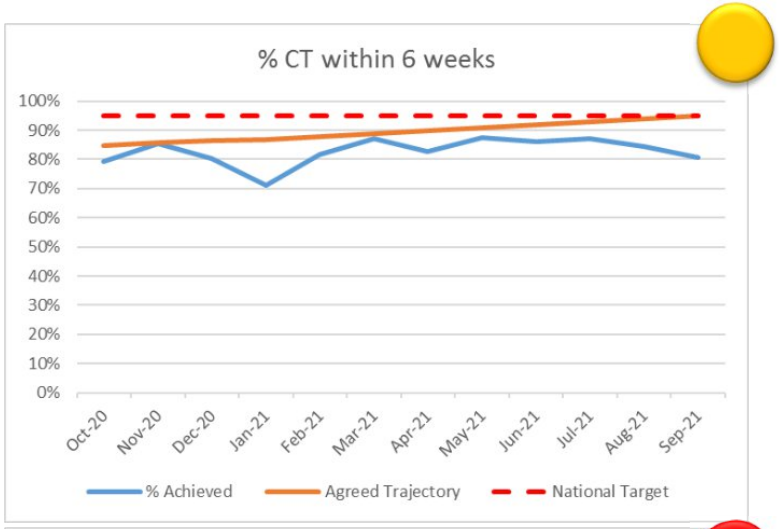


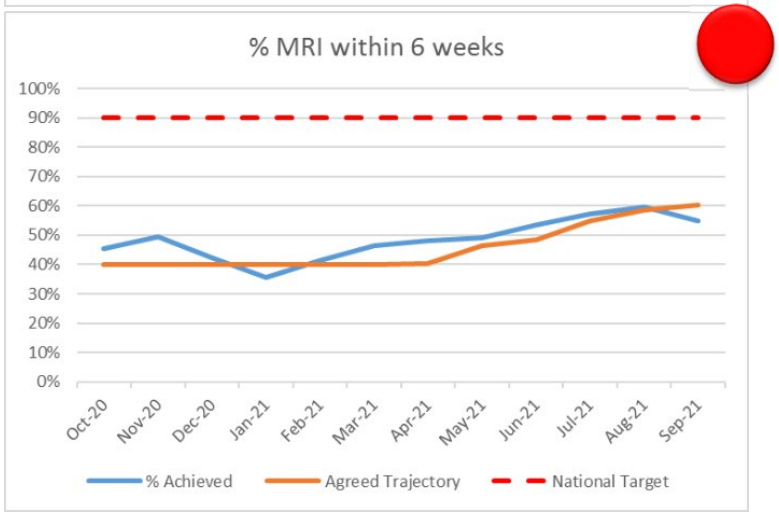




- **What is driving performance?**
  - Impact of COVID lockdown and preparations for the NZNO and MERAS strikes
  - Work continues on system improvements to address our waiting list management along with a strong focus to maximise clinic capacity and improve scheduling processes.
  - A 2DHB project relating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

CT & MRI wait times

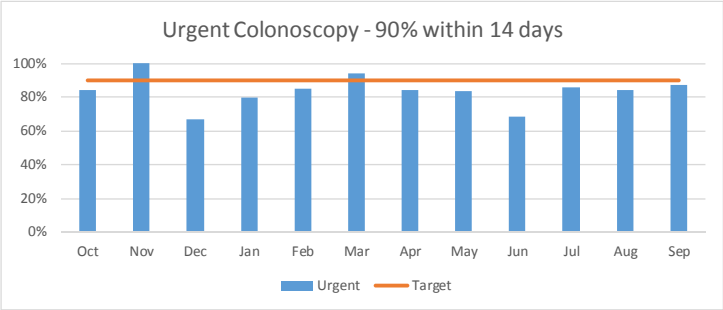


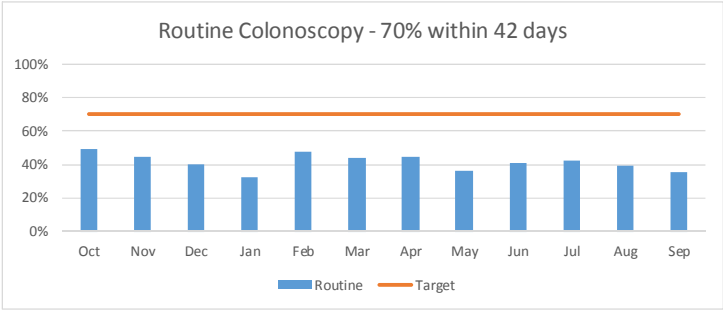


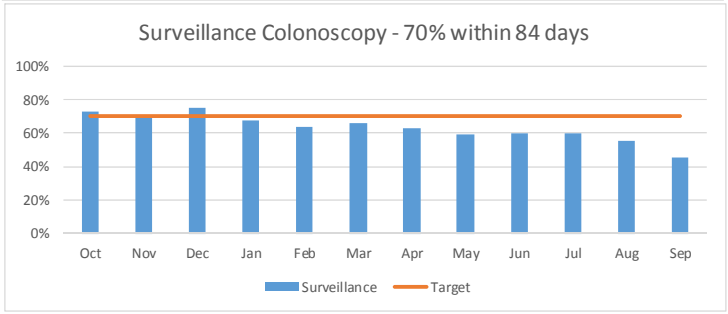
- **What is this measure?**
  - The delivery of computerised tomography (CT) scans and Magnetic Resonance Imaging (MRI) scans in a timely fashion to non-acute patients (within 42 days of referral).
- **Why is it important?**
  - Delayed diagnostic results can negatively affect health outcomes.
- **How are we performing?**
  - The % of patients receiving their MRI within 6 weeks is improving.
  - CT wait times remain close to target.
- **What is driving performance?**
  - CT performance continues to improve with 91.4% scanned and reported within 6 weeks.
  - MRI performance is just below the newly agreed (with MOH) trajectory with 54% scanned and reported within 6 weeks. Outsourced scans/reports have been delayed due to capacity issues with the external provider.
  - Covid-19 Response meant only Urgent patients were scanned from 18 August 2021 (P1 and P2 priority), with most outpatient work deferred.

- **Management comment**
  - Actions currently underway:
    - CT weekends have recommenced with Outpatient lists for Saturdays and Sundays
    - Voluntary overtime weekend MRI day lists – approximately 4 days per month have recommenced
    - MOH additional Planned Care trajectory funding assumption of additional revenue is being used to outsource 30 MRIs per month & the reading of 100 CT scans per month

Colonoscopy Wait Times







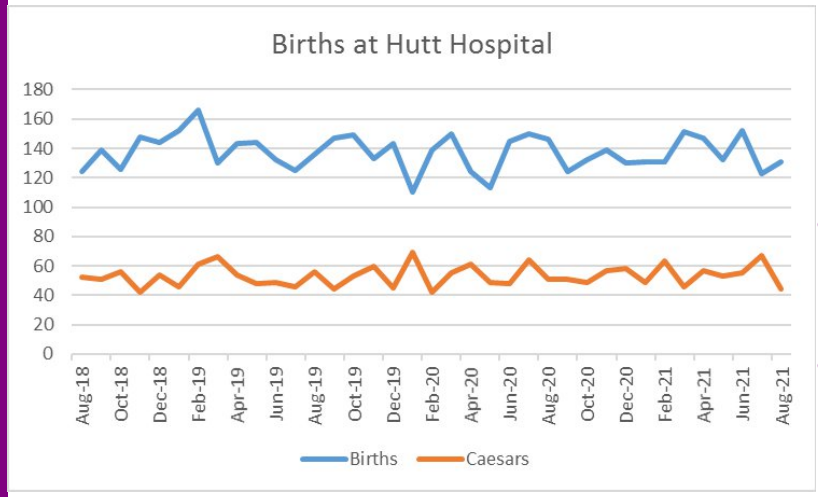
Urgent
85% YTD

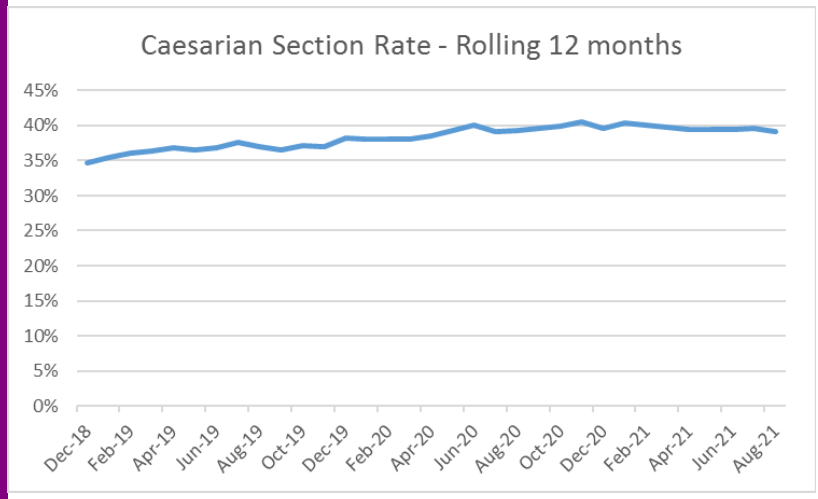
Routine
46% YTD

Surveil
57% YTD

- **What is this measure?**
  - The delivery of Colonoscopy, urgent within 14 days, routine 42 days and surveillance within 84 days of being due.
- **Why is it important?**
  - Delayed diagnostic results can negatively affect health outcomes.
- **How are we performing?**
  - The service is balancing the overall improvement in performance with a trajectory to full compliance within the coming months.
  - August sees an improved performance across the urgent wait times and a similar outcome to June for routine and surveillance
- **What is driving performance?**
  - The growing surveillance waitlist continues to put additional pressure on the service along with overall increase in referrals.
  - We have adapted the way Maori and Pacifica patients are booked, prioritising contact and booked as soon as referral is received. The recent hospital alert level changes has meant some patients booked were required to be re-scheduled for their September dates. There is a total of 20 Maori or Pacific patients who are overdue across all categories (including 3 deferred).
  - The recent level 4 and 3 lockdown has meant some of the patients booked were required to be re-scheduled for September dates.
- **Management comment**
  - A new performance and monitoring plan has been developed as is being used in the service.
  - Revised trajectories due to the hospital alert level changes are now seeing full recovery by December 2021.

Maternity

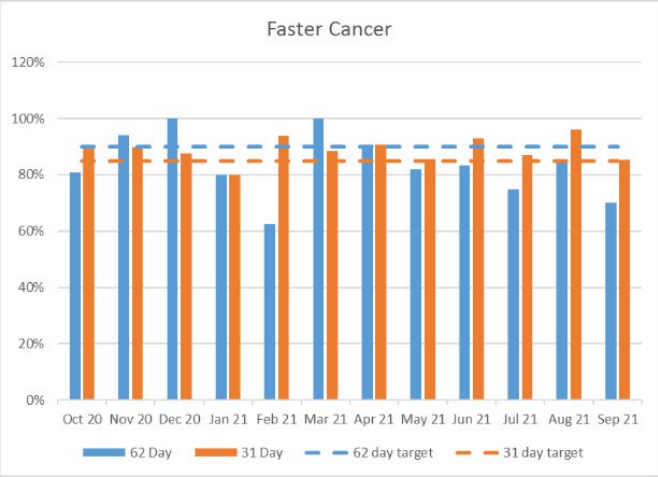


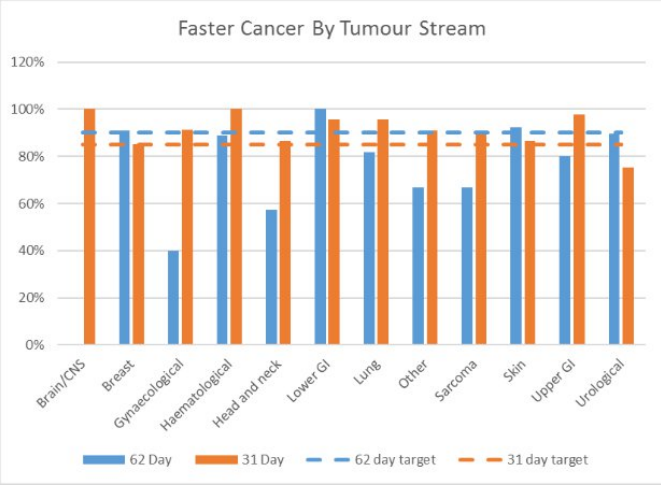


Due to Coding Lag these graphs run 1 month behind

- **What is the issue?**
  - In 2019 a number of clinical and community concerns around Hutt hospital's maternity services were identified.
- **Why is it important?**
  - An external review of the service and HDC investigations showed a number of areas where improvements needed to be made.
- **How are we performing?**
  - Hutt Valley DHB continues to progress the birthing optimisation project and audit of caesarean cases. This audit covers the period from April-June 2021 and focuses on the criteria for caesarean sections and pathways for optimal birth.
- **Management comment**
  - On 23 September the Te Awakairangi birthing centre at Melling ceased operating
  - 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. An upgrade of rooms 1-6 in the post-natal ward will be undertaken in Q2.
  - The Senior Midwives, Service Group Manager and Director of Midwifery have worked in partnership with MERAS to design a work programme aimed at improving the retention and recruitment of our Midwives.
  - Midwifery workforce vacancies remain an issue. Active recruitment and retention planning is underway. 1.0 FTE Midwifery coach position is being funded by MoH with full funding in year one - recruitment of 0.5 FTE has been made to the role. A casual Midwifery Support Worker role has been developed with strong interest from student midwives.
  - With the closure of Te Awakairangi Birthing Centre and upcoming Xmas period plans have been developed for managing the impact of increased births between October to February.
  - A paper is in development for the next board meeting outlining the quality improvements undertaken over the past two years since the external review.

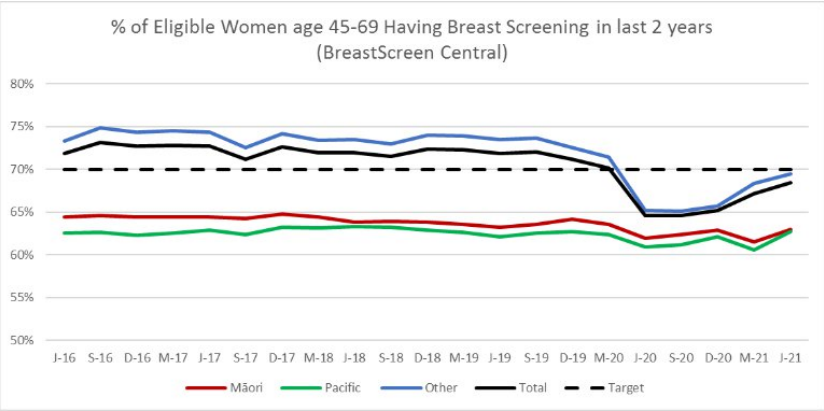
Faster Cancer Treatment

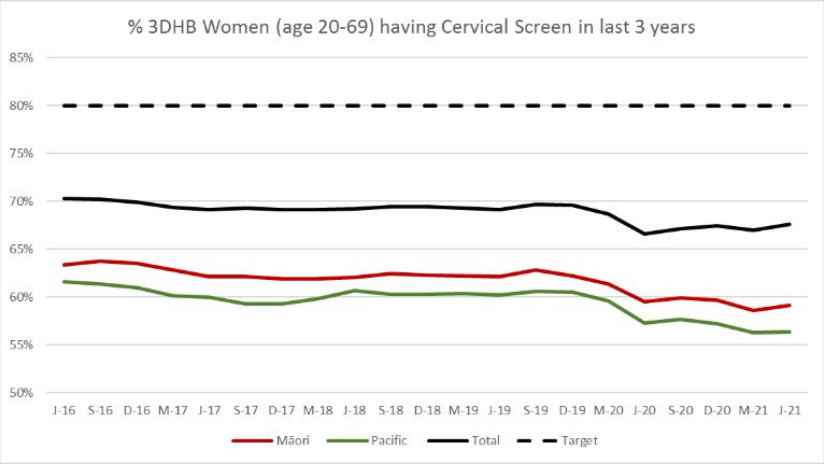




- **What is the issue?**
  - 62 day target: 90% of patients should receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.
  - 31 day indicator: The maximum length of time a patient should have 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?**
  - 70% of patients met the HVDHB 62 day pathway for September - (3 out of 10 patients breached due to capacity related issues post lockdown). 85.3% for the 31 day target pathway was achieved.
  - In September there were no breeches for either Maori or Pacific People.
- **What is driving performance?**
  - The first component of assessment from referral is well achieved and the latter part of treatment is the area needing focus.
- **Management Comment**
  - Individual breaches are viewed through MDT across both DHBs.

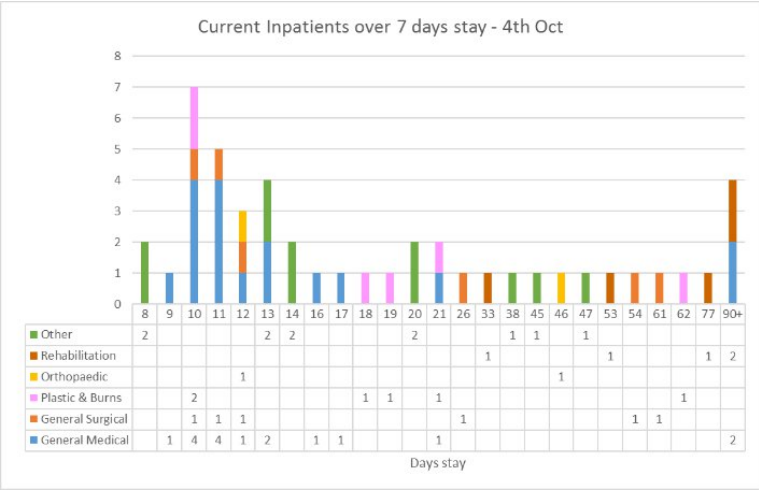
Screening

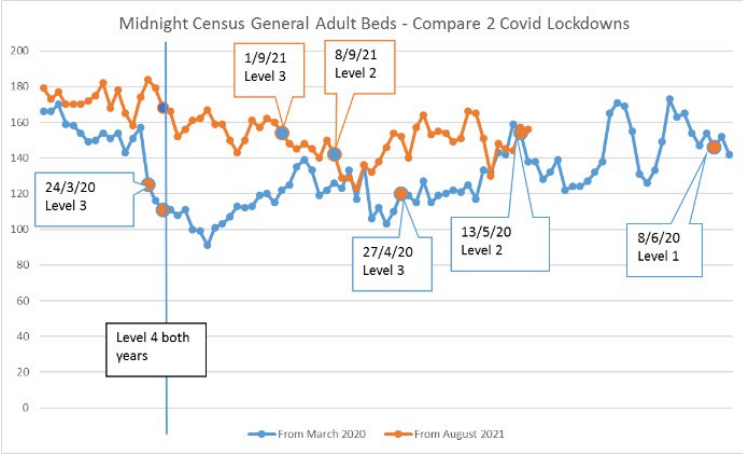




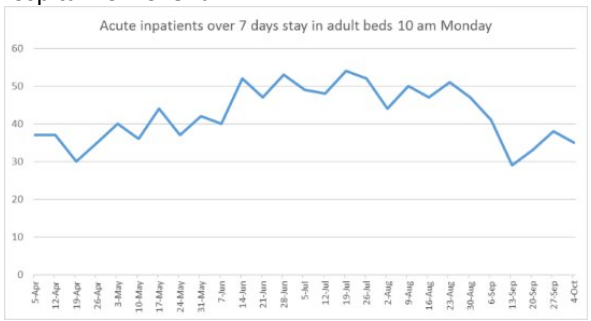
- **What is the issue?**
  - 80% of Women aged 25-69 have completed cervical screening in the previous three years
  - 70% of Women aged 45-69 have completed breast screening in the previous two years
- **Why is it important?**
  - By improving breast and cervical screening coverage DHBs will assist in delivery of the Government's priority to support healthier, safer and more connected communities and our health system outcome that we live longer in good health
- **How are we performing?**
  - Cervical Screening coverage in September continued to be impacted by COVID, priority population clinics had to be deferred resulting in the loss of 140 screens in September.
- **What is driving performance?**
  - During September 118 priority women attended their first screen (84 Maori and 34 Pacific). This is a direct result of the concerted effort that occurring during the recent alert level restrictions where there was a total of 256 priority women enrolled into BreastScreening (116 Maori and 140 Pacific).
  - The service continues to provide Saturday and evening sessions on a (staff) volunteer basis while Medical Imaging Technologist (MIT) recruitment has been pursued. Two MIT interviews are organised for next month. Recruitment for replacement Breast Radiologist has resulted in two offers being signed it is expected they will start December / January.
  - Symptomatic Services are running Saturday clinics for new referrals until the service can return to all day Monday clinics with the arrival of two new breast radiologists in the New Year.
- **Management Comment**
  - The service is on track to make up screening numbers that were deferred from recent hospital alert level response, with extended clinics on weekends and evening.
  - Māori, Pacific and Asian women continue to be identified through the PHO data matching and prioritised for screening in both Cervical and Breast Screening.

Long Stay inpatients





- **What is this measure?**
  - For medical and surgical these are patients who have stayed more than 7 days. For rehabilitation and neonates where stays are longer these are cases staying over last year's average.
- **Why is it important?**
  - These patients are reducing the ability of the hospital to cope with acute demand. Longer stays are often associated with deconditioning and adverse outcomes for the patient.
- **How are we performing?**
  - On 6th Sept there were 41 current long staying patients; most were acute adults. There has been a reduction in occupancy with Covid-19 but not as marked as last year.
- **What is driving performance?**
  - A group of extremely complex patients remain unable to be discharged because community services and supports are reluctant to support these patients on discharge either due to extremely high needs, complex behaviour, housing issues, or health and safety concerns for service staff.
- **Management comment**
  - A dedicated role to work with these and similar patients is planned to work with clinical, NASC, and commissioning staff to put sustainable different discharge arrangements in place for these folk. Enhanced Early Supported Discharge for mild-moderate stroke patients and some medical patients will go live in August. This will support earlier discharge for this group of patients and better hospital flow over all.



Section 4

Financial Performance & Sustainability

Summary of Financial Performance for September 2021

Month					$000s	Year to Date					Annual				
Actual	Budget	Variance	Last Year	Variance		Actual	Budget	Variance	Last Year	Variance	Forecast	Budget	Variance	Last Year	Variance
					Revenue										
42,160	42,249	(89)	40,740	1,420	Devolved MoH Revenue	127,775	126,748	1,027	122,027	5,748	510,596	506,994	3,602	489,113	21,483
1,890	1,775	115	2,116	(226)	Non Devolved MoH Revenue	5,826	5,017	808	5,903	(78)	20,987	20,179	808	21,680	(692)
508	605	(97)	581	(73)	ACC Revenue	1,415	1,781	(366)	1,821	(406)	6,610	6,976	(366)	7,129	(520)
353	502	(150)	510	(157)	Other Revenue	1,381	1,515	(135)	1,618	(237)	5,902	6,054	(153)	7,483	(1,581)
9,680	9,557	124	10,049	(369)	IDF Inflow	28,278	28,670	(391)	28,514	(235)	114,671	114,678	(7)	111,945	2,726
1,199	1,025	174	977	222	Inter DHB Provider Revenue	3,574	3,075	498	2,227	1,347	12,800	12,302	498	13,197	(397)
55,790	**55,714**	**76**	**54,973**	**817**	**Total Revenue**	**168,249**	**166,808**	**1,441**	**162,110**	**6,139**	**671,566**	**667,183**	**4,383**	**650,547**	**21,020**
					Expenditure										
					Employee Expenses										
5,394	5,476	83	5,072	(321)	Medical Employees	16,490	16,444	(46)	15,914	(576)	65,441	65,246	(195)	62,678	(2,763)
6,289	6,176	(113)	5,854	(434)	Nursing Employees	18,589	18,478	(111)	18,911	322	74,246	73,986	(261)	72,415	(1,831)
2,672	2,562	(109)	2,320	(352)	Allied Health Employees	7,657	7,680	23	7,843	186	30,444	30,467	23	28,663	(1,780)
856	807	(49)	816	(40)	Support Employees	2,574	2,419	(155)	2,344	(230)	9,774	9,619	(155)	9,579	(195)
2,280	2,284	4	1,904	(376)	Management and Admin Employees	6,838	6,896	58	6,898	59	26,995	27,053	58	26,733	(261)
17,490	**17,305**	**(185)**	**15,966**	**(1,523)**	**Total Employee Expenses**	**52,148**	**51,918**	**(230)**	**51,909**	**(238)**	**206,899**	**206,370**	**(529)**	**200,068**	**(6,831)**
					Outsourced Personnel Expenses										
310	205	(106)	310	(0)	Medical Personnel	695	615	(80)	941	246	2,538	2,458	(80)	5,973	3,435
18	15	(3)	115	98	Nursing Personnel	45	45	(0)	294	249	181	181	(0)	6,407	6,227
52	60	7	47	(5)	Allied Health Personnel	58	179	121	125	67	695	715	21	4,561	3,866
55	42	(12)	53	(2)	Support Personnel	196	127	(70)	162	(35)	577	507	(70)	491	(86)
747	621	(126)	726	(22)	Management and Admin Personnel	1,933	1,864	(69)	1,222	(711)	7,526	7,457	(69)	7,031	(494)
1,182	**943**	**(239)**	**1,252**	**69**	**Total Outsourced Personnel Expenses**	**2,927**	**2,830**	**(98)**	**2,745**	**(183)**	**11,516**	**11,318**	**(198)**	**24,463**	**12,947**
974	956	(18)	3,002	2,029	Outsourced Other Expenses	2,456	2,862	406	4,474	2,018	11,598	11,454	(144)	13,157	1,559
2,381	2,466	85	2,346	(34)	Treatment Related Costs	7,795	7,412	(383)	7,679	(116)	31,206	30,698	(509)	33,080	1,874
2,170	2,050	(120)	2,112	(58)	Non Treatment Related Costs	6,185	6,182	(3)	5,950	(235)	24,768	24,765	(3)	36,000	11,232
11,831	11,991	160	9,798	(2,033)	IDF Outflow	36,369	35,974	(396)	27,542	(8,828)	142,894	143,894	1,000	108,813	(34,082)
18,831	20,230	1,398	18,749	(82)	Other External Provider Costs	59,329	61,257	1,928	57,045	(2,284)	235,208	244,201	8,993	223,654	(11,554)
1,921	2,110	189	2,227	306	Interest, Depreciation & Capital Charge	5,677	6,330	653	6,757	1,080	24,315	25,321	1,006	23,537	(779)
56,781	**58,052**	**1,270**	**55,454**	**(1,327)**	**Total Expenditure**	**172,886**	**174,764**	**1,878**	**164,101**	**(8,785)**	**688,405**	**698,022**	**9,617**	**662,772**	**(25,633)**
(991)	**(2,338)**	**1,347**	**(481)**	**(511)**	**Net Result**	**(4,638)**	**(7,957)**	**3,319**	**(1,991)**	**(2,646)**	**(16,839)**	**(30,839)**	**14,000**	**(12,226)**	**(4,613)**
					Result by Output Class										
(863)	(2,131)	1,267	692	(1,556)	Funder	(4,781)	(6,960)	2,179	1,960	(6,741)	(13,900)	(27,012)	13,112	11,939	(25,839)
68	10	59	69	(0)	Governance	214	27	186	98	116	298	112	186	1,261	(963)
(196)	(217)	21	(1,241)	1,045	Provider	(70)	(1,024)	954	(4,049)	3,978	(3,237)	(3,939)	701	(25,425)	22,188
(991)	**(2,338)**	**1,347**	**(480)**	**(511)**	**Net Result**	**(4,638)**	**(7,957)**	**3,319**	**(1,991)**	**(2,646)**	**(16,839)**	**(30,839)**	**14,000**	**(12,226)**	**(4,613)**

Executive Summary – Financial Position

Financial performance year to date

- Total Revenue favourable $1,441k
- Personnel and outsourced Personnel unfavourable ($328k)
  - Medical unfavourable ($125k); Nursing unfavourable ($111k); Allied Health favourable $144k, Support Staff unfavourable ($225k); Management and Admin unfavourable ($11k); Annual leave Liability cost has increased by $1,505k since September 2020
- Outsourced other expenses favourable $406k
- Treatment related Costs unfavourable ($383k)
- Non Treatment Related Costs unfavourable ($3k)
- IDF Outflow unfavourable ($396k)
- Other External Provider Costs favourable $1,928k
- Interest depreciation and capital charge favourable $653k

Analysis of Operating Position – Revenue

- **Revenue:** Total revenue favourable $76k for the month
  - Devolved MOH revenue ($89k) unfavourable, reflecting negative adjustment for COVID-19 Community Pharmacy, largely offset by Planned Care Improvement Initiative Income.
  - Non Devolved revenue $115k favourable driven largely by Public Health COVID-19 funding $357k, offset by other variances.
  - ACC Revenue ($97k) unfavourable.
  - Other revenue ($150k) unfavourable for the month driven by Holidays Act remediation recoveries wash-up.
  - IDF inflows favourable $124k for the month reflecting prior year wash-ups.
  - Inter DHB Revenue favourable $174k.

COVID–19 Revenue and Costs

YTD Result - September 2021	Funder	Provider (excl. Regional Public Health)	Provider - Regional Public Health (RPH) [1]	Total
$000s	Actual	Actual	Actual	Actual
Revenue				
MoH Revenue Recognised - COVID19	1,519	42	840	2,401
Expenditure				
Employee Expenses				
Medical Employees		40	65	106
Nursing Employees		34	149	183
Allied Health Employees		11	173	184
Support Employees		18	0	18
Management and Admin Employees		33	42	75
Total Employee Expenses	**0**	**136**	**430**	**566**
Expenses				
Outsourced - Provider	0	0		0
External Providers - Funder	1,519			1,519
Clinical Expenses - Provider	0	0	4	4
Non-clinical Expenses- Provider	0	39	58	97
Total Non Employee Expenses	**1,519**	**39**	**61**	**1,620**
Total Expenditure	**1,519**	**175**	**492**	**2,186**
Net Impact	**(0)**	**(133)**	**348**	**215**

- The September year to date financial position includes $2.2m additional costs in relation to COVID-19.
- Revenue of $2.4m has been recognised to fund additional costs for community providers and Regional Public Health.
- The net impact year to date is $0.2m surplus.

Analysis of Operating Position – Personnel

- **Total Personne**l including outsourced unfavourable ($424k) for the month
  - Medical personnel incl. outsourced favourable ($23k). Outsourced costs are ($106k) unfavourable. Medical Staff Internal are ($83k favourable, driven by SMO vacancies.
  - Nursing incl. outsourced ($116k) unfavourable. Employee costs are ($113k) unfavourable driven largely by the use of internal Bureau Nurses and Overtime.
  - Allied Health incl. outsourced ($102k) unfavourable, with outsourced favourable $7k and internal employees unfavourable ($109k).
  - Support incl. outsourced unfavourable ($62k), with Outsourced ($62k) unfavourable, and employee costs ($49k) unfavourable, driven by Orderlies ($18k), Sterile Assistants ($13k) and Tradesmen ($17k).
  - Management & Admin incl. outsourced unfavourable ($122k), internal staff favourable $4k, outsourced unfavourable ($126k).
  - Sick leave for September was 2.7%, which is lower than this time last year.

FTE Analysis

Month					FTE Report	Year To Date					Annual	
Actual	Budget	Variance	Last Year	Variance	Sep-21	Actual	Budget	Variance	Last Year	Variance	Budget	Last Year
					FTE							
280	290	10	287	7	Medical	282	290	7	285	3	289	279
755	781	27	822	67	Nursing	758	781	24	823	65	790	763
349	365	16	395	46	Allied Health	348	365	17	397	48	365	352
151	147	(5)	143	(8)	Support	151	147	(5)	143	(8)	147	147
314	341	27	346	32	Management & Administration	320	341	21	347	27	338	321
1,848	**1,924**	**75**	**1,993**	**145**	**Total FTE**	**1,860**	**1,924**	**64**	**1,995**	**135**	**1,930**	**1,862**
					$ per FTE							
19,280	18,911	(369)	17,674	(1,606)	Medical	58,399	56,789	(1,611)	55,778	(2,622)	225,203	233,613
8,331	7,903	(428)	7,121	(1,210)	Nursing	24,532	23,646	(886)	22,977	(1,555)	93,735	97,019
7,659	7,015	(644)	5,875	(1,783)	Allied Health	21,988	21,025	(963)	19,780	(2,208)	83,067	86,588
5,660	5,500	(160)	5,695	34	Support	17,004	16,494	(509)	16,380	(624)	66,338	65,337
7,264	6,699	(565)	5,502	(1,763)	Management & Administration	21,362	20,228	(1,134)	19,866	(1,496)	79,819	84,263
9,462	**8,995**	**(467)**	**8,010**	**(1,451)**	**Average Cost per FTE all Staff**	**28,039**	**26,986**	**(1,053)**	**26,017**	**(2,022)**	**106,872**	**110,832**

Medical under budget for the month by 10 FTE, driven by SMOs under budget by 12 FTE, partly offset by RMO's & House Officers.

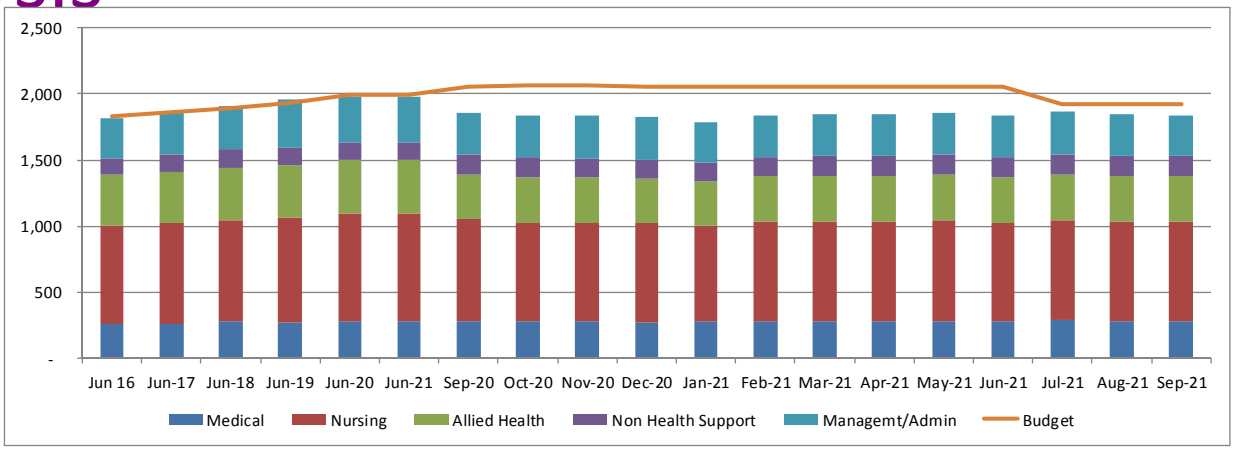
Nursing under by 27 FTE for the month the contribution to movements were; Internal Bureau Nurses, Midwives and HCA's are over budget (16) FTE mostly driven by General Surgery (2) FTE, General Medical (1) FTE, ED (6FTE) and other variances. This is offset by Midwives 15 FTE and Registered Nurses 11 FTE and HCA's. This reflects the transition to changes made under both CCDM recommendations and the Maternity Review.

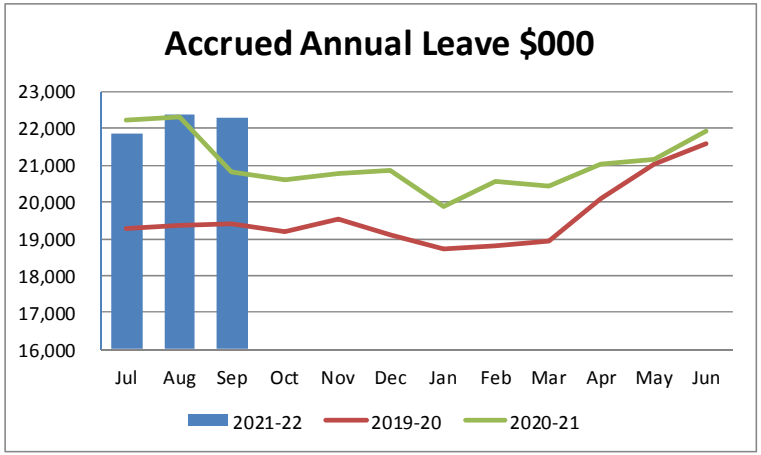
Allied FTEs are under by 16 FTEs for the month, driven by Regional Public Health 7 FTE, Community Health 6 FTE.

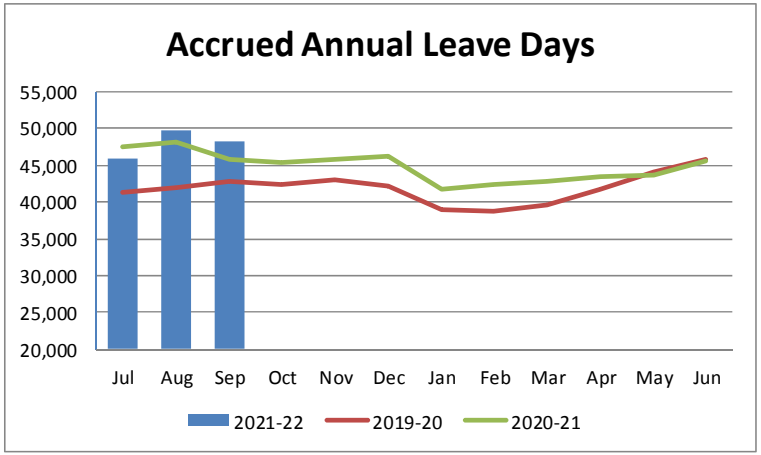
Support FTEs are (5) FTEs over budget driven by Food Services (3) FTE, Property services (1) FTE and Orderlies (4) FTE and other variances.

Management & Admin are under budget by 27 FTEs driven by SPO 2 FTE, Quality 7 FTE, Communications 1FTE, Surgical Women's & Children's 6 FTE, Medical and Acute 8 FTE and Regional Screening 3 FTE and other variances.

FTE Analysis







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

Analysis of Operating Position – Other Expenses

- **Other Operating Costs**
  - Outsourced other unfavourable ($18k) for the month, due to favourable variance for IT Services $170k, outsourced Finance functions $26k, offset by outsourced Clinical Services ($91k) Procurement Services ($34k) and other variances, .
  - Treatment related costs $85k favourable for the month driven by Instruments and Equipment $129k, Implants and Prostheses $110k offset by Pharmaceuticals ($111k) and other minor variances.
  - Non Treatment Related costs unfavourable ($120k), driven largely by Hotel and Laundry expenses ($105k).
  - IDF Outflows $160k favourable for the month, driven by the COVID-19 lockdown.
  - Other External Provider costs favourable $1,398k, mostly driven by Community Pharmaceuticals.
  - Interest, Depreciation & Capital Charge favourable $189k, driven by Depreciation $186k, which is expected to continue over the year.

Section 5

Additional Financial Information & Updates

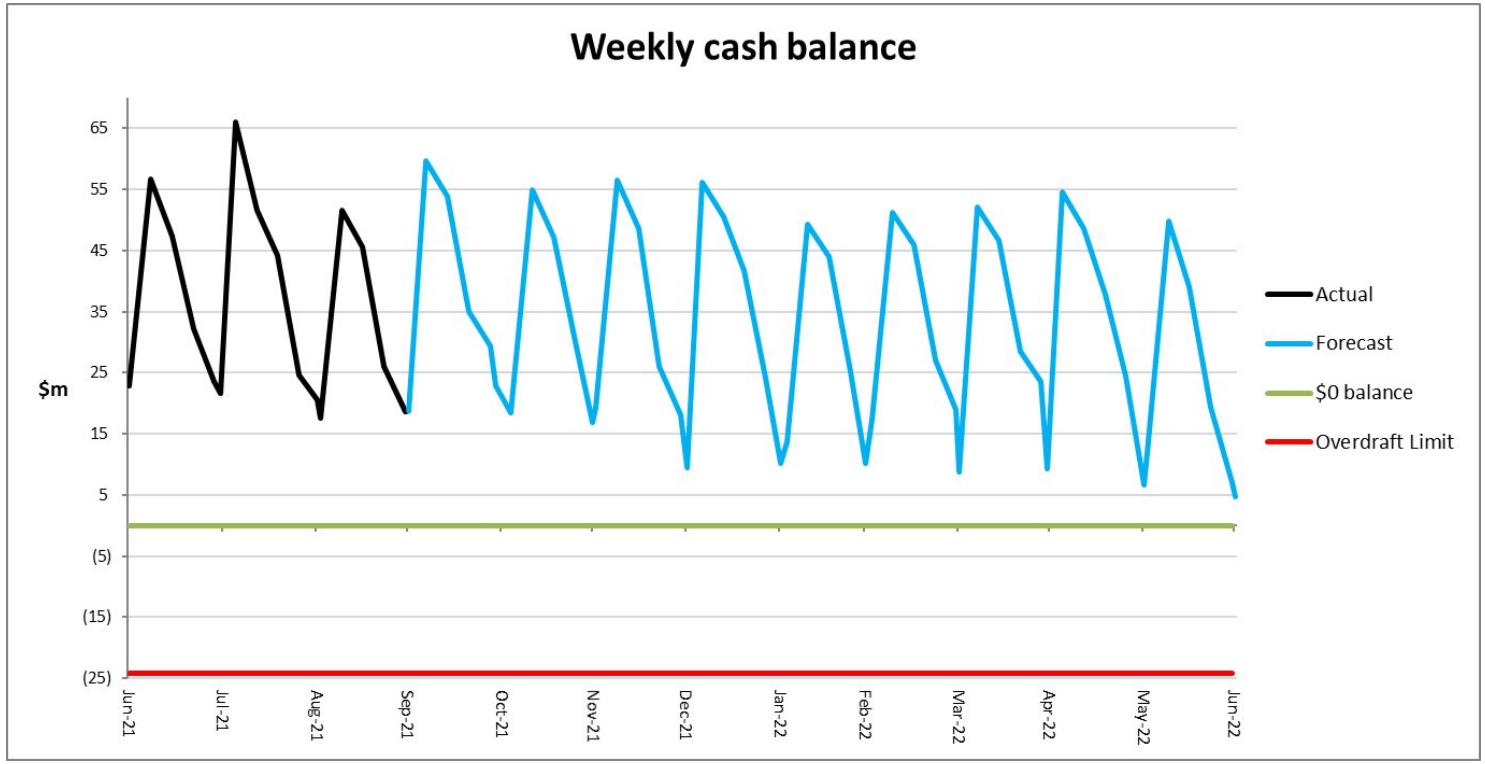
Financial Position as at 30 September 2021

$000s	Actual	Budget	Variance	Jun 21	Variance	Explanation of Variances Between Actual and Budget
Assets						
Current Assets						
Bank	18,754	5,177	13,577	22,890	(4,136)	Average bank balance in Sep-21 was $38.6m
Bank - Non DHB Funds *	1,995	5,831	(3,836)	5,236	(3,241)	
Accounts Receivable & Accrued Revenue	39,778	24,081	15,697	33,457	6,321	
Stock	1,944	2,614	(670)	2,322	(378)	
Prepayments	1,924	1,161	763	1,241	683	
Total Current Assets	**64,395**	**38,864**	**25,531**	**65,146**	**(751)**	
Fixed Assets						
Fixed Assets	222,000	229,781	(7,782)	223,741	(1,741)	
Work in Progress	10,340	7,905	2,436	9,218	1,122	
Total Fixed Assets	**232,340**	**237,686**	**(5,346)**	**232,958**	**(619)**	
Investments						
Investments in Associates	1,150	1,150	0	1,150	0	
Trust Funds Invested	1,245	1,266	(22)	1,221	24	
Total Investments	**2,395**	**2,416**	**(22)**	**2,371**	**24**	
Total Assets	**299,129**	**278,966**	**20,163**	**300,476**	**(1,346)**	
Liabilities						
Current Liabilities						
Accounts Payable and Accruals	83,975	77,223	(6,752)	79,873	(4,102)	Includes Holidays Act Provision of $30.9m
Crown Loans and Other Loans	31	3	(28)	42	10	
Capital Charge Payable	2,075	4,001	1,926	0	(2,075)	
Current Employee Provisions	27,410	28,199	789	27,029	(381)	
Total Current Liabilities	**113,492**	**109,426**	**(4,065)**	**106,944**	**(6,548)**	
Non Current Liabilities						
Other Loans	136	178	42	136	0	
Long Term Employee Provisions	9,150	8,972	(178)	9,150	0	
Non DHB Liabilities	1,995	5,831	3,836	5,236	3,241	
Trust Funds	1,206	1,226	20	1,221	15	
Total Non Current Liabilities	**12,486**	**16,207**	**3,720**	**15,743**	**3,256**	
Total Liabilities	**125,978**	**125,633**	**(345)**	**122,686**	**(3,292)**	
Net Assets	**173,151**	**153,334**	**19,818**	**177,789**	**(4,638)**	
Equity						
Crown Equity	158,709	146,918	11,790	158,709	0	
Revaluation Reserve	146,289	146,289	0	146,289	0	
Opening Retained Earnings	(127,208)	(131,916)	4,708	(114,982)	(12,226)	
Net Surplus / (Deficit)	(4,638)	(7,957)	3,319	(12,226)	7,588	
Total Equity	**173,151**	**153,334**	**19,817**	**177,789**	**(4,638)**	

Statement of Cash Flows to 30 September 2021

$000s	Jul Actual	Aug Actual	Sep Actual	Oct Forecast	Nov Forecast	Dec Forecast	Jan Forecast	Feb Forecast	Mar Forecast	Apr Forecast	May Forecast	Jun Forecast
Operating Activities												
Government & Crown Agency Revenue	43,259	43,479	44,926	44,157	44,168	44,311	44,157	44,157	44,311	44,230	44,182	44,311
Receipts from Other DHBs (Including IDF)	10,208	7,504	10,523	10,624	10,624	10,624	10,624	10,624	10,624	10,624	10,624	10,624
Receipts from Other Government Sources	492	664	623	728	810	685	658	725	613	653	613	725
Other Revenue	4,907	(460)	(4,228)	116	113	263	271	113	113	116	113	113
Total Receipts	**58,866**	**51,187**	**51,844**	**55,625**	**55,715**	**55,883**	**55,710**	**55,619**	**55,661**	**55,623**	**55,532**	**55,773**
Payments for Personnel	(17,569)	(16,888)	(20,053)	(17,512)	(18,307)	(19,184)	(17,577)	(16,901)	(19,269)	(17,675)	(18,456)	(18,460)
Payments for Supplies (Excluding Capital Expenditure)	(9,630)	(5,793)	(2,437)	(5,561)	(5,548)	(5,619)	(5,613)	(5,685)	(5,685)	(5,690)	(5,712)	(6,024)
Capital Charge Paid	0	0	0	0	0	(4,150)	0	0	0	0	0	(4,150)
GST Movement	(848)	8	828	0	0	0	0	0	0	0	0	0
Payments to Other DHBs (Including IDF)	(11,963)	(11,858)	(11,945)	(11,836)	(11,836)	(11,836)	(11,836)	(11,836)	(11,836)	(11,836)	(11,836)	(11,836)
Payments to Providers	(18,979)	(16,766)	(19,201)	(19,910)	(19,849)	(19,814)	(19,402)	(18,364)	(19,273)	(19,663)	(19,933)	(19,671)
Total Payments	**(58,989)**	**(51,297)**	**(52,809)**	**(54,819)**	**(55,540)**	**(60,603)**	**(54,429)**	**(52,786)**	**(56,063)**	**(54,864)**	**(55,937)**	**(60,141)**
Net Cashflow from Operating Activities	**(123)**	**(110)**	**(966)**	**807**	**175**	**(4,720)**	**1,281**	**2,833**	**(401)**	**759**	**(405)**	**(4,368)**
Investing Activities												
Interest Receipts	23	23	22	21	21	21	21	21	21	21	21	21
Dividends	0	0	0	4	4	4	4	4	4	4	4	4
Total Receipts	**23**	**23**	**22**	**25**	**25**	**25**	**25**	**25**	**25**	**25**	**25**	**25**
Capital Expenditure	(1,192)	(1,007)	(783)	(2,926)	(2,256)	(2,926)	(2,926)	(2,256)	(2,256)	(2,905)	(2,256)	(2,914)
Increase in Investments and Restricted & Trust Funds Assets	(24)	7	(8)	0	0	0	0	0	0	0	0	0
Total Payments	**(1,216)**	**(999)**	**(791)**	**(2,926)**	**(2,256)**	**(2,926)**	**(2,926)**	**(2,256)**	**(2,256)**	**(2,905)**	**(2,256)**	**(2,914)**
Net Cashflow from Investing Activities	**(1,193)**	**(976)**	**(769)**	**(2,901)**	**(2,231)**	**(2,901)**	**(2,901)**	**(2,231)**	**(2,231)**	**(2,880)**	**(2,231)**	**(2,889)**
Financing Activities												
Equity Injections - Capital	0	0	0	2,000	0	0	2,000	0	0	4,000	0	5,000
Total Receipts	**0**	**0**	**0**	**2,000**	**0**	**0**	**2,000**	**0**	**0**	**4,000**	**0**	**5,000**
Interest Paid on Finance Leases	(0)	(0)	(0)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)
Total Payments	**(0)**	**(0)**	**(0)**	**(2)**	**(2)**	**(2)**	**(2)**	**(2)**	**(2)**	**(2)**	**(2)**	**(2)**
Net Cashflow from Financing Activities	**(0)**	**(0)**	**(0)**	**1,998**	**(2)**	**(2)**	**1,998**	**(2)**	**(2)**	**3,998**	**(2)**	**4,998**
Total Cash In	58,889	51,211	51,866	57,650	55,740	55,908	57,735	55,644	55,686	59,648	55,557	60,798
Total Cash Out	(60,204)	(52,296)	(53,600)	(57,747)	(57,798)	(63,531)	(57,357)	(55,044)	(58,321)	(57,771)	(58,195)	(63,056)
Net Cashflow												
Opening Cash	22,890	21,575	20,489	18,754	18,658	16,600	8,977	9,356	9,956	7,321	9,198	6,560
Net Cash Movements	(1,316)	(1,086)	(1,734)	(96)	(2,058)	(7,623)	378	600	(2,634)	1,877	(2,638)	(2,258)
Closing Cash	**21,575**	**20,489**	**18,754**	**18,658**	**16,600**	**8,977**	**9,356**	**9,956**	**7,321**	**9,198**	**6,560**	**4,302**

Weekly Cash Flow – Actual to 30 September 2021



Note

- the overdraft facility shown in red is set at $24.2 million as at September 2021
- the lowest bank balance for the month of September was $17.7m

Capital expenditure – Actual to 30 September 2021

Project description	Budget rolled over from 2020/21	New budget for 2021/22	Prior year approved projects budget	Prior year approved projects spend	Committed costs from prior year approved projects budget	Total maximum spend in 2021/22	Actual 2021/22 spend till date	Remaining funds available in 2021/22
	$000	$000	$000	$000	$000	$000	$000	$000
Baseline								
Buildings and Plant	4,385	7,700	3,651	2,720	931	13,017	820	12,197
Clinical Equipment	629	6,043	3,824	974	2,850	9,522	821	8,701
Information Technology (Hardware)	1,211	1,828	862	408	454	3,493	42	3,451
Intangible Assets (Software)	56	2,853	356	185	170	3,079	36	3,043
Baseline Total	**6,282**	**18,425**	**8,691**	**4,287**	**4,404**	**29,112**	**1,719**	**27,391**
Strategic								
Buildings and Plant	1,065	-	-	-	-	1,065	-	1,065
Clinical Equipment	2,275	1,460	2,301	451	1,850	5,586	111	5,474
IT	722	2,145	1,066	359	707	3,575	82	3,493
Strategic Total	**4,063**	**3,605**	**3,367**	**809**	**2,558**	**10,226**	**193**	**10,033**
Pandemic								
Buildings and Plant	-	-	-	-	-	-	-	-
Clinical Equipment	-	-	-	-	-	-	-	-
IT	-	-	-	-	-	-	17	(17)
Pandemic Total	**-**	**-**	**-**	**-**	**-**	**-**	**17**	**(17)**
Total Capital (excluding MOH, Trust, Gym)	**10,345**	**22,030**	**12,058**	**5,096**	**6,962**	**39,338**	**1,929**	**37,407**

Summary of Leases – as at 30 September 2021

		Original Cost	Monthly Amount	Annual Amount	Total Lease Cost	Start Date	End Date	Lease type
Rental Property Leases	**Occupants**							
Wainuiomata Health Centre	District Nurses		1,199	14,386		1/11/2020	31/10/2023	Operating
Public Trust House Lower Hutt	Community Mental Health		27,717	332,601		1/09/2017	1/09/2023	Operating
CREDS - Johnsonville	Eating Disorders		5,370	64,435		1/01/2015	Rolling lease	Operating
RPH - Porirua Public Health	RPH School Health - Promotional Health		10,241	122,887		15/03/2015	14/03/2025	Operating
Criterion Lane, Lagan Building, Upper Hutt	Physiotherapy & Counselling		2,626	31,510		5/01/2021	31/12/2023	Operating
Criterion Lane, Lagan Building, Upper Hutt	Midwives		500	5,998		16/06/2020	16/05/2023	Operating
Upper Hutt Health Centre	District Nurses		974	11,688		24/01/2015	1/02/2022	Operating
Pretoria St, Lower Hutt	RPH & Covid Team		8,360	100,320		1/08/2021	31/01/2023	Operating
			56,987	**683,825**				
Motor Vehicle Leases								
Motor Vehicle Lease plus Management Fees (121 Vehicles, including 2 Nissan Leaf EV's)			37,018	444,213		Ongoing	Ongoing	Operating
			37,018	**444,213**				
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			**225,417**	**2,705,012**				

Treasury as at 30 September 2021

NZHP banking activities for the month	Current month ($000)	Last month ($000)
Average balance for the month	$38,603	$38,522
Lowest balance for the month	$17,652	$20,499
Average interest rate	0.71%	0.71%
Net interest earned/(charged) for the month	$22	$23

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	2
Total value of transactions	$2,261 NZD
Largest transaction	$1,181 NZD

	No. of transactions	Equivalent NZD
AUD	2	$2,261
GBP		
SGD		
USD		
Total	**2**	$2,261

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
Ministry of Health	$6,507	$6,272	$35	$73	$104	$28	$0	($4)
Capital & Coast District Health Board	$5,472	$216	$16	$212	$1,665	$85	$232	$3,046
Accident Compensation Corporation	$393	$127	$0	$4	$4	$21	$40	$196
Health Workforce NZ Limited	$154	$154	$0	$0	$0	$0	$0	$0
Wellington Southern Community Laboratories	$98	$0	$0	$0	$98	$0	$0	($0)
ESR Limited	$61	$61	$0	$0	$0	$0	$0	$0
Wairarapa District Health Board	$53	$39	$0	$5	$9	$0	$0	$0
Estate of Crispin Gondra	$53	$0	($0)	$0	$0	$0	$0	$53
Ministry of Social Development	$48	$0	$0	$0	$48	$0	$0	$0
WellNZ Limited	$48	$0	$0	$24	$1	($0)	$19	$5
Total Top 10 Debtors	**$12,889**	**$6,869**	**$51**	**$319**	**$1,929**	**$134**	**$291**	**$3,296**

Board Information – Public

1 December 2021

CCDHB Financial and Operational Performance Report – September 2021

Action Required

The Boards note:

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

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

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

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 delivery against target performance for the DHB
Contributors	Finance Team, Mental Health and 2DHB Hospital Services, GM MHAIDS.

Executive Summary

1. There is ongoing significant cost due to the COVID-19 response into the 2021/22 fiscal year. The DHB is being reimbursed for the large portion of the DHB COVID-19 response costs in 2021/22.
2. The Ministry have asked DHBs to separately report unfunded net COVID-19 impacts for 2021/22, these being considered outside the DHB's responsible deficit and budgets.
3. Excluding the COVID-19 net expenses the DHB's result for the three months month's to 30 September 2021 is $6.5m deficit, versus a budget deficit of $11.2m. Additional net COVID-19 related expenditure above funding, year to date is $8.1m.
    - For the three month's to 30 September 2021 the overall DHB year to date result, including COVID-19 costs is $14.7m deficit.
4. The DHB has submitted an Annual baseline budget of $1m surplus, excluding the $60m Donation for the Children's Hospital the underlying deficit is ($59m). The Board have approved a budget reduction of $6m which will be updated in the October reporting. The revised budget including the donation will be $7m surplus.
5. Capital Expenditure including equity funded capital projects was $21.6m year to date.
6. The DHB has a negative cash Balance at month-end of $37.0 million offset by positive "Special Funds" of $13.5 million (net $23.5m). It should be noted that there are certain financial impacts of the COVID-19 response that remains unfunded by the Ministry at this time and this has a cash

impact on the DHB. Overall the DHB cash balance is better than budget due to additional revenue and delayed capital expenditure. The deficit support of $46.5m signalled in the 2021/22 Annual Plan will be requested for the 3rd quarter of the year.

Hospital:

7. The impact of COVID-19 lockdown was felt across all specialities and services with a total of 5557 cancellations across planned care, inpatient, outpatient, radiology, and endoscopy in particular. This is on top of underlying disruptions created by acute demand, RSV outbreaks, and industrial action.
8. Last month we highlighted the service delivery and financial risk that in the constrained environment the DHBs will not be able to deliver the full planned care funding schedule nor reduce waiting list size so that people are treated within 120 days; this is now a given. To mitigate the impacts both DHBs are maximising utilisation of current theatre and bed capacity as well as private hospital outsourcing capacity. Investment in innovation will help to provide alternative solutions for people to access and reduce the number of people requiring treatment, these will take time to implement. SMOs continue to lead planning surgery based on those with greatest clinical urgency and long waiting times.
9. Work continues with the Front of Whare, 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) – in respect of the former, this work is supported by expertise from the MOH and is inextricably linked to other ongoing work to assess and address overall hospital capacity.
10. Ongoing and intractable workforce shortages across midwifery and nursing, allied health in particular sonographer social work and radiographers which remain 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.
11. A cautious start at the end of the first quarter– meeting budget.

Funder:

12. In this report we have also highlighted key areas of performance with a focus on our core services and achieving equity. We have developed and implemented initiatives with Māori and community providers but they are stymied by a lack of scaled investment to support all of those who need these response to have a significant impact:
13. CCDHB is progressing a range of initiatives that provide more choice and options for young people to engage in primary care. These include: Youth one stop shop (YOSS) for Rangatahi in Porirua with Te Runanga o Toa Rangatira; The four YOSS providers across the 2DHBs were successful in a Youth Mental Health RFP for 12-18 year olds and Tū Ora Compass Health have rolled out a new SXT app in sexual health services to enable young people to anonymously contact their sexual partners when diagnosed with an STI.
14. CCDHB has invested in a range of initiatives to support older people living in the region, including: CHOPI uses the skills of nurse practitioners and pharmacists along with speciality advice from geriatricians in partnership with general practice to work with frail older people in community settings; AHOP is effective at moving older people with frailty through ED faster. Although AHOP patients have a slightly longer average length of stay in hospital, they are less likely to be

readmitted and AWHI works to reduce the functional decline of patients. It optimises the use of our allied health workforce, demonstrates material improvements in outcomes for patients and is showing savings.

15. 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 also implementing a mental health model of care in ED, and enhancing the support to mental health and addiction patients who present to ED.

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 281 FTE below our annual budget
Financial	Planned surplus including the children's hospital donation for CCDHB is $1 million with no COVID-19 impacts included. The Planned surplus will be updated for October reporting and increased to $7 million surplus as approved by the Board.
Governance	The Board has a responsibility to scrutinise the financial reports alongside FRAC, and report back issues as identified.

Engagement/Consultation

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

Identified Risks

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

Attachment/s

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

Capital & Coast District Health Board

Monthly Financial and Operational Performance Report

For the period ending 30 September 2021

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

Contents

Section 1

Financial and Performance Overview and Executive Summary

Executive Summary

- There is ongoing significant cost due to the COVID-19 response into the 2021/22 fiscal year. The DHB is being reimbursed for the large portion of the DHB COVID-19 response costs in 2021/22. The Ministry have asked DHBs to separately report unfunded net COVID-19 impacts for 2021/22, these being considered outside the DHB's responsible deficit and budgets.

- Excluding the COVID-19 net expenses the DHB's result for the three months to 30 September 2021 is $6.5m deficit, versus a budget deficit of $11.2m.

- Additional net COVID-19 related expenditure above funding, year to date is $8.1m.

- For the three month's to 30 September 2021 the overall DHB year to date result, including COVID-19 costs is $14.7m deficit.

- The DHB has submitted an Annual baseline budget of $1m surplus, excluding the $60m Donation for the Children's Hospital the underlying deficit is ($59m). The Board have approved a budget reduction of $6m which will be updated in the October reporting. The revised budget including the donation will be $7m surplus.

- Capital Expenditure including equity funded capital projects was $21.6m year to date.

- The DHB has a negative cash Balance at month-end of $37.0 million offset by positive "Special Funds" of $13.5 million (net $23.5m). It should be noted that there are certain financial impacts of the COVID-19 response that remains unfunded by the Ministry at this time and this has a cash impact on the DHB. Overall the DHB cash balance is better than budget due to additional revenue and delayed capital expenditure. The deficit support of $46.5m signalled in the 2021/22 Annual Plan will be requested for the 3rd quarter of the year.

Executive Summary continued

Hospital: The impact of COVID-19 lockdown was felt across all specialities and services with a total of 5557 cancellations across planned care, inpatient, outpatient, radiology, and endoscopy in particular. This is on top of underlying disruptions created by acute demand, RSV outbreaks, and industrial action.

- Last month we highlighted the service delivery and financial risk that in the constrained environment the DHBs will not be able to deliver the full planned care funding schedule nor reduce waiting list size so that people are treated within 120 days; this is now a given. To mitigate the impacts both DHBs are maximising utilisation of current theatre and bed capacity as well as private hospital outsourcing capacity. Investment in innovation will help to provide alternative solutions for people to access and reduce the number of people requiring treatment, these will take time to implement. SMOs continue to lead planning surgery based on those with greatest clinical urgency and long waiting times.
- Work continues with the Front of Whare, 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) – in respect of the former, this work is supported by expertise from the MOH and is inextricably linked to other ongoing work to assess and address overall hospital capacity.
- Ongoing and intractable workforce shortages across midwifery and nursing, allied health in particular sonographer social work and radiographers which remain 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.
- A cautious start at the end of the first quarter– meeting budget.

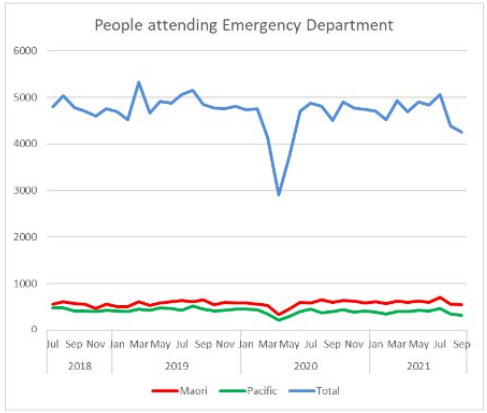
Funder: In this report we have also highlighted key areas of performance with a focus on our core services and achieving equity. We have developed and implemented initiatives with Māori and community providers but they are stymied by a lack of scaled investment to support all of those who need these response to have a significant impact:

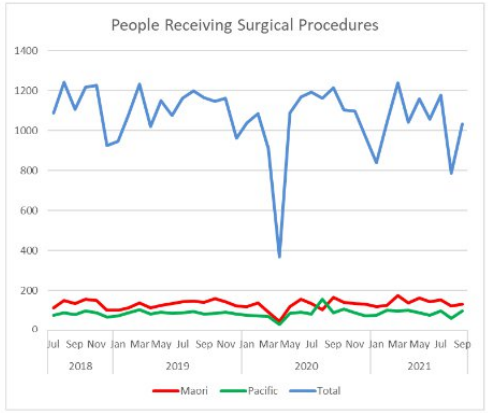
- CCDHB is progressing a range of initiatives that provide more choice and options for young people to engage in primary care. These include: Youth one stop shop (YOSS) for Rangatahi in Porirua with Te Runanga o Toa Rangatira; The four YOSS providers across the 2DHBs were successful in a Youth Mental Health RFP for 12-18 year olds and Tū Ora Compass Health have rolled out a new SXT app in sexual health services to enable young people to anonymously contact their sexual partners when diagnosed with an STI.
- CCDHB has invested in a range of initiatives to support older people living in the region, including: CHOPI uses the skills of nurse practitioners and pharmacists along with speciality advice from geriatricians in partnership with general practice to work with frail older people in community settings; AHOP is effective at moving older people with frailty through ED faster. Although AHOP patients have a slightly longer average length of stay in hospital, they are less likely to be readmitted and AWHI works to reduce the functional decline of patients. It optimises the use of our allied health workforce, demonstrates material improvements in outcomes for patients and is showing savings.
- 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 also implementing a mental health model of care in ED, and enhancing the support to mental health and addiction patients who present to ED.

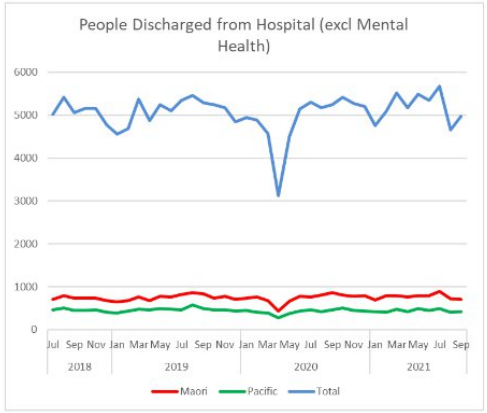
Performance Overview: Activity Context (People Served)

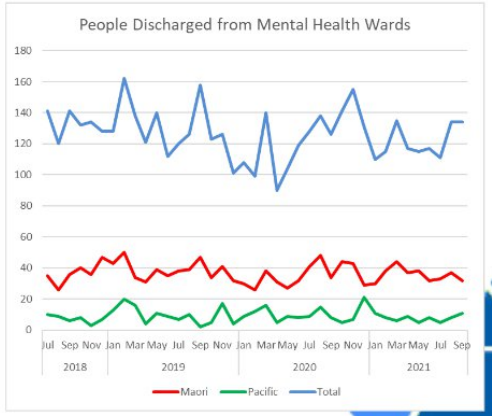
CCDHB funds services that touch thousands of people in our community every month. Unless otherwise indicated, the numbers below count individuals once and are based on CCDHB being the DHB of Service. Our services have returned to delivering services to our population without the restrictions due to COVID-19.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

People attending ED	**4,292**	549 Maori, 323 Pacific
People receiving Surgical Procedures (in main theatres)	**1033**	131 Maori, 98 Pacific
People discharged from Kenepuru Community Hospital or Wellington Regional Hospital (excl Mental Health)	**4,973**	706 Maori, 424 Pacific
People discharged from Mental Health Wards	**134**	32 Maori, 11 Pacific



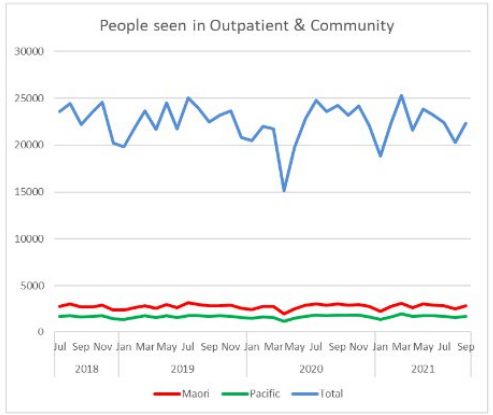


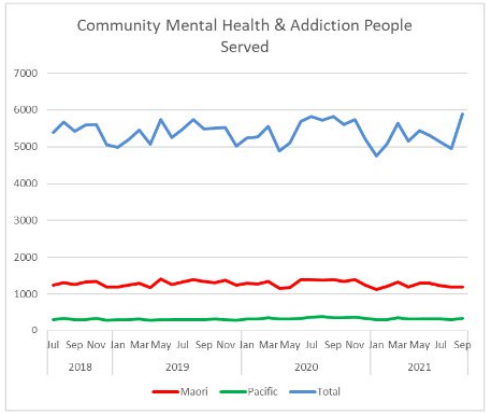


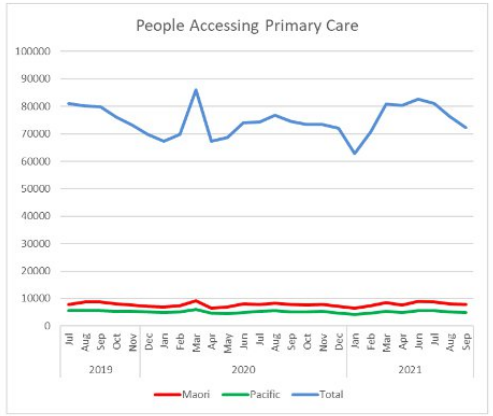


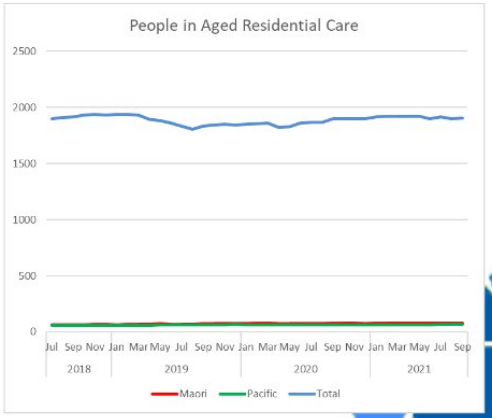
Performance Overview: Activity Context (People Served)

People seen in Outpatient & Community	**22,314**	2,847 Maori, 1,765 Pacific
Community Mental Health & Addiction People Served	**4,897**	1,197 Maori, 338 Pacific
People accessing primary care	**72,313**	7,771 Maori, 4,849 Pacific
People in Aged Residential Care	**1,906**	82 Maori, 71 Pacific









Financial Overview – September 2021

YTD Operating Position

$14.7m deficit

Incl. $8.1m net COVID-19 costs

Against a budgeted YTD deficit of $11.2m. BAU Month result was $2.8m favourable. YTD $4.6m favourable BAU variance.

YTD Provider Position

$4.6m deficit

Incl. $8.1m net COVID-19 costs

Against a budgeted YTD surplus of $641k. BAU Month result was $1.0m favourable. BAU YTD $4.4m favourable variance.

YTD Funder Position

$10.2m deficit

Against a budgeted YTD Deficit of $10.5m. BAU Month result was $500k unfavourable result. YTD $267k favourable BAU variance.

YTD Capital Exp

$21.6m spend

Incl. $12.7m strategic capex

Against a KPI of a budgeted baseline (non-strategic) spend of $10m.
Strategic incorporates funded project such as Children's Hospital & ISU

YTD Activity vs Plan (CWDs)

0.6% behind[1]

-1,217 CWDs behind PVS plan (-646 IDF CWDs , but -234 Hutt behind). Month result -627 CWDs excluding work in progress.

YTD Paid FTE

5,786.79[3]

YTD 281 below annual budget of 6,068 FTE. There is 571 FTE vacancies at end of September

Annual Leave Taken

($19.3m) annualised[4]

Underlying YTD annual leave taken is under by 7.5 days per FTE and Lieu leave taken for public holidays is short by 4.1 days.

[1] Note that the PVS (Price volume schedule for HHS/MHAIDS) is not total Surgical/Medical case-weight throughput largely due to Non-Residents & ACC. Also Outsourced PVS cases within this result cannot yet be compared to target, however a total of 718 cwd outsourced (365 events) ~$4.4m 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 – September 2021

ED (SSIED) 6 Hour rule	ESPI 5 Long Waits	Specialist Outpatient Long Waits	Serious Safety Events[2]
64.8%	694	607**	8
30.20% below the ED target of 95% Monthly -1.2%	Against a target of zero long waits a monthly movement of +143	Against a target of zero long waits, a monthly movement of +192 .**internal figures	An expectation is for nil SSEs at any point.

YTD Activity vs Plan (CWDs)	YTD Paid FTE	YTD Cost per WEIS
0.6% behind[1]	3,734[3]	$6,135*
-1,217 CWDs behind PVS plan (-646 IDF CWDs , but -234 Hutt behind). Month result -627 CWDs excluding work in progress.	YTD 105 below annual budget of 3,839 FTE. 254FTE vacancies at month end.	Against a national case-weight price per WEIS of $6,100.*to Sep 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 718 cwd outsourced (365 events) ~$4.4m dollars at WEIS price. This is largely Cardiothoracic sent to Wakefield and Orthopaedics sent to Southern Cross.
[2] An SSE is classified as SAC1 or SAC2 serious adverse events per HQSC
[3] Paid FTE ignores leave balance movement which is YTD 12 FTE worse than budgeted, Outsourced staff are also not counted in this metric which is currently $1.3m adverse

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

Section 2.1

Funder Performance

Executive Summary – Funder Performance

- The Funder has a favourable YTD variance of $0.3m made up of a favourable revenue variance of $14.3m offset by an unfavourable cost variance of ($14.0m).
- CCDHB has additional COVID-19 accrued and paid revenue of $17.77m. The offsetting COVID-19 costs are ($17.77m). MoH has agreed to a full cost recovery for the COVID-19 response. The ongoing demand for managed isolation facilities, and community surveillance continues. The COVID-19 vaccination rollout is progressing and will ramp up over the next 4 to 6 months. Due to the Delta outbreak and the level 4 lockdown, the vaccination programme was accelerated with a number of pop-up and drive-through vaccination sites activated at very short notice. There is a strong focus on equity for Māori, Pacific and vulnerable communities as part of the rollout to make sure vaccination coverage of these populations is prioritised.
- The cost of funding BAU community services is ($0.07m) unfavourable to budget. 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 immunisations, urgent dental and other services are .
- The volume throughput in HHS reduced in September due to the level 4 lockdown in the first few weeks and the funder paid $4m less to the Provider Arm for services and received ($4.4m) less IDF revenue from other DHBs.
- 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. We have developed and implemented initiatives with Māori and community providers but they are stymied by a lack of scaled investment to support all of those who need these response to have a significant impact:
- CCDHB is progressing a range of initiatives that provide more choice and options for young people to engage in primary care. These include: Youth one stop shop (YOSS) for Rangatahi in Porirua with Te Runanga o Toa Rangatira; The four YOSS providers across the 2DHBs were successful in a Youth Mental Health RFP for 12-18 year olds and Tū Ora Compass Health have rolled out a new SXT app in sexual health services to enable young people to anonymously contact their sexual partners when diagnosed with an STI.
- CCDHB has invested in a range of initiatives to support older people living in the region, including: CHOPI uses the skills of nurse practitioners and pharmacists along with speciality advice from geriatricians in partnership with general practice to work with frail older people in community settings; AHOP is effective at moving older people with frailty through ED faster. Although AHOP patients have a slightly longer average length of stay in hospital, they are less likely to be readmitted and AWHI works to reduce the functional decline of patients. It optimises the use of our allied health workforce, demonstrates material improvements in outcomes for patients and is showing savings.
- 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 also 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 of Performance

Month			Variance		Capital & Coast DHB Funder Result - $000 Sep 2021	Year to Date			Variance	
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year		Actual	Budget	Last year	Actual vs Budget	Actual vs Last year
76,176	76,176	72,885	(0)	3,291	Base Funding	228,527	228,527	218,655	(0)	9,872
5,405	5,292	4,875	113	530	Other MOH Revenue - Funder	16,682	15,876	14,161	806	2,521
8,134	0	1,120	8,134	7,014	COVID Revenue from MOH	17,771	0	3,172	17,771	14,599
52	46	211	6	(159)	Other Revenue	185	138	639	47	(454)
2,890	2,892	2,953	(2)	(63)	IDF Inflows PHOs	8,855	8,676	9,180	179	(326)
20,876	23,133	18,395	(2,257)	2,480	IDF Inflows 20/21 Wash-up Prov	64,914	69,398	53,863	(4,484)	11,050
113,533	**107,539**	**100,439**	**5,994**	**13,093**	**Total Revenue**	**336,935**	**322,616**	**299,672**	**14,319**	**37,263**
					Internal Provider Payments					
839	839	824	0	(15)	DHB Governance & Administration	2,517	2,517	2,471	0	(46)
55,593	59,277	53,509	3,685	(2,084)	DHB Provider Arm Internal Costs - HHS	177,124	183,048	164,161	5,925	(12,963)
11,558	11,558	7,799	(0)	(3,759)	DHB Provider Arm Internal Costs - MH	34,674	34,674	23,302	(0)	(11,371)
1,548	201	1,940	(1,347)	392	DHB Provider Arm Internal costs - Corp	1,984	402	3,880	(1,582)	1,896
1,745	0	0	(1,745)	(1,745)	DHB Provider Arm Internal costs - COVID	4,005	0	0	(4,005)	(4,005)
71,282	**71,875**	**64,072**	**593**	**(7,211)**	**Total Internal Provider**	**220,303**	**220,641**	**193,814**	**338**	**(26,489)**
					External Provider Payments:					
6,570	6,571	6,593	1	23	- Pharmaceuticals	19,709	19,712	18,159	3	(1,551)
7,056	6,932	6,715	(124)	(341)	- Capitation	21,209	20,797	20,174	(413)	(1,035)
7,708	7,454	7,460	(255)	(248)	- Aged Care and Health of Older Persons	22,440	22,362	21,527	(79)	(913)
2,541	3,184	2,827	643	286	- Mental Health	9,238	9,552	8,592	314	(646)
1,434	879	786	(555)	(648)	- Child, Youth, Families	2,838	2,638	2,361	(201)	(477)
832	845	551	13	(281)	- Demand driven Primary Services	2,425	2,534	1,830	109	(595)
2,416	2,440	2,384	24	(32)	- Other services	7,210	7,320	6,964	110	(247)
4,002	4,002	3,814	0	(188)	- IDF Outflows Patients to other DHBs	12,006	12,006	11,456	0	(549)
5,635	5,190	5,250	(445)	(386)	- IDF Outflows Other	16,036	15,569	16,050	(467)	14
38,194	**37,496**	**36,380**	**(697)**	**(1,814)**	**Total External Providers**	**113,113**	**112,489**	**107,114**	**(623)**	**(5,998)**
6,389	0	1,255	(6,389)	(5,134)	- Community COVID PHO	11,606	0	4,163	(11,606)	(7,444)
0	0	224	0	224	- Community COVID Other	2,160	0	797	(2,160)	(1,363)
115,865	**109,372**	**101,930**	**(6,493)**	**(9,025)**	**Total Expenditure**	**347,182**	**333,130**	**305,887**	**(14,052)**	**(41,294)**
(2,332)	**(1,833)**	**(1,491)**	**(499)**	**(841)**	**Net Result**	**(10,247)**	**(10,514)**	**(6,216)**	**267**	**(4,031)**

Funder Financials – Variance Explanations

Revenue

SPP Funder Revenue Variances	Mth $000's	YTD $000's
COVID-19 MIQ and Vaccine rollout	1,745	4,005
COVID-19 Community funding	6,389	13,766
PHOs volume variances offset	59	643
Mental Health, Aged Care, Family CFAs	24	286
CWD IDF 2020/21 below target	(2,223)	(4,382)
Year to Date Revenue Variances	**5,994**	**14,319**

External Revenue Variances

- COVID-19 actual funding and accrued provision of **$17,77m** in support of GP assessment testing, vaccine rollout, quarantine hotel staffing & response funding for Maori and Pacific groups. The DHB will be fully funded for all COVID response and vaccination rollout costs.
- PHO additional wash-ups and volume funding of **$0.6m**. There are increased costs of ($0.42m) offsetting this revenue. New funding for Mental Health and Child & Youth services of **$0.3m** has been contracted to NGO Providers.

Internal Revenue Variances

- The Provider Arm has not achieved IDF CWD targets by **($4.4m)** mainly due to COVID lockdown period in August.

CCDHB Funder Arm total net variance to budget for the month of Aug 2021 is $0.8m

Payments to Internal and External Providers

SPP Funder Payment Variances	Mth $000's	YTD $000's
COVID-19 MIQ & Vaccine	(1,745)	(4,005)
COVID-19 Community funding	(6,389)	(13,766)
HHS PVS services reduced due to COVID	2,338	4,343
PHOs volume variances offset revenue	(69)	(418)
Volume driven costs impacted by COVID	(629)	(206)
Year to Date Payment Variances	**(6,493)**	**(14,052)**

External Provider Payments:

- Community, MIQ and Vaccine rollout COVID-19 response costs **($17.77m)** due to ongoing GP test assessment claims and vaccine rollout in support of the COVID-19 response as directed by the Ministry. Community increase due to Price per Dose vaccinations cost.
- PHO Capitation expenses are **($0.42m)** unfavourable. Additional costs due to volume changes are offset by additional revenue.
- Other Community NGO contracts have a net YTD variance of (**$0.2m)**. New funded NGO contracts offset lower volume trends in NGO contracted services such as immunisations and aged care costs.

Internal Provider Payments:

- Provider Arm paid **$4.3m** less due to lower volumes achieved related to COVID lockdown period.

Inter District Flows (IDF)

IDF Inflow Categories Variance to Budget Target	YTD Sep 2021 $000's
Inpatient CWD	(3,942)
Outpatient Non DRG	(352)
Uncoded & PCT	(88)
PHO Volume changes	184
Other IDF Inflows	(108)
Total per Financials	**(4,305)**

Inter District Revenue Inflows

We have recognised changes in IDF inflows which has resulted in an unfavourable variance of ($4.3m) YTD. Breakdown of the variance commented below:

- The majority of the lower IDF inflows (actuals) are caused by planed care inpatient lower volumes:
  - Acute: ($1.9m): Cardiology ($537k), Spec Paediatric Surgery Neonates ($394), Haematology ($384k), General Surgery ($353k), Neurosurgery ($270k), Vascular Surgery ($242k), Renal Medicine ($214k), Gen Med ($154k) Emergency Medicine ($145k), and Offset by Cardiothoracic Surgery $396k, Otorhinolaryngology (ENT) $328k, Maternity Service $166k Orthopaedic Surgery 115k
  - Planned Care: ($2.0m); Cardiothoracic ($863k), Neurosurgery ($428k), Vascular Surgery ($229k), General Surgery ($209k) , Orthopaedic ($154k),Cardiology ($146k), Paediatric Surgical Services ($141k) and offset by Ophthalmology $203k
- Outpatient Non DRG inflow relates to all IDF patient visits that do not require a overnight stay
- PHO Volume change inflows relates to a increase in PHO enrolments through a quarterly wash-up by the Ministry
- Non DRG inflow relates to all IDF patient visits that do not require a overnight stay

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

Commissioning: Families & Wellbeing

What is this measure?

Youth health and wellbeing

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

Why is this important?

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

How are we performing?

- The proportion of CCDHB-domiciled 10-24 year olds enrolled in a PHO is 90% for Māori, 97% for Pacific and 85% for non-Māori, non-Pacific.
- The proportion of 10-24 year olds accessing primary care in the last month is 17% for Māori, 13% for Pacific, and 19% for non-Māori, non-Pacific.
- The rate of presentation per 1,000 for 10-24 year olds is 53 for Māori, 52 for Pacific, and 42 for non-Māori, non-Pacific.

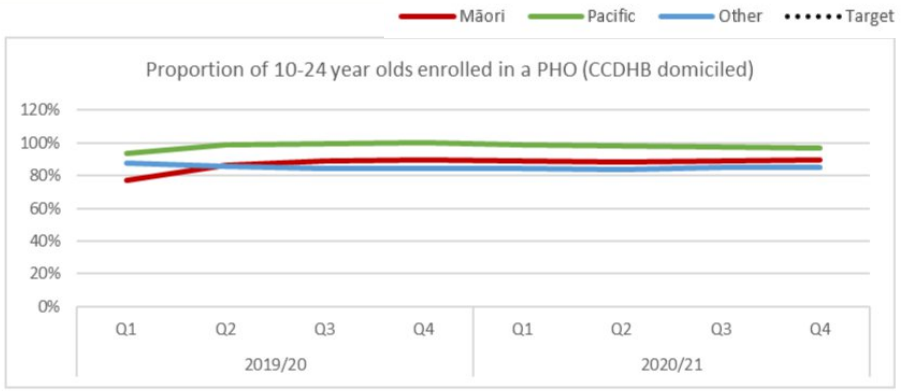
What is driving performance?

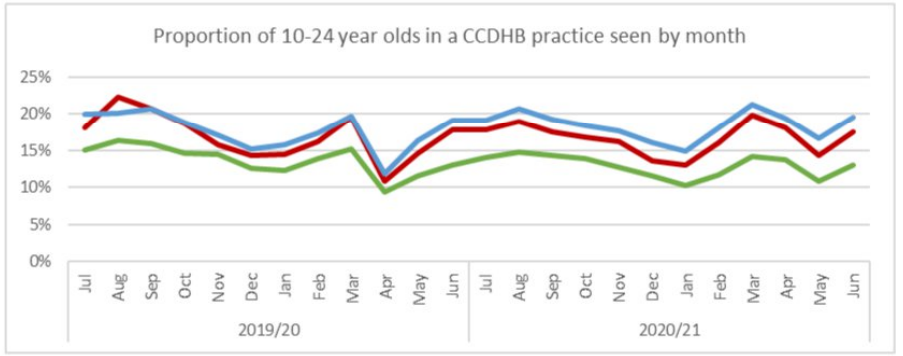
- Young people require a unique mix of social and health services which traditional and mainstream primary care services are not always best equipped to respond to.

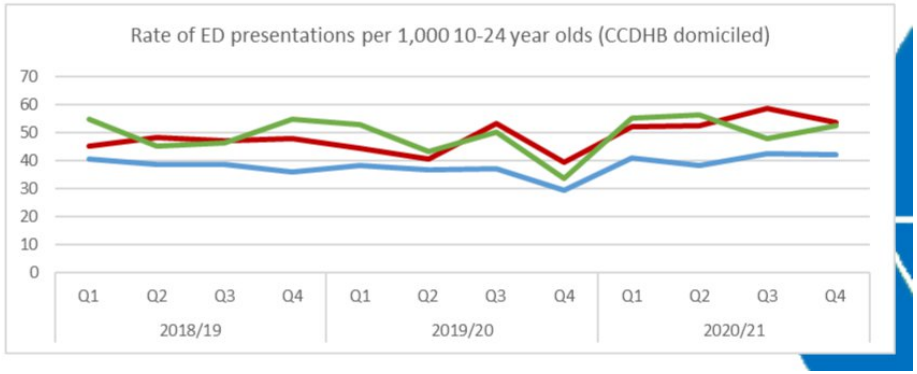
Management Comment

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

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







Commissioning: Primary & Complex Care

What is this measure?

Older People and Frailty

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

Why is this important?

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

How are we performing?

- The proportion of CCDHB domiciled 75+ year olds living at home is 92% for Māori, 93% for Pacific, and 92% for non-Māori, non-Pacific.
- The acute bed day rate is 2,039 for Māori, 2,121 for Pacific, and 1,668 for non-Māori, non-Pacific 75+ year olds.
- Performance for 0-28 day acute readmissions is 10% for Māori, 11%for Pacific, and 12% for non-Māori, non-Pacific 75+ year olds.

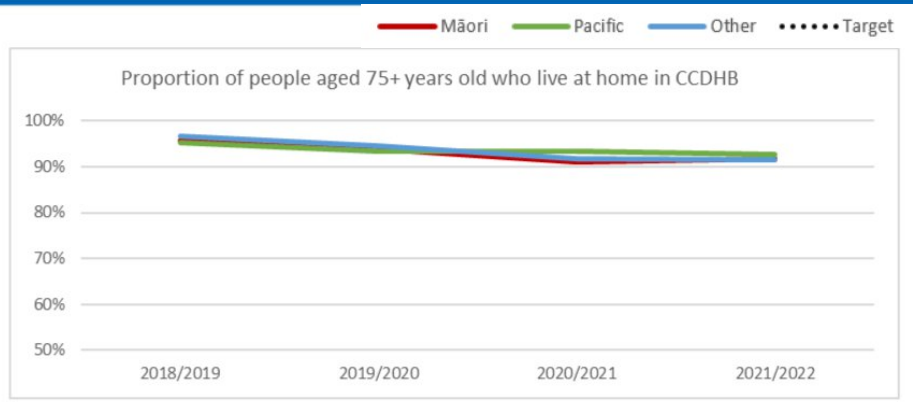
What is driving performance?

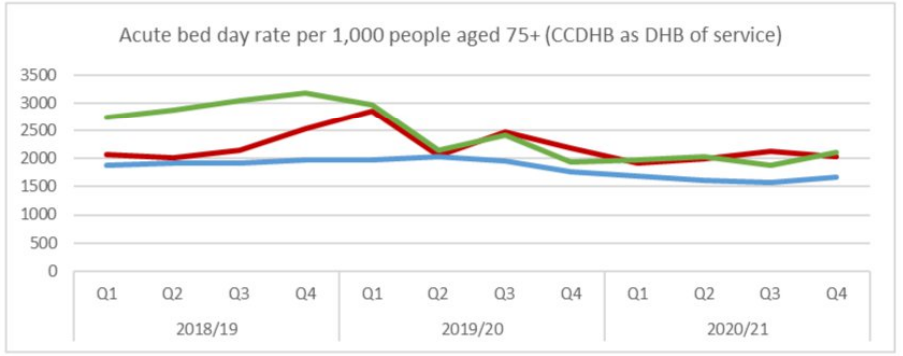
- Frail older people contribute to a significant volume of hospital bed occupancy due to their complex health and social circumstances. We have invested to support frailty across our health system to reduce their length of stay in hospital and decrease risk of further functional decline.

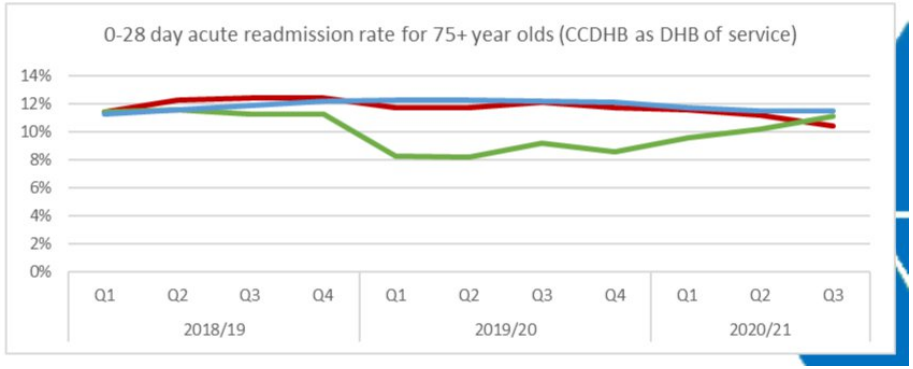
Management comment:

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

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







Commissioning: Hospital & Speciality Services

What is this measure?

Acute Flow at Wellington Regional Hospital

- 95% of people presenting to ED seen with 6hrs (admitted and non-admitted)
- ED Occupancy above 90%
- General Adult Hospital Occupancy

Why is this important?

- **Acute flow** at an individual level describes the journey a person takes through our health system to receive care for urgent or unplanned events. **Acute flow** at a system level describes the flow of all acute patients through our system. **Acute demand** measures how many people require acute care in a period of time.
- Recently, there has been increased discussion about acute demand and presentations to EDs across New Zealand. Addressing capacity constraints and mitigating acute demand is important for ensuring that people receive appropriate and timely access to acute care with equitable outcomes.

How are we performing?

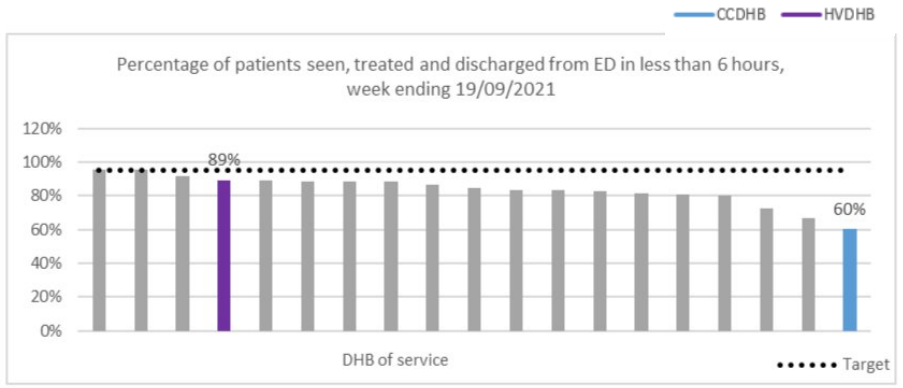
- The proportion of people presenting to ED and seen in under 6 hours was 89% (for the week ending 19 Sep).
- ED occupancy was over 90% in the week ending 19 Sep 19% of the time.
- Hospital occupancy was over 90% in the week ending 19 Sep 95% of the time.

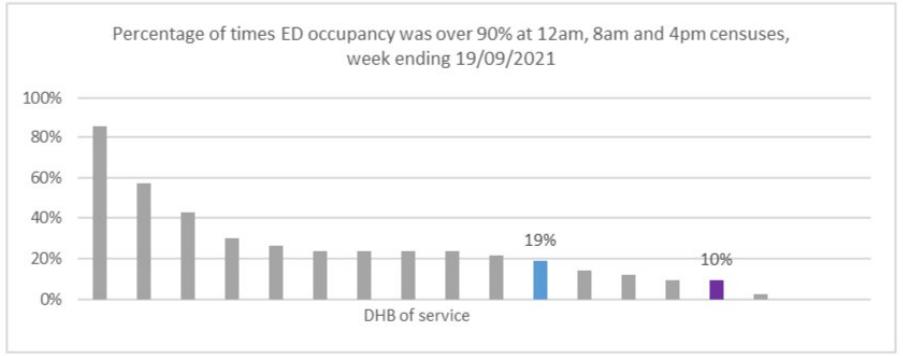
What is driving performance?

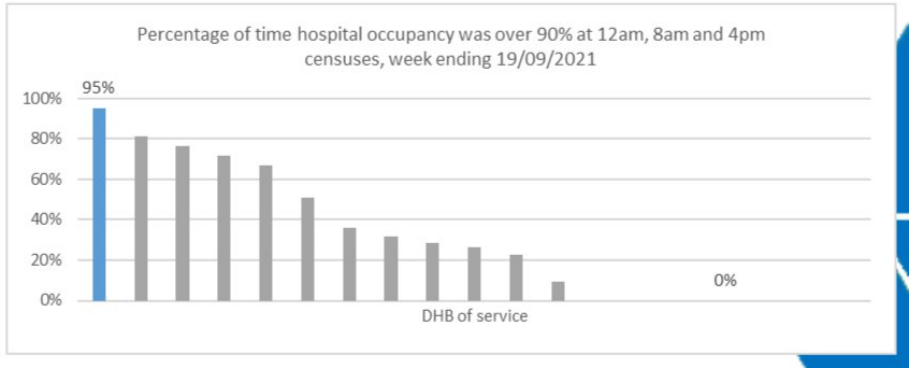
- The average general adult bed deficit is 37 at Wellington Regional Hospital in 2020/21.
- ED is at capacity and undersized, hospital occupancy continues to be high all year round.
- COVID-19 disruption to care delivery heightens system stress in the medium to long term.
- Quality of care is hindered when occupancy of general adults beds is higher 90%
- Significant workforce vulnerabilities and stresses impact delivery and safety.

Management comment:

- Destravis has been engaged to provide options on the best use of facilities across HVDHB and CCDHB in the 2DHB Hospital Network in the medium to long term.
- In response to capacity constraints we are undertaking the following projects identifying options for increasing **Bed and Theatre Capacity** across our three hospitals within the next two years while optimising use of current capacity. We are identifying options for increasing capacity and flow through Wellington ED and acute assessment areas as part of the **Front of Whare** project.
- These are part of the Hospitals strategic work programme for 2021/22.







Commissioning: Mental Health & Addictions

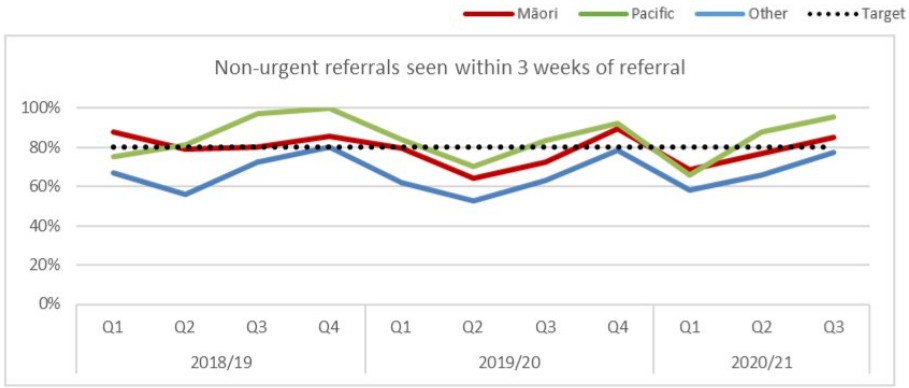
What is this measure?
- ≥80% of non-urgent referrals seen within 3 weeks
- Number of patients discharged from TWOM with a Length of Stay of more than 14 days
- Number of people aged 0-19 years referred to AOD services

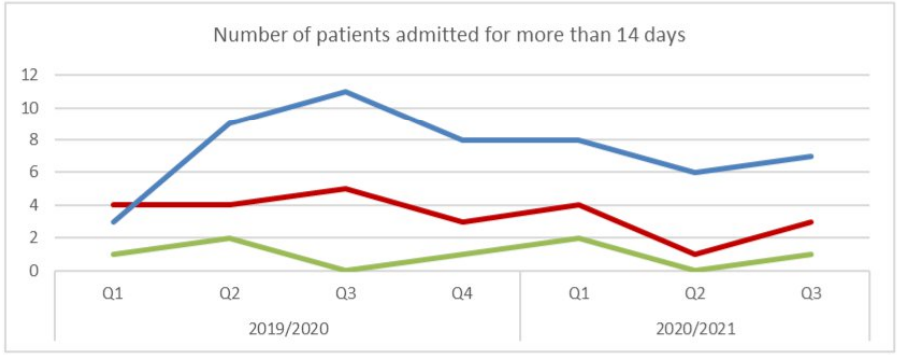
Why is this important?
- Reducing wait times corresponds to earlier treatment in the progression of illness and links to better outcomes. Timeliness is a key quality indicator.
- The demand for acute inpatient services continues to grow. Length of stay has an impact on ward occupancy and therefore the 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.

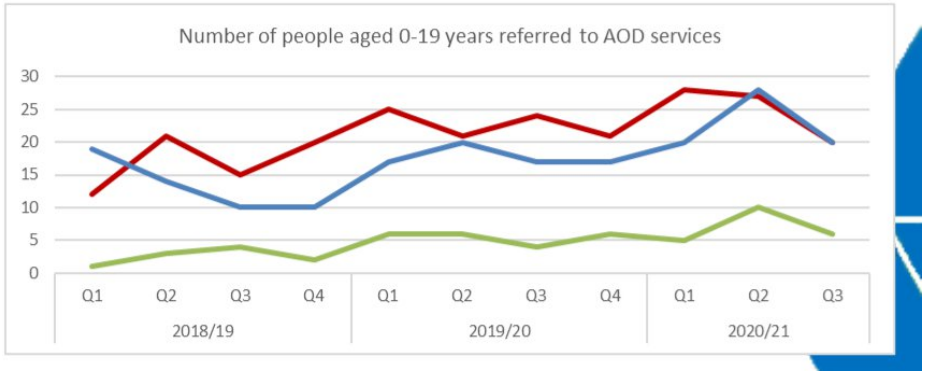
How are we performing?
- Performance is above the 80% target for non-urgent referrals seen within 3 weeks for Māori (85%) and Pacific (95%) and below target for non-Māori, non-Pacific (77%).
- The number of patients admitted to TWOM for more than 14 days was 3 for Māori, 1 for Pacific, and 7 for non-Māori, non-Pacific.
- The number of people aged 0-19 years old referred to AOD services were 20 for Māori, 6 for Pacific, and 20 for non-Māori, non-Pacific.

What is driving performance?
- MHAIDS are developing smart systems as a key enabler of 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?

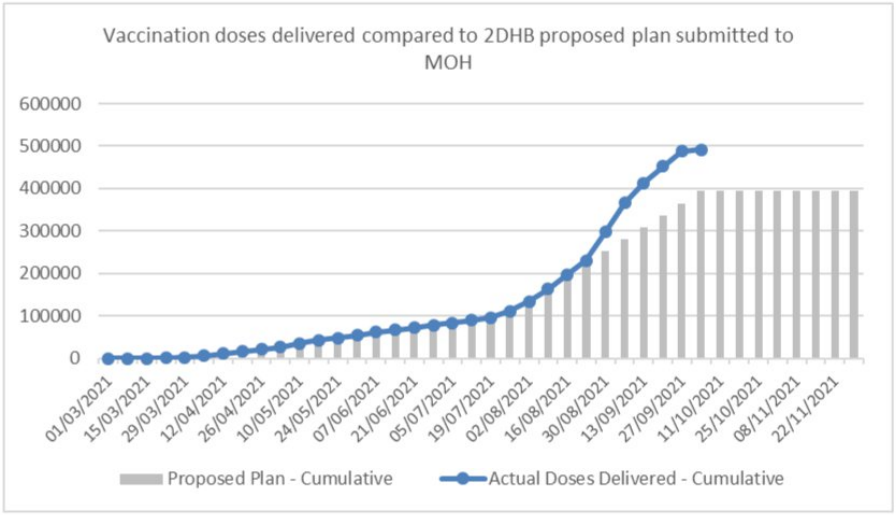
- **Group 1: Protect our border and MIQ workers**
  - Border and MIQ workers and employees and the people they live with

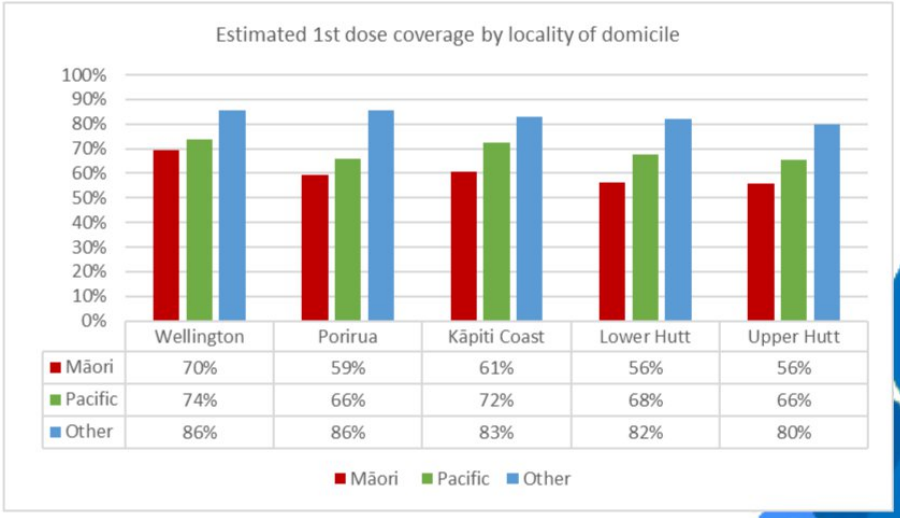
- **Group 2: Protect our high-risk frontline workers and people living in high-risk places**
  - High-risk frontline health care workers (public and private)
  - People living in long-term residential care
  - People working in long-term residential environments
  - Older Māori and Pacific people cared 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.





	Wellington	Porirua	Kāpiti Coast	Lower Hutt	Upper Hutt
Māori	70%	59%	61%	56%	56%
Pacific	74%	66%	72%	68%	66%
Other	86%	86%	83%	82%	80%

Data Sources: COVID-19: Vaccination 2DHB Qlik App
Date Range: 22/02/2021 to 27/08/2021
Data current at: 28/08/2021 @9.35am

Section 2.2

Hospital Performance

Executive Summary – Hospital Performance

- The impact of COVID-19 lockdown was felt across all specialities and services with a total of 5557 cancellations across planned care, inpatient, outpatient, radiology, and endoscopy in particular. This is on top of underlying disruptions created by acute demand, RSV outbreaks, and industrial action.
- Last month we highlighted the service delivery and financial risk that in the constrained environment the DHBs will not be able to deliver the full planned care funding schedule nor reduce waiting list size so that people are treated within 120 days; this is now a given. To mitigate the impacts both DHBs are maximising utilisation of current theatre and bed capacity as well as private hospital outsourcing capacity. Investment in innovation will help to provide alternative solutions for people to access and reduce the number of people requiring treatment, these will take time to implement. SMOs continue to lead planning surgery based on those with greatest clinical urgency and long waiting times.
- Work continues with the Front of Whare, 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) – in respect of the former, this work is supported by expertise from the MOH and is inextricably linked to other ongoing work to assess and address overall hospital capacity.
- Ongoing and intractable workforce shortages across midwifery and nursing, allied health in particular sonographer social work and radiographers which remain 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.
- A cautious start at the end of the first quarter– meeting budget.

CCDHB Contract Activity Performance

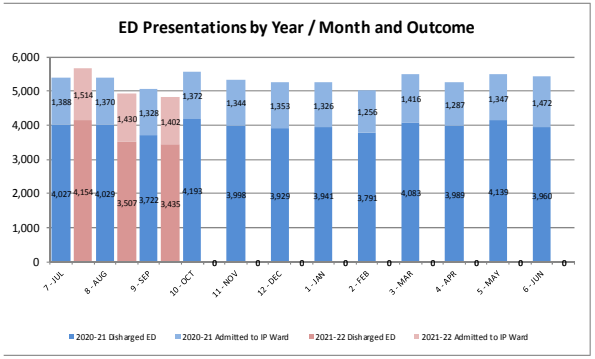
Capital and Coast DHB: September 2021

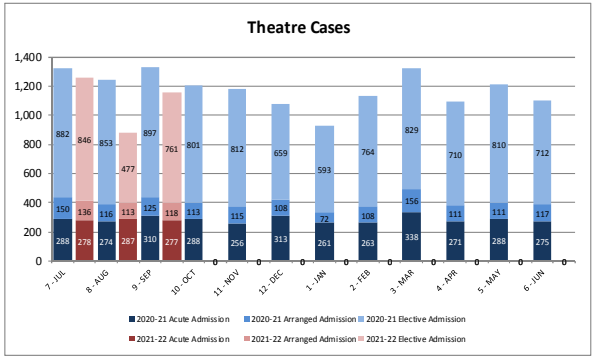
ED Presentations

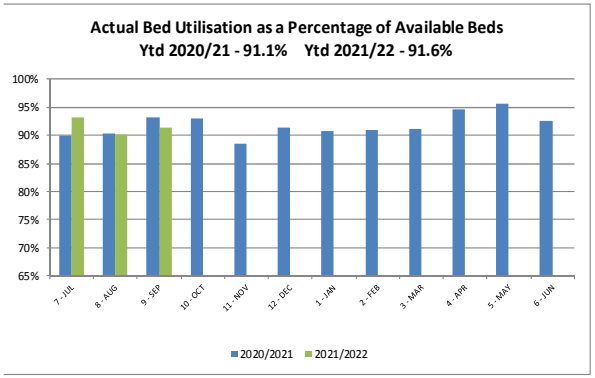
	2020/21	2021/22
YTD Totals	15,864	15,442
Change		-422
% Change		-3%

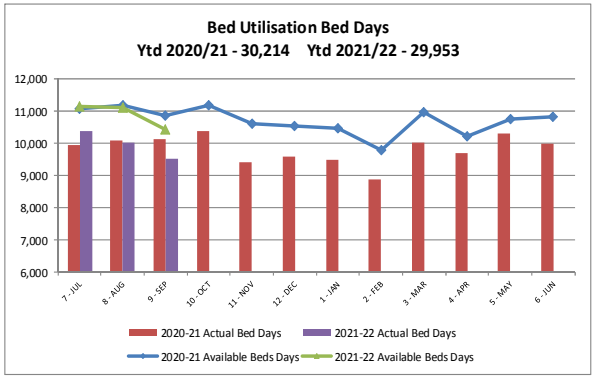
Theatre Cases

	2020/21	2021/22
YTD Totals	3,895	3,293
Change		-602
% Change		-15%









ED

- The total number of presentations to ED in September 2019 was 5,416 (this includes 476 DNWs)
- The total number of presentations to ED in September 2020 was 5,047 (this includes 357 DNWs)
- The total number of presentations to ED in September 2021 was 4,813 (this includes 275 DNWs)
- The average number of daily presentations in September 2021 was 160.4, this is slightly higher than August 2021 160.1 with both months lower than expected which can be largely attributed to lockdown protocols.
- The average number of presentations during lockdown level 3 (1st September to 7th September) was 139, the average number of presentations during lockdown level 2 (8th September to 30th September) was 167 which is consistent with September 2020 which had a daily average of 168 presentations per day.
- The number of Patients with a triage level of 1-3 combined in September 2021 is 3,279 this represents 68.1% of the total presentations, this is higher as percentage than both September 2020 (3,328 - 65.9%) and September 2019 (3,328 - 61.4%).
- The proportion of triage level 1-3 presentations may have increased but the counts of presentations are similar so the reduction in the overall count of presentations is in the number of level 4-5 presentations. The totals of level 4-5 presentations in September 2019 was 2,088 in September 2020 it was 1,761 in September 2021 it was 1,534.

Bed Utilisation

- The utilisation of available of adult beds in core wards in September was 91.4% which is lower than the rate of 93.2% rate recorded in September 2020. The number of available beds in September 2021 (348) is lower than in September 2020 (362) which EDOU absorbed by ED and a reduction in the number of open beds on Ward 7 North.
- The number of Elective theatre cases has decreased for the month of September 2021 by 13.2%
- (176 cases) when compared to September 2020 with decreases most evident in Paediatric Surgery (-39) Gynaecology (-21), Orthopaedics (-21), Ophthalmology (-17) and ENT (-18).

CCDHB Activity Performance

Capital and Coast DHB: September 2021

HSS Inpatient Caseweight Activity

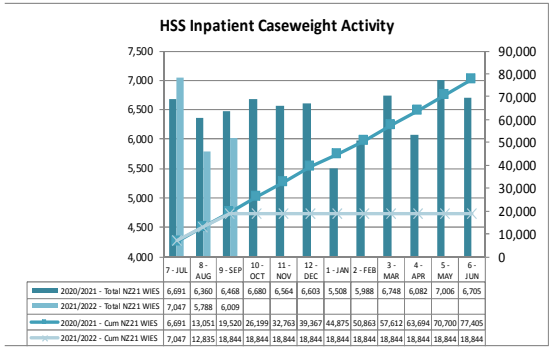
	2020/21	2021/22
YTD Totals	19,520	18,844
Change		-675
% Change		-3.5%

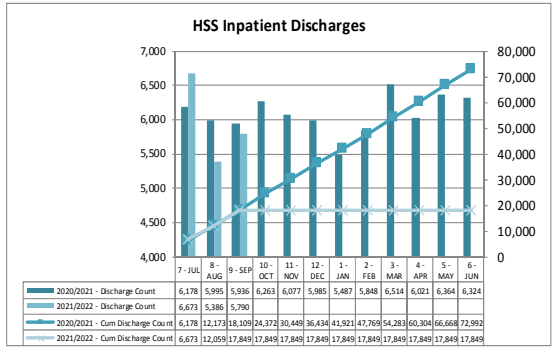
** This includes all Hospital Acitivty including ACC, Non Resident, Non-Casemix but excludes Mental Health*

HSS Inpatient Discharges

	2020/21	2021/22
YTD Totals	18,109	17,849
Change		-260
% Change		-1.4%

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



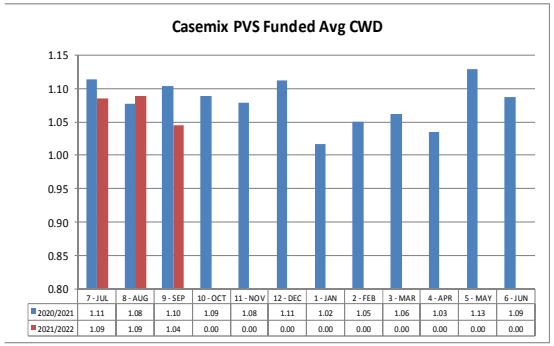


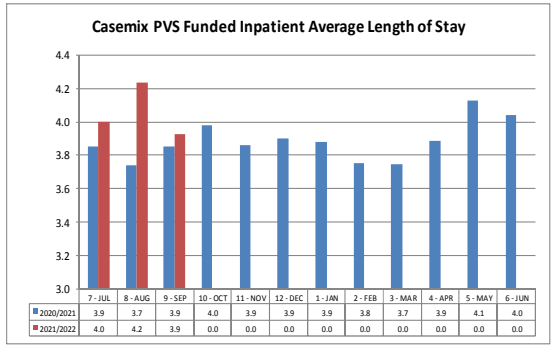
Casemix PVS Funded Avg CWD

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

Casemix PVS Funded Inpatient Average Length of Stay

	2020/21	2021/22
YTD Totals	3.89	4.05
Change		0.16
% Change		4.2%





Comparisons with same period last year:

- Local acute CWDs are higher than then previous financial year (453 CWDs) with an increase in discharges; a higher ALOS and a similar average CWD. The discharge increase is driven primarily by Paediatric Medicine and Emergency Medicine. The CWD increase is driven primarily by Paediatric Medicine, Orthopaedics and Emergency Medicine.
- Local Elective CWDs are lower than the previous financial year (-507 CWDs) with a decrease in discharges; a similar ALOS and average CWD. The discharge decrease is driven primarily by General Surgery, Cardiology and ENT. The CWD decrease is driven primarily by Orthopaedic Surgery, General Surgery and Cardiology.
- IDF acute CWDs are higher (130 CWDs) than the previous financial year also with an increase in discharges; a similar ALOS and average CWD. The discharge increase is driven primarily by Gynaecology, ENT and Radiotherapy. The CWD increase is driven primarily by Neonatal, ENT and Radiotherapy.
- IDF Elective CWDs are lower than the previous financial year (-594 CWDs) with less discharges; a higher ALOS and a higher average CWD. The discharge decrease is driven primarily by Vascular Surgery, and Paediatric Surgery. The CWD decrease is driven by Cardiothoracic Surgery, Vascular Surgery and Neurosurgery.
- In combination these four admission groups equate to a decrease of 519 CWDs compared to the previous year. The services that most significantly impact this shift are Cardiothoracic Surgery (-332), Neurosurgery (-192) and Vascular Surgery (-148) countered by increases in Neonatal (148), Paediatric Medicine (134)* and General Medicine (128)*.
- The increases in General Medicine and Paediatric Medicine were realised in July 2021 and August 2021 with the results for September 2021 showing a drop off in both these specialties.

Discharges:

- The number of publicly funded casemix discharges for the month of September 2021 has decreased by 130 (2.4%) in comparison to the number of discharges recorded in September 2020. This decrease can be largely attributed to the impact of lockdown with a decrease in the number of discharges most evident in General Medicine (-52), Paediatric Medicine (-36) and Respiratory Medicine (-22). Also of note was the reduction in the number of discharges in Vascular Surgery (-38) but this can be attributed to lower levels of outsourced activity in September 2021 compared to September 2020. The overall decrease was countered by increases in both Obstetrics (19 Mothers, 35 Babies) and Cardiology (27) during September 2021.
- The number of outsourced discharges recorded in September 2021 was 136 which is 37 higher than September 2020. CCDHB in September 2021 has utilised Boulcott Hospital, Bowen Hospital, Southern Cross Hospital and Wakefield Hospital.

HHS Operational Performance Scorecard – period Sep 20 to Sep 21

Domain	Indicator	2021/22 Target	2020-Sep	2020-Oct	2020-Nov	2020-Dec	2021-Jan	2021-Feb	2021-Mar	2021-Apr	2021-May	2021-Jun	2021-Jul	2021-Aug	2021-Sep
Care	Serious Safety Events	TBD	11	5	19	6	12	14	3	10	7	4	9	2	8
	Total Reportable Events	TBD	1,370	1,359	1,418	1,514	1,424	1,483	1,452	1,424	1,539	1,365	1,487	1,253	1,162
Patient and Family Centred	Complaints Resolved within 35 calendar days	TBD	93.9%	94.9%	90.9%	83.0%	93.1%	95.5%	92.3%	93.7%	93.4%	87.8%	76.9%	89.3%	95.5%
	% Discharges with an Electronic Discharge summary	TBD													
Access	Emergency Presentations		5,050	5,565	5,342	5,282	5,267	5,047	5,499	5,276	5,486	5,432	5,668	4,937	4,837
	Emergency Presentations Per Day		168	180	178	170	170	180	177	176	177	181	183	159	161
	Emergency Length of Stay (ELOS) % within 6hrs	≥95%	65.6%	65.1%	67.6%	65.9%	68.6%	62.5%	66.3%	63.3%	66.8%	64.0%	56.2%	66.6%	64.8%
	ELOS % within 6hrs - non admitted	TBD	77.4%	74.7%	75.4%	75.6%	78.0%	72.7%	77.5%	74.0%	78.3%	75.2%	66.4%	79.3%	75.9%
	ELOS % within 6hrs - admitted	TBD	46.0%	47.5%	53.5%	49.4%	52.4%	45.4%	47.2%	45.0%	45.6%	45.3%	39.6%	44.0%	41.4%
	Total Elective Surgery Long Waits	Zero Long Waits	99	183	206	301	485	525	513	517	344	364	429	551	694
	Additions to Elective Surgery Wait List		1,543	1,397	1,391	1,288	922	1,243	1,455	1,224	1,452	1,354	1,230	923	1,035
	% Elective Surgery treated in time	TBD	90.3%	89.0%	86.3%	88.4%	75.5%	75.6%	72.2%	72.1%	75.0%	82.4%	83.2%	81.5%	72.5%
	No. surgeries rescheduled due to specialty bed availability	TBD	13	14	1	6	2	6	11	7	13	21	16	6	0
	Total Elective and Emergency Operations in Main Theatres	TBD	1,254	1,130	1,118	1,002	878	1,076	1,270	1,063	1,190	1,085	1,209	807	1,062
	Faster Cancer Treatment 31 Day - Decision to Treat to Treat	85%	87.0%	82.0%	85.0%	88.0%	82.0%	90.0%	88.0%	86.0%	83.0%	96.0%	85.0%	83.0%	83.0%
	Faster Cancer Treatment 62 Day - Referral to Treatment	90%	88.0%	88.0%	83.0%	89.0%	88.0%	83.0%	96.0%	79.0%	84.0%	91.0%	76.0%	81.0%	87.0%
	Specialist Outpatient Long Waits	Zero Long Waits	314	245	225	314	353	355	302	244	211	265	295	412	607
	% Specialist Outpatients seen in time	Zero Long Waits	90.1%	88.7%	92.1%	92.9%	89.1%	88.0%	85.5%	79.9%	90.4%	90.2%	89.1%	88.3%	81.9%
	Outpatient Failure to Attend %	TBD	7.0%	7.6%	7.6%	7.9%	7.3%	7.6%	7.2%	7.2%	7.4%	7.0%	7.3%	7.1%	6.0%
	Maori Outpatient Failure to Attend %	TBD	15.2%	15.3%	16.0%	16.7%	16.1%	16.2%	15.7%	15.7%	15.1%	15.2%	16.6%	14.6%	14.6%
	Pacific Outpatient Failure to Attend %	TBD	14.5%	16.4%	16.1%	18.7%	19.5%	17.8%	16.7%	15.6%	16.3%	15.5%	15.9%	16.7%	15.1%
Financial Efficiency	Forecast full year surplus (deficit) ($million)		($62.0m)	($62.0m)	($62.0m)	($62.0m)	($62.4m)	($62.4m)	($62.4m)	($62.4m)	($62.4m)	($46.5m)	$1m	$1m	$1m
	Contracted FTE (Internal labour)		5,237	5,267	5,264	5,257	5,256	5,344	5,346	5,366	5,364	5,340	5,334	5,361	5,383
	Paid FTE (Internal labour)		5,607	5,608	5,651	5,694	5,695	5,813	5,727	5,792	5,784	5,746	5,759	5,828	5,765
	% Main Theatre utilisation (Elective Sessions only)	85.0%	82.0%	82.0%	80.0%	78.2%	81.0%	80.0%	83.0%	83.0%	81.0%	80.0%	79.0%	79.0%	81.0%
Discharge and Occupancy	% Patients Discharged Before 11AM	TBD	24.8%	22.2%	25.1%	22.6%	22.3%	21.9%	23.2%	25.3%	23.6%	25.3%	20.7%	21.8%	20.6%
	Adult Long Stay Patients Not Yet Discharged (>14 days) WLG	TBD	51	33	34	37	37	38	41	37	35	38	44	40	30
	Adult Overnight Beds - Average Occupied WLG	TBD	382	378	363	360	355	373	381	381	386	387	383	355	349
	Adult Long Stay Patients Not Yet Discharged (>14 days) KEN	TBD	18	23	18	17	16	14	19	19	22	17	32	34	21
	Adult Overnight Beds - Average Occupied KEN	TBD	74	76	67	64	67	71	69	72	73	73	79	83	80
	Child Overnight Beds - Average Occupied	TBD	22	23	24	22	17	19	22	22	22	25	30	23	19
	NICU Beds - ave. beds occupied	36	38	36	33	35	38	39	44	39	42	36	40	38	32
ALOS	Overnight Patients - Average Length of Stay (days)	TBD	3.85	3.98	3.86	3.90	3.88	3.75	3.75	3.88	4.13	4.04	4.00	4.24	3.93
Care	Rate of Presentations to ED within 48 hours of discharge	TBD	4.3%	4.6%	3.2%	3.2%	4.1%	4.0%	3.5%	4.7%	4.6%	4.0%	4.0%	4.3%	4.0%
	Presentations to ED within 48 hours of discharge	TBD	215	254	171	170	218	202	194	247	253	218	224	211	194
Staff Experience	Staff Reportable Events	TBD	138	179	173	175	147	185	162	156	149	158	158	127	140
	% sick Leave v standard	TBD	3.6%	3.4%	3.4%	3.2%	2.0%	2.7%	3.5%	3.0%	3.6%	3.8%	4.3%	3.9%	2.7%
	Nursing vacancy	TBD	251.1	247.4	267.4	268.5	267.8	223.4	234.7	235.6	244.0	249.1	275.4	271.2	253.0
	% overtime v standard (medical)	TBD	2.1%	1.9%	2.0%	1.8%	1.8%	2.0%	1.9%	1.8%	2.0%	1.9%	2.4%	2.2%	2.0%

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.
- September 2021 had an average of 160 presentations per day compared to 168 average presentations per day in September 2020.
- The impact of lockdown protocols is demonstrated below in relation to the average number of presentations per day.
- CCDHB performance for ED admitted patients for September 2021 was 42%, which is 4% lower than the result for September 2020.
- Reducing ED length of stay will improve the public's confidence in being able to access services when they need to, increasing their level of trust in health services, as well as improving the outcomes from those services.
- Increasing performance on this measure will also result in a more unified health system, because a coordinated, whole of system response is needed to address the factors across the whole system that influence ED length of stay.

How are we performing?

- CCDHB SSIED performance for September 2021 was 65.0%. This result is a slight decrease on the 66.4% recorded last month in August 2021.
- The count of breaches in ED 1,587 in September 2021 is similar to 1,615 recorded in August 2020 1,569. The performance for ED treated and discharged patients for September 2021 was 76%, for ED admitted patients was 43% similar levels to August 2020
- During the month of September 2021 there were no presentations recorded where the patient was suspected of having COVID-19.

Performance	JUL	AUG	SEP
2018-19	78%	75%	75%
2019-20	73%	68%	66%
2020-21	56%	66%	65%

Breaches	JUL	AUG	SEP
2018-19	1,149	1,315	1,254
2019-20	1,358	1,576	1,615
2020-21	2,223	1,569	1,587

ED Volumes	JUL	AUG	SEP
2018-19	5,285	5,284	4,940
2019-20	5,024	4,998	4,690
2020-21	5,036	4,664	4,538

What is driving performance?

- Bed occupancy continues to be one of the most significant contributing factors to SSiED compliance. The occupancy percentage utilisation for September was 91% (optimum occupancy of 95%) however Covid worksteams displaced some bed availability in part through bed closure with the upgrade work for the Oxygen Supply and Related Environmental Systems Programme and more particularly as we continue to operate parallel processes in our inpatient wards to manage COVID case definition vs. non-COVID patients. .

Management Comment

- The acute flow collaborative is well underway. Coupled with the Front of Whare project 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.
- Regular reporting of progress is in place – a more in depth update will be provided next month.

Planned Care – Inpatient Surgical Discharges/Minor Procedures

What is this measure?

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

Why is this important?

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

How are we performing?

- Year to date we are reporting 538 behind our target of 2,845.
- Planned care results for September month end show us 113 adverse to the planned 847 discharges. IDF outflow results are 1 ahead of the planned 92.
- Our in-house elective surgical PUC results were 65 adverse to the planned 552 and outsourcing adverse 42 to the planned 154. Elective non-surgical PUC resulted 4 ahead of our planned target. Arranged surgical 2 behind plan and arranged non-surgical 8 behind plan.
- IDF September results show elective surgical PUC 14 ahead of the planned 77 which offset the slightly adverse results of the other IDF measures.
- Minor procedures in-house reporting 223 over the planned 250 for September.
- Patients are waiting longer:
  - September EPSI 2 (outpatient assessment) results show a decline of 180 patients from the previous month. This is due to cancelled face to face clinic appointment from August 19 onwards, although we increased our clinics mid-September it was not enough to do any catch up from level 4 lockdown.
  - September EPSI 5 (inpatient assessment) results show a decline of 128 patients from the previous month. Our September theatre session increased from the previous month, however not to capacity over the whole month. Our private providers also had a backlog of patients they had deferred so also could not offer us any additional capacity. Theatre lists continue to be prioritised in clinical urgency.

What is driving performance?

- Reduced access to theatres because of the COVID 19 pandemic from 19 August which continued to the beginning of September.

Management Comment

- Mid-September saw an increase in our theatre capacity in-house with drop in COVID levels both in Wellington and Kenepuru, however capacity with our private providers did not occur as they too are working on a back log of deferred patients.
- SMOs continue to be involved with planning surgery based on those with greatest clinical urgency and long waiting times.
- Work on the 2 DHB closed RFP for outsourcing progressed in September and a recommendation on providers is now with ELT. It is anticipated that outsourcing will commence in Quarter 2 at the latest post some pricing and volume negotiation.
- We have had interest from four specialties wanting to explore ability to operate elective lists on a Saturday, requests for anaesthetic and nursing staff to facilitate this happening have been submitted to the relevant teams.
- 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 and high technical staffing vacancies.

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 Four: CT wait times

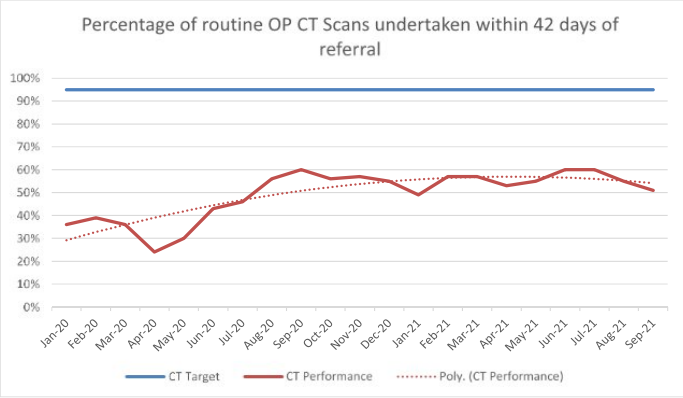
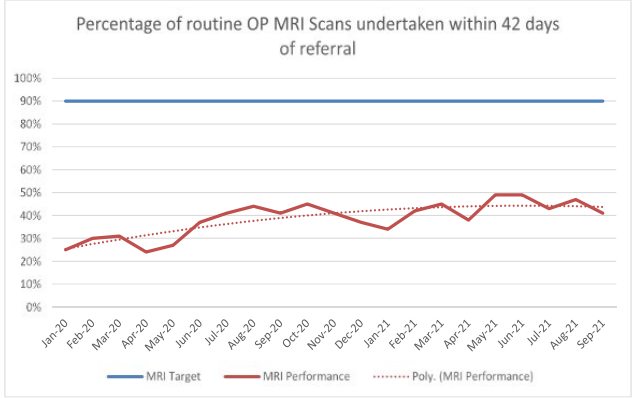


Figure Five: MRI wait times



Management Comment

- With current waiting times there is still risk of patient harm, including disease progression, while waiting for imaging appointments. The service continues to prioritise based on clinical urgency and process images for inpatient and ED patients within expected timeframes in order to maximise inpatient flow.
- The Radiology service has received over 12 resignations from within the technical team (MIT – Medical Imaging Technologist) workforce since Easter 2021. This is over 20% of MIT workforce and creates a significant gap in capacity. For CT scanning this has resulted in an approximately 17% reduction in outpatient (OP) booking slots as shifts are unable to be filled.
- Recruitment for the vacant positions continues but due to the specialised nature of the MIT workforce and lack of a timely overseas recruitment process, we are unlikely to see any significant reduction in the MIT vacancy within the department. We do not anticipate a recovery of internal OP capacity until 2022 following the yearly intake of NZ-trained MITs who will graduate in December 2021.
- The latest lockdown will again further increase waiting times with significant disruption to both internal capacity and outsourced capacity. Recovery from this dip will be extremely challenging as private capacity to increase outsourced services is limited.
- 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 is 97.2% this month.

What is driving performance?

- Target has been met this month. Administration/booking continue to focus on ensuring timeframes are met, and interventional session cover has improved. 3 patients did not meet target due to COVID rescheduling and loss of an angiography session to training day.

Management Comment

- On track to maintain compliance. Recruitment of an additional interventionist position currently in progress

Acute Coronary Syndrome

Key clinical quality improvement indicators

What is this measure?

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

Why is this important?

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

- **How are we performing?**

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

National Performance	80.6% (591/733)
Central Region	77.3% (116/150)
CCDHB	93.3% (28/30)
Hawkes Bay	51.5% (17/33)
Hutt Valley	90.0% (18/20)
Mid Central	72.4% (21/29)

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

What is driving performance?

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

Management Comment

- While access to beds in Ward 6 South remains an issue, a number of initiatives have been introduced which will help to reduce the length of stay on the ward, provide alternatives to admission, and allow us to manage cardiology in-patient pressures by utilizing beds in both Hutt and WRH CCUs. The regional waiting times are also monitored on a daily basis with escalation measures taken if required.
- A proposal has been submitted which in the medium to long term would provide 6 additional beds in Ward 6 South.

Faster Cancer Treatment

What is this measure?

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

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

Why is this important?

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

How are we performing?

- CCDHB is non-compliant with the 62 day target for September at 84% which is below the aim of 90% of patients receiving their first cancer treatment within 62 days of being referred with a high suspicion of cancer.
- CCDHB is non-compliant with the 31 day indicator for September at 82% vs the aim of 85% of patients commencing treatment within 31 days from decision to treat.

What is driving performance?

- Of the seven patients who breached the 62 day target all experienced delays in diagnostic phase including accessing a FSA appointment. Two had surgical delays due to covid restrictions. The breaches occurred in the Gynae (3 patients), breast (2 pts), Lower GI and head and neck. Five Māori and one Pacifica patients were covered by the 62 day target and one Maori breached. Note acute presentations are excluded from the 62 day target.
- Fourteen of the seventeen breaches in the 31 day indicator were due to capacity reasons – access to surgery including eight due to covid restrictions/rescheduling. Urological (5), Breast (4), Gynae (3), Lung (1), Head and Neck (1). 31 day compliance was 83 % for Māori (10/12pts), 100% Pacifica (6/6pts) and 65/80 81% for other ethnicities.

Management Comment

- Acute demand and staffing vacancies is having a negative effect upon access to FSA, diagnostic services (imaging & pathology) and surgical services. This was exacerbated in some services due to deferrals for covid -19.
- Eight patients who commenced treatment in September had a delay in their pathway due to covid-19.
- Thirty patients who have been referred with a suspicion of cancer but have yet to commence treatment, have experienced a disrupted pathway due to covid-19. This includes deferred diagnostic procedures (biopsies, hysteroscopies, other scopes), FSAs, pre assessments and surgery dates. A few patients have been referred for an alternative treatment due to surgical delays.
- Work underway includes:
  - Working with gynaecology service to improve compliance -establishment of a bleeding clinic being scoped.
  - Diagnosis via ED presentation pathway improvement project.
  - Faster Cancer Tracker role now within cancer services has secured a high quality applicant.

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 Eleven: FCT 62 day target

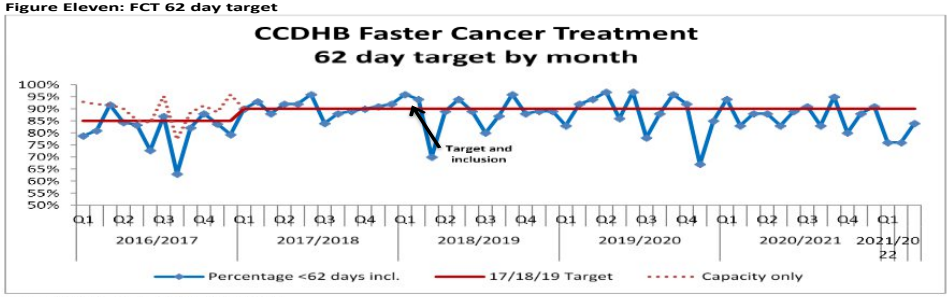
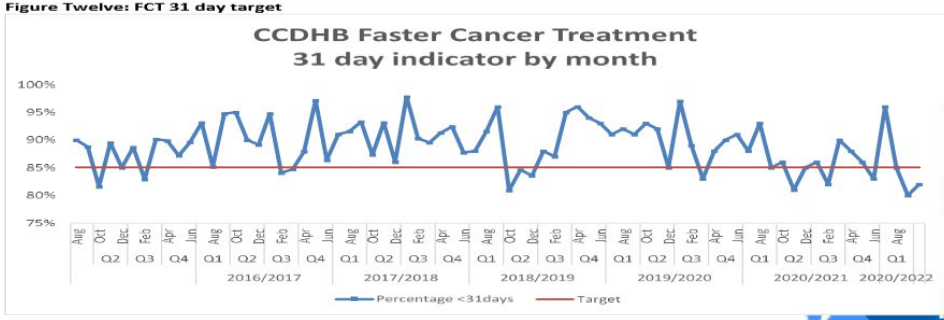


Figure Twelve: FCT 31 day target



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 exceeded the Ministry of Health target for urgent colonoscopies with a performance of 100% (target 90%). This was a significant improvement in the 56% achieved in July. For diagnostic waits, we achieved 33% (target 70%) in September, which was a reduction in the August performance of 46%.

We just missed the Ministry of Health target for surveillance achieving 69% (target 70%). This is a reduction from the August performance of 78.7%.

What is driving performance?

We had identified in the August report that performance was significantly impacted by the change in COVID alert levels which resulted in the cancellation of all but the very urgent/acute lists. As the COVID restrictions extended into September our performance continued to be impacted.

Management Comment

The hospital is returning to normality and all of our colonoscopy lists have resumed which should see performance improve in the October report. The outsourcing contract is now in operation and the provider has also been able to resume activity after the change in COVID alert levels.

Figure Seven: Colonoscopy – Wait Time Indicator

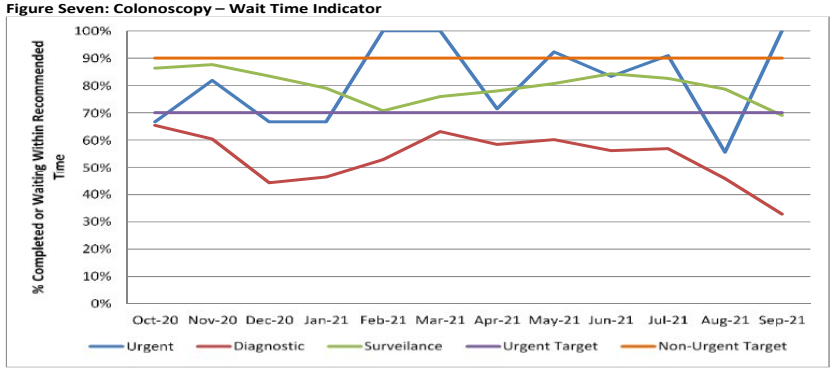
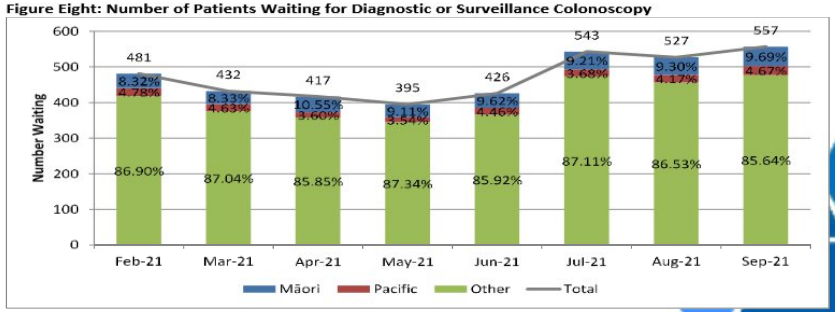


Figure Eight: Number of Patients Waiting for Diagnostic or Surveillance Colonoscopy



Maternity and Neonatal Intensive Care services

Maternity

What is the issue?

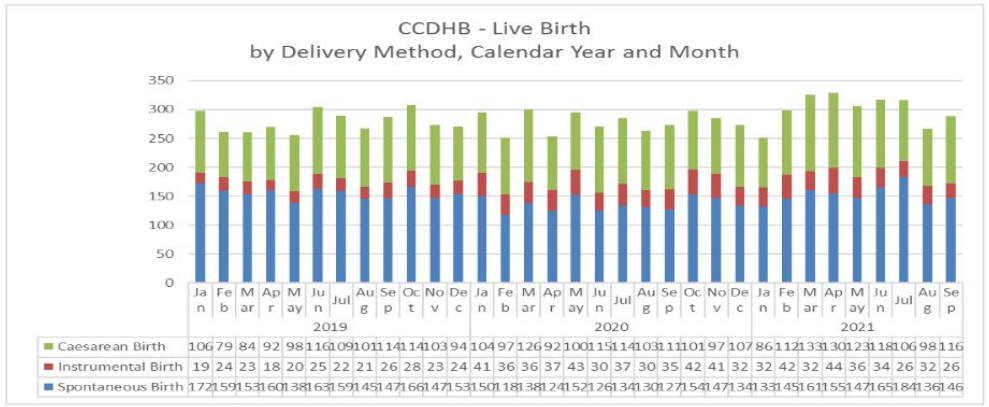
- The regions maternity units are experiencing increasing pressure due to high demand for inpatient services and workforce challenges.
- The Wellington Regional Hospital Maternity and Delivery Suite and continues to experience a high acuity and bed utilisation. Also impacted by this trend is our Neonatal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

WHS Management Comment

- September data indicates an increase of births across all birthing unit from the previous month. Bed utilisation for WRH birthing Suite and WRH postnatal and antenatal ward remains high (111%) for September.

- Vacancy rate for 4NM and WRH Birthing suite continues to trend up 30.7% for September. This rate is expected to increase through to December. With the high CMT volumes expected over December and January, the service is anxious and is currently trying to work through how to best manage this expected demand.

- The service is working with HVDHB and a recruitment agency to support the appointment of overseas and local midwives. An advertising campaign has been finalised and agreed. The service has had a small interest in Australian new graduate midwives wishing to begin their practice here. The MoH funded clinical coach roles (1.5 FTE) have been advertised and interviewed and will start in November.



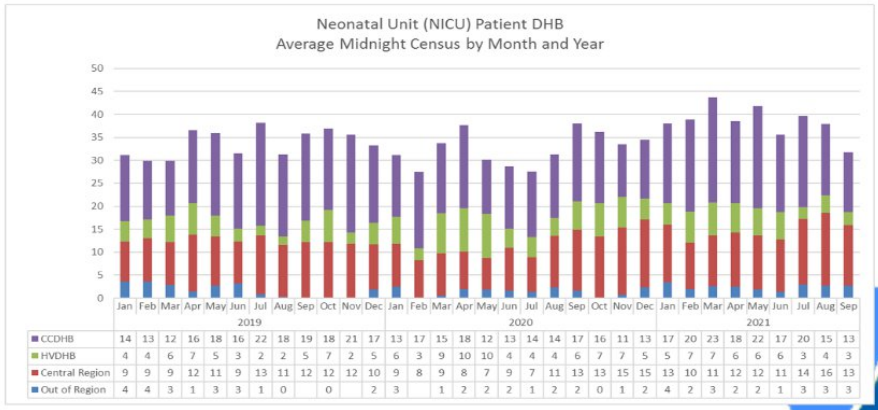
Neonatal Intensive Care Unit

How are we performing?

- Over occupancy has been the issue in NICU for the last 12 months
- However in September NICU saw a reduction in occupancy to an average of 32 down from 37 in August and 40 in September.
- NICU occupancy correlates to the reduced number of births and bed utilisation in the WHS over September. Given on average 20% of women transition to NICU from the WHS.

How are we performing?

- CCDM RN staffing continues to be successfully recruited too.
- Further CCDM work indicates an increase in RN numbers of the base roster.
- FTE calculations yet to be confirmed.
- NICU is safely managing the physical wellbeing of infants and families (with the above impacts).
- The retrieval service over the last 3 years, on average, has transported 381 infants per year.
- In 2019/20 there were, on average, 26 transports undertaken per month.
- In 2020/21 there were, on average, 32 transports undertaken per month.



Section 3

Financial Performance and Sustainability

Executive Summary Financial Performance and Position

- The DHB has an annual budgeted surplus of $1m, resulting from the recognition of $60m donation of the new Children's Hospital in March 22. The underlying deficit is ($59m) including Holidays Act Provision.
- The responsible deficit YTD was $4.6m favourable against budget.
- As an extraordinary item COVID-19 is not included within the budget, which the Ministry of Health has advised is regarded as outside the DHBs performance assessment:
  - ($8.1m); COVID-19: net additional costs during COVID-19

- The DHB's cash is under pressure for 2021/22 partly due to MOH guidance on cash funding for provider arm COVID-19 costs. This was mitigated at 2020/21 year end by significant delays to capex spend (offset by non cash depreciation). The DHBs bank balance at the end of September was an overdraft of ($35.7m) with $13.5m 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 are shown on the next slide, this is in addition to the unfunded ($4m) from the prior financial year in which cash has not been provided.

COVID-19 Revenue and costs

Full Last Year		Capital & Coast DHB Operating Results - $000s	Part Year to Date		
COVID-19 change from Trend - Provider	COVID-19 change from Trend - Funder	YTD September 2021	COVID-19 change from Trend - Provider	COVID-19 change from Trend - Funder	COVID-19 change from MOH Unfunded
	(31,026)	Devolved MoH Revenue		(19,578)	
		Non-Devolved MoH Revenue			
693		Other Revenue	0		197
		IDF Inflow			4,343
		Inter DHB Provider Revenue			
693	**(31,026)**	**Total Revenue**	**0**	**(19,578)**	**4,540**
		Personnel			
(6,336)		Medical	(25)		(1,111)
(4,360)		Nursing	(969)		(1,455)
		Allied Health	(135)		(438)
		Support	(10)		(65)
		Management & Administration	(749)		(524)
(10,696)	**0**	**Total Employee Cost**	**(1,887)**	**0**	**(3,594)**
		Outsourced Personnel			
(88)		Medical	(85)		
		Nursing	0		
		Allied Health	0		
		Support	0		
		Management & Administration	(113)		
(88)	**0**	**Total Outsourced Personnel Cost**	**(197)**	**0**	**0**
(5,088)		Treatment related costs - Clinical Supp	(312)		
(564)		Treatment related costs - Outsourced	0		
(2,028)		Non Treatment Related Costs	(2,697)		
		IDF Outflow			
	(15,828)	Other External Provider Costs (SIP)		(14,484)	
		Interest Depreciation & Capital Charge			
(7,680)	**(15,828)**	**Total Other Expenditure**	**(3,009)**	**(14,484)**	**0**
(18,464)	**(15,828)**	**Total Expenditure**	**(5,094)**	**(14,484)**	**(3,594)**
19,157	**(15,198)**	**Net result**	**5,094**	**(5,095)**	**8,134**

- The year to date financial position includes $13.2m of additional costs in relation to COVID-19.
- Revenue of $5.1m has been received to fund additional costs for community providers however this has not been sufficient to over all the costs.
- COVID-19 costs are spread across personnel, clinical supplies, outsourced treatment and infrastructure and non-clinical costs.

CCDHB Operating Position – September 2021

Month - September 2021									Capital & Coast DHB Operating Results - $000s	Year to Date								
			Variance		Adjustments			Variance					Variance		Adjustments			Variance
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	COVID-19 change from Trend MOH Funded	COVID-19 change from Trend MOH Non Funded	Actuals exc COVID	Actuals exc Funded COVID vs Budget	YTD September 2021	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	COVID-19 change from Trend MOH Funded	COVID-19 change from Trend MOH Non Funded	Actuals exc COVID	Actuals exc COVID vs Budget
89,743	81,468	78,880	8,275	10,863	9,814	0	79,929	(1,539)	Devolved MoH Revenue	263,009	244,404	235,989	18,605	27,020	19,578	0	243,431	(973)
3,498	3,077	3,789	420	(292)		0	3,498	420	Non-Devolved MoH Revenue	11,775	10,822	11,509	953	265		0	11,775	953
4,722	2,914	2,913	1,808	1,810	0	(197)	4,920	2,005	Other Revenue	10,356	8,839	9,635	1,517	721	0	(197)	10,553	1,714
23,766	26,024	21,348	(2,259)	2,418		(4,343)	28,108	2,084	IDF Inflow	73,768	78,073	63,044	(4,305)	10,725		(4,343)	78,111	38
1,960	1,506	3,664	455	(1,704)		0	1,960	455	Inter DHB Provider Revenue	4,759	4,441	5,608	318	(849)		0	4,759	318
123,689	**114,990**	**110,595**	**8,699**	**13,094**	**9,814**	**(4,540)**	**118,414**	**3,425**	**Total Revenue**	**363,666**	**346,579**	**325,785**	**17,088**	**37,882**	**19,578**	**(4,540)**	**348,628**	**2,049**
									Personnel									
17,413	16,824	15,763	(590)	(1,651)	5	757	16,651	172	Medical	50,688	50,322	45,572	(366)	(5,116)	25	1,111	49,552	770
21,635	21,504	20,391	(131)	(1,245)	377	488	20,770	734	Nursing	66,375	64,673	60,315	(1,702)	(6,060)	969	1,455	63,951	723
6,585	6,813	6,348	229	(237)	71	128	6,386	428	Allied Health	19,983	20,832	17,872	849	(2,111)	135	438	19,410	1,422
967	979	938	11	(29)	4	7	957	22	Support	2,986	2,960	2,664	(25)	(322)	10	65	2,910	50
8,229	7,826	7,132	(403)	(1,097)	389	152	7,689	138	Management & Administration	23,881	23,123	20,062	(759)	(3,819)	749	524	22,609	514
54,830	**53,946**	**50,572**	**(884)**	**(4,258)**	**846**	**1,531**	**52,452**	**1,494**	**Total Employee Cost**	**163,913**	**161,911**	**146,486**	**(2,003)**	**(17,428)**	**1,887**	**3,594**	**158,432**	**3,479**
									Outsourced Personnel									
846	525	907	(321)	61	31	0	815	(290)	Medical	2,473	1,585	2,206	(888)	(267)	85	0	2,388	(803)
116	101	82	(15)	(34)	0		116	(15)	Nursing	146	302	180	156	34	0		146	156
141	143	89	2	(51)	0		141	2	Allied Health	478	428	330	(50)	(148)	0		478	(50)
69	22	21	(47)	(48)	0		69	(47)	Support	94	66	115	(29)	21	0		94	(29)
357	234	337	(124)	(20)	35		323	(89)	Management & Administration	1,136	701	1,042	(436)	(94)	113		1,024	(323)
1,528	**1,024**	**1,435**	**(505)**	**(93)**	**66**	**0**	**1,463**	**(439)**	**Total Outsourced Personnel Cost**	**4,328**	**3,082**	**3,874**	**(1,246)**	**(454)**	**197**	**0**	**4,130**	**(1,048)**
11,363	11,472	10,607	109	(756)	139		11,223	249	Treatment related costs - Clinical Supp	33,013	35,198	33,086	2,185	73	312		32,701	2,497
2,852	2,563	2,061	(289)	(791)	0		2,852	(289)	Treatment related costs - Outsourced	7,721	7,842	6,926	121	(795)	0		7,721	121
10,147	8,139	7,505	(2,008)	(2,642)	713	0	9,434	(1,295)	Non Treatment Related Costs	28,178	23,933	20,742	(4,245)	(7,436)	2,697	0	25,481	(1,548)
9,637	9,192	8,975	(445)	(662)			9,637	(445)	IDF Outflow	28,042	27,575	27,226	(467)	(816)			28,042	(467)
34,946	28,305	28,884	(6,641)	(6,062)	7,106		27,839	466	Other External Provider Costs (SIP)	98,837	84,914	84,847	(13,922)	(13,990)	14,484		84,353	561
4,791	4,451	4,857	(340)	66			4,791	(340)	Interest Depreciation & Capital Charge	14,311	13,279	14,877	(1,032)	566			14,311	(1,032)
73,736	**64,121**	**62,889**	**(9,614)**	**(10,847)**	**7,959**	**0**	**65,777**	**(1,655)**	**Total Other Expenditure**	**210,102**	**192,741**	**187,705**	**(17,361)**	**(22,397)**	**17,493**	**0**	**192,609**	**132**
130,094	**119,091**	**114,895**	**(11,003)**	**(15,199)**	**8,871**	**1,531**	**119,692**	**(600)**	**Total Expenditure**	**378,343**	**357,734**	**338,065**	**(20,609)**	**(40,279)**	**19,578**	**3,594**	**355,171**	**2,562**
(6,405)	**(4,102)**	**(4,300)**	**(2,304)**	**(2,105)**	**943**	**(6,071)**	**(1,277)**	**2,824**	**Net result**	**(14,677)**	**(11,155)**	**(12,280)**	**(3,522)**	**(2,397)**	**0**	**(8,134)**	**(6,543)**	**4,612**
(2,332)	(1,833)	(1,491)	(499)	(841)					Funder	(10,247)	(10,514)	(6,216)	267	(4,031)				
53	(0)	32	53	21					Governance	88	0	167	88	(79)				
(4,126)	(2,269)	(2,842)	(1,858)	(1,284)					Provider	(4,518)	(641)	(6,231)	(3,877)	1,713				
(6,405)	**(4,102)**	**(4,300)**	**(2,304)**	**(2,105)**					**Net result**	**(14,677)**	**(11,155)**	**(12,280)**	**(3,522)**	**(2,397)**				

Note
Adjustments are made for COVID-19

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

Executive Summary – Financial Variances

- The DHB deficit year to date is ($14.7m) compared to a budget deficit of ($11.2m).
- Included within this result is recognition of the adjustment to an estimated net impact of COVID-19 of ($8.1m).
- Excluding the COVID-19 above this brings the year to date deficit to ($6.5m) being $4.6m favourable to budget.
- Revenue is favourable by $17.1m YTD, after excluding COVID-19 revenue, this is on budget.
- Personnel costs including outsourced is ($3.2m) unfavourable YTD, excluding COVID-19 related costs of ($2.2m) the net favourable variance is $1.0m. Currently the DHB has a large number of vacancies which has been offset by ($2.3m) of vacancy savings targets.
- Treatment related clinical supplies is $2.2m favourable including favourable variances for Implants/Prostheses & Treatment disposables as volumes were down through the COVID-19
- Outsourced clinical services is favourable YTD by $136k; favourable movement due to outsourced surgical service delayed compared to plan, also partly due to the COVID-19 level 4 lockdown.
- Non treatment related costs ($5.3m) YTD unfavourable, however after excluding COVID-19 related costs of ($2.7m), the unfavourable variance was due to additional depreciation on 30 June building revaluation, seismic assessments costs, catch-up of deferred maintenance & Capital Charge
- The funder arm is favourable YTD due to additional revenue from spend requirements for the community COVID-19 response which is fully funded. Some new programmes in the NGO space have commenced alongside increased revenue from MoH to support these initiatives.

Analysis of the Operating Position – Revenue and Personnel

Revenue

- Revenue is $17.1m favourable YTD
- The variance is due to revenue for special MHAIDS additional funding $1.3m, The funder arm is also favourable by $14.3m revenue however with offsetting community cost and COVID-19 related costs in the Provider.

Personnel (including outsourced)

- Medical Personnel is ($910k) unfavourable for the month, ($1.3m) YTD. The unfavourable position for the month is driven by vacancies across other services, most notably MHAIDS offset by centrally held vacancy savings targets and increased outsourcing in SWC & MHAIDS
- Nursing Personnel is ($146k) unfavourable to budget for the month. ($1.5m) YTD Operationally nursing across the hospital is on budget, however the variance is a result of COVID-19 related costs and front loading of vacancy savings.
- Allied Personnel labour is $238k favourable to budget for the month, $800k YTD as a result of vacancies.
- Support Personnel labour month is on budget.
- Management/Admin Personnel is unfavourable in the month by ($526k), ($1.2m) YTD Operationally across the hospital Management/Admin is favourable to budget, however the variance is a result of front loading of vacancy savings and increased outsourcing as a result of Vacancies and COVID

Section 4

Financial Position

Cash Management – 30 September 2021

Month : Sep 2021					Capital & Coast DHB Statement of Cashflows	Year to Date				
			Variance						Variance	
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	YTD Sep 2021	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year
					Operating Activities					
126,227	116,074	111,987	10,153	14,240	Receipts	365,093	348,222	333,737	16,870	31,356
					Payments					
46,865	54,654	43,542	7,789	(3,323)	Payments to employees	148,358	163,963	147,980	15,605	(378)
75,875	60,941	63,248	(14,933)	(12,627)	Payments to suppliers	215,629	183,821	187,199	(31,808)	(28,430)
0	0	0	0	0	Capital Charge paid	0	11,102	12,110	11,102	12,110
(1,988)	0	(196)	1,988	1,792	GST (net)	(222)	0	(1,553)	222	(1,331)
120,752	115,595	106,594	(5,156)	(14,158)	Payments - total	363,765	358,886	345,736	(4,879)	(18,029)
5,475	479	5,393	4,996	82	Net cash flow from operating Activities	1,328	(10,664)	(11,999)	11,991	13,327
					Investing Activities					
0	16	(69)	15	(69)	Receipts	42	47	101	5	59
					Payments					
6,584	11,255	5,101	4,671	(1,483)	Purchase of fixed assets	21,587	33,764	13,370	12,177	(8,217)
6,584	11,255	5,101	4,671	(1,483)	Payments - total	21,587	33,764	13,370	12,177	(8,217)
(6,584)	(11,239)	(5,170)	4,686	(1,553)	Net cash flow from investing Activities	(21,545)	(33,717)	(13,269)	12,182	(8,158)
					Financing Activities					
0	0	0	0	0	Equity - Capital	0	39,815	0	(39,815)	0
0	7,730	0	(7,730)	0	Other Equity Movement	12,187	23,190	674	(11,003)	11,513
0	0	0	0	0	Other	0	0	0	0	0
0	7,730	0	(7,730)	0	Receipts	12,187	63,005	674	(50,818)	11,513
					Payments					
0	0	0	0	0	Interest payments	0	0	0	0	0
0	0	0	0	0	Payments - total	0	0	0	0	0
0	7,730	0	(7,730)	0	Net cash flow from financing Activities	12,187	63,005	674	(50,818)	11,513
(1,109)	(3,030)	223	1,952	(1,471)	Net inflow/(outflow) of CCDHB funds	(8,030)	18,624	(24,594)	(26,644)	16,682
(22,374)	(2,480)	(6,581)	19,894	15,793	Opening cash	(15,452)	(24,134)	18,236	(8,682)	33,688
126,227	123,820	111,918	2,438	14,170	Net inflow funds	377,322	411,274	334,512	(33,942)	42,928
127,336	126,850	111,695	(486)	(15,641)	Net (outflow) funds	385,352	392,650	359,106	7,298	(26,246)
(1,109)	(3,030)	223	1,952	(1,471)	Net inflow/(outflow) of CCDHB funds	(8,030)	18,624	(24,594)	(26,644)	16,682
(23,483)	(5,510)	(6,358)	(17,973)	(17,125)	Closing cash	(23,482)	(5,510)	(6,358)	(17,972)	(17,124)

RECONCILIATION OF CASH FLOW TO OPERATING BALANCE

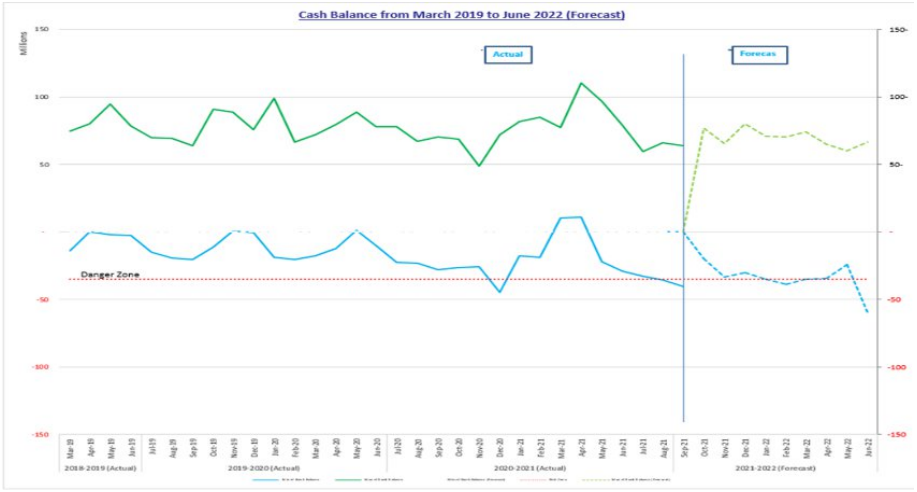
	YTD Sep 2021		
	Actual $000	Budget $000	Variance $000
Net Cashflow from Operating	1,328	(10,664)	11,991
Non operating financial asset items	3	-	3
Non operating non financial asset items	(853)	-	(853)
Non cash PPE movements	(9,182)	(10,674)	1,492
Working Capital Movement			
Inventory	235	-	235
Receipts and Prepayments	27,585	-	27,585
Payables and Accruals	(33,793)	6,595	(40,388)
Total Working Capital movement	**(5,973)**	**6,595**	**(12,568)**
Operating balance	**(14,677)**	**(14,743)**	66

1. The net cash flow from operating activities is favourable to budget due to COVID-19 revenue for the month. Higher than expected payments to suppliers.
2. The net cash flow from investment activities is unfavourable to budget due to less spend on Capital activity then budgeted;

Debt Management / Cash Forecast – 31 August 2021

Accounts Receivable
30-Sep-21

Aged Debtors report ($'000)	Total	Current	1-30	31 - 60	61 - 90	91+	Previous Period
Ministry of Health	24,024	5,588	85	16667	-	1684	22863
Other DHB's	3924	1,466	381	168	496	1413	3193
Kenepuru A&M	213	29	33	12	139		218
ACC	165	192	-137	-62	6	166	125
Misc Other	2746	741	154	61	106	1684	2728
Total Debtors	31,072	8,016	516	16,846	747	4,947	29,127
less : Provision for Doubtful Debts	(4,125)						(4,107)
Net Debtors	26,947						25,020



Debt Management

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

2. The single largest debtor in 'Other DHB's' outstanding is HVDHB with $1.38m.

3. Kenepuru A&M includes significant number of low value patient transactions. Provision for the overdue debts is $121k

4. 'Misc Other' debtors includes non resident debt of approx. $1.89m. About 83.76% of the non resident debt have payment arrangements in place. The balance will be referred to collection agencies if unpaid.

Cash Management

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

Note: that the monthly actual cash balance exceeds the monthly forecasted cash balance due to a high buffer being maintained over the holiday period, release payment for construction projects.

Balance Sheet / Cashflow – as at 30 September 2021

Aug-21	Month : Sep 2021			Variance		Capital & Coast DHB Balance Sheet
Actual	Actual	Budget	At Sep 2020	Actual vs Budget	Actual vs Sep 2020	YTD Sep 2021
31	31	31	31	0	0	Bank
50	2	824	10	(822)	(8)	Bank NZHP
13,237	13,499	13,561	12,783	(62)	716	Trust funds
79,009	84,704	63,930	62,851	20,774	21,853	Accounts receivable
9,873	9,628	9,466	10,078	162	(450)	Inventory/Stock
10,550	10,254	7,902	8,651	2,351	1,602	Prepayments
112,751	**118,118**	**95,714**	**94,405**	**22,404**	**23,713**	**Total current assets**
502,632	500,064	532,106	516,087	(32,042)	(16,024)	Fixed assets
16,058	5,875	5,875	14,796	0	(8,920)	Work in Progress - CRISP
102,623	119,491	103,005	68,119	16,486	51,373	Work in progress
621,312	**625,431**	**640,986**	**599,002**	**(15,556)**	**26,429**	**Total fixed assets**
1,150	1,150	1,150	1,150	0	0	Investment in Allied Laundry
1,150	**1,150**	**1,150**	**1,150**	**0**	**0**	**Total investments**
735,213	**744,699**	**737,850**	**694,556**	**6,848**	**50,142**	**Total Assets**
35,693	37,015	19,927	19,182	(17,088)	(17,833)	Bank overdraft HBL
80,501	86,254	72,575	82,386	(13,679)	(3,868)	Accounts payable, Accruals and provisions
3,016	4,524	5,551	5,428	1,027	904	Capital Charge payable
593	593	593	593	0	0	Insurance liability
10,269	10,064	123,911	105,310	113,847	95,246	Current Employee Provisions
181,115	189,171	67,997	64,875	(121,174)	(124,297)	Accrued Employee Leave
18,440	17,894	22,515	15,325	4,621	(2,569)	Accrued Employee salary & Wages
329,627	**345,515**	**313,069**	**293,098**	**(32,446)**	**(52,417)**	**Total current liabilities**
97	100	92	104	(8)	4	Restricted special funds
605	605	605	605	0	0	Insurance liability
6,222	6,222	6,564	6,563	343	341	Long-term employee provisions
6,924	**6,927**	**7,262**	**7,272**	**335**	**345**	**Total non-current liabilities**
336,551	**352,442**	**320,331**	**300,370**	**(32,111)**	**(52,072)**	**Total Liabilities**
398,662	**392,256**	**417,519**	**394,186**	**(25,263)**	**(1,930)**	**Net Assets**
858,191	858,780	885,237	811,815	(26,456)	46,966	Crown Equity
0	0	0	0	0	0	Capital repaid
590	0	0	0	0	0	Capital Injection
130,659	130,659	130,659	130,659	0	0	Reserves
(590,779)	(597,184)	(606,107)	(548,289)	8,922	(48,895)	Retained earnings
398,661	**392,256**	**417,519**	**394,185**	**(25,264)**	**(1,929)**	**Total Equity**

Balance Sheet

1. The DHB's cash overdraft balance at the end of September2021 is unfavourable due to a budgeted claim on the children's hospital not yet being received ($18.0m);
2. Accounts receivable is high than budget due to timing differences and the claim mentioned in 1. outstanding;
3. Accounts payable, accruals and provisions is higher than the budget mainly due to timing differences but a large drop on the end of June figures;

Cash flow

1. Cash on hand is below budget due to changes in the opening balance and a budgeted claim on the children's hospital not yet being received ($16.0m);

Financial ratios

1. Cash on hand is below budget due to changes in the opening balance and a budgeted claim on the children's hospital not yet being received ($16.0m);
2. Improved Debt to Equity Ratio - This ratio determines how the DHB has financed the asset base. DHB's total liability to equity ratio is 0.90 (August – 0.84).

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 on Prior Year Approved September 2021

Capital Expenditure Projects

					Forecast spend on approved projects						
Asset Category	Approved Capex Budget	PY Spend to 30 June 2021	Actual YTD Spend	Actual LTD Spend	To spend	December Quarter forecast	March Quarter forecast	June Quarter forecast	Forecast cash spend to June 22*	Total forecast to spend for FY2021/22	Carry forward to FY22-23
Buildings	27,456,044	16,017,443	975,857	16,993,301	10,462,743	1,597,140	5,113,321	3,284,950	9,995,411	26,988,711	467,333
Clinical Equipment	58,062,831	42,615,125	3,873,678	46,488,802	11,574,029	2,913,537	4,634,377	1,457,131	9,005,045	55,493,847	2,568,984
ICT	11,882,523	9,546,425	5,480	9,551,905	2,330,618	383,610	726,419	95,094	1,205,124	10,757,029	1,125,494
Prior Year projects	**97,401,398**	**68,178,993**	**4,855,015**	**73,034,008**	**24,367,390**	**4,894,286**	**10,474,117**	**4,837,176**	**20,205,579**	**93,239,587**	**4,161,810**

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

- $29.2m in approved but incomplete projects was carried forward from the previous year to FY2020/21
- Total cash spend for the Sept Quarter $4.9m with a further $20.2m is forecasted to be spent by 30 June 2022, leaving an estimated $4.2m to be carried forward to FY2022/23
- The forecast is based on cash phasing with the March 2022 quarter expected to be high due to the high spending in ICT and Clinical Equipment
- The cash spending forecast will be reviewed monthly and adjusted to reflect changes from both internal and external factors (workforce, logistics, supply chain)

Capital Expenditure Summary 2021/22 September 2021

				Quarterly forecast				
Row Labels	Capital Plan 2021/22	Approved	Actual LTD	Quarter 2	Quarter 3	Quarter 4	Forecast cash spend to June 22	Carry forward
Clinical Equipment/Non Clinical Equipment	15,280,105	3,675,367	273,136	4,492,386	5,309,182	7,018,908	17,093,612	- 1,813,507
Facilities or Building	37,378,945	8,736,015	1,702,079	1,480,625	3,382,126	9,288,262	15,853,092	21,525,853
ICT	5,199,917	3,100,000	315,329	898,020	1,576,900	1,306,905	4,097,154	1,102,763
Small capex pool	10,796,925	3,264,698	1,058,834	2,434,523	2,434,523	2,434,523	8,362,402	2,434,523
Grand Total	68,655,892	18,776,080	3,349,377	9,305,554	12,702,731	20,048,597	45,406,259	23,249,633

Key highlights to FY2021/22 Capital plan:

- $68.7m was approved by the Board in the FY2021/22 Capital Plan
- The development of business cases from the 2021/22 Capital Plan are at various stages with $18.8m having been approved to September 2021
- Spend to September 2021 $3.3m and reflects the changes. The COVID level 4 lockdown impacted the spending rate
- Business units have indicated when business cases will be submitted and a high level cash forecast has been projected from this with $45.4m to be spent by 30 June 2022, and $23.2m carried forward to next financial year
- The cash spending forecast will be reviewed on a monthly basis and adjusted to reflect our capacity to submit business cases for approval, procure and install projects

Board Information – Public

1 December 2021

2DHB Strategic Priorities Update

Action Required

The Boards note:

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

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

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

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

Executive Summary

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

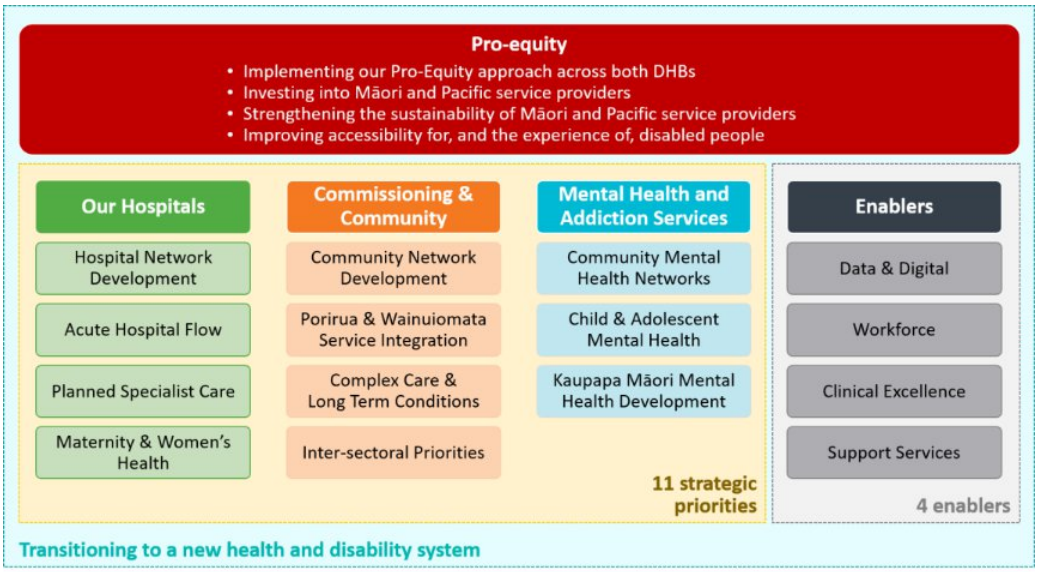
Our focus remains on delivering equitable health outcomes and intensifying support for Māori, Pacific people and those living with disability, mental illness and addiction.

We will:

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

This paper focusses on the first bullet point.

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



The 2DHB Maternity and Neonatal Strategy Plan spans both the 'Our Hospitals' and the 'Commissioning & Community' Focus Areas.

Strategic Considerations

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

Engagement/Consultation

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

Identified Risks

Risk ID	Risk Description	Risk Owner	Current Control Description	Current Risk Rating	Projected Risk Rating
N/A	There is a risk of diluting our focus and resources across areas of work that are not critical to the needs of our populations during this time of change and transition to the new system.	Fionnagh Dougan	Communicating an agreed set of strategic priorities and enablers ensures that we are focussed on meeting the needs of our populations during this period of transition. The Director Transformation role is designed to ensure there is executive level focus and alignment across the programme.	Low Risk	Low Risk

Implementing our Strategic Priorities

Governances

There are three ELT-led Groups overseeing the Strategic Priorities work programme. In addition, a Maternity & Neonatal Health Planning Advisory Group supports the Maternity & Neonatal Health Workstream.

Programme and Project Development – Key Deliverables

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

Rolling Programme of Reporting

There will be a rolling programme of 'deep dive' reports and commissioning decisions for each workstream to the concurrent Board and Committees. The following strategic priority reports are scheduled:

- Health System Committee on 16 March 2022 – update on the Commissioning & Community workstream
- Disability Support Advisory Committee on 16 March 2022 – update on the Mental Health and Addiction Workstream (including the Kaupapa Māori project)

These updates will be reported at the concurrent Board meeting on 30 March 2022 by the Committee Chairs.

Mental Health and Addictions Commissioning - Update

This Focus Area is co-creating and commissioning community mental health networks to improve local service integration and achieve equity. A key focus of this work is improving Māori mental health and addiction outcomes. Porirua and Wainuiomata are the first locations prioritised for this development. We are in the process of confirming local representation and key partners to lead service design at a local level. Analytics insights are being prepared to support this co-creation process.

MHAIDS is engaging with relevant stakeholders to redesign its community mental health and crisis response. This will allow co-designing the enhanced acute care service model and enhanced clinical

pathways. A Mental Health and Addictions Crisis Service subgroup has been established as a working group to facilitate the co-design of an enhanced acute care pathway.

Community & Commissioning - Update

This Focus Area will improve access to health services and reduce inequities for Māori and Pacific peoples. This will be achieved by developing community health networks in Wellington, Hutt Valley, and Kāpiti communities. The community networks will enhance local health service integration and improve links with social sector services. A focus on intersectoral collaboration will allow strategic priorities in primary health care to support emergency and social housing, and a strengthened health response to family violence.

We are concentrating effort in Porirua and Wainuiomata. A team is currently being recruited to support the implementation and formalise functions in these localities. Additional investment in Wainuiomata providers is being progressed to build capacity.

We are also working to reduce acute flow into our hospitals by scaling up Early Supported Discharge (EDS) and the Advancing Wellness at Home Initiative (AWHI) to a wider cohort of patients across both DHBs. Community radiology access is also being extended to reduce unnecessary attendance at the emergency departments, and we are developing an accident and medical model to extend access in Kapiti, Hutt Valley and Porirua. An investment case being developed for decision and implementation in February/March 2022.

The Health System Committee was presented an overview of the activity being undertaken by the 2DHBs that is organised using a locality based approach. The presentation outlined the localities framework proposed in the Pae Ora (Health Futures) Bill which will shape the health system operating model from 1 July 2021. This presentation can be located in the Health System Committee folder in the Resource Centre on Diligent.

2DHB Maternity and Neonatal Health

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

The strategy seeks to deliver a whole-of-system approach to improving maternal and neonatal care for all families in our region, with a pro-equity focus on actions to improve outcomes for Māori and Pacific whānau & families, and disabled women and babies with impairments.

Once the strategy is endorsed, we will work with the Maternity & Neonatal Health Planning Advisory Group and other lived experience, cultural and clinical experts to implement the new system.

2DHB Hospital Network

The update and recommendations on the 2DHB Hospital Network are provided in a separate paper.

We are developing a coordinated operating model and building programme across the network of our hospitals. This will improve the coordination of specialist care across our network, enable us to better manage acute flow, and improve equity of access and outcomes.

Board Information – Public

1 December 2021

Health System Committee (HSC) update from Committee meeting dated 24 November 2021

Action Required

The Boards note:

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

Item 2.1: 2DHB Maternal and Neonatal Health System Plan

Health System Committee recommends the Boards:

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

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

(c) **note** a whole of system approach, defining care and experience across the maternal care service continuum has been adopted to develop the above. This has created specific interdependent actions that need to be implemented in order to realise the shifts outlined in the strategy.

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

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

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

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

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

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

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

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

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

iii. amend page 33 of the Plan (page 58 on Diligent) to include an action to create a pathway that better integrates maternal and neonatal pathways for babies with impairments with pathways to children's services including child development services.

Item 2.2 Commissioning in Localities

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

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

Presented by	Sue Kedgley, Chair - Health System Committee
Purpose	Provide the Boards with an update regarding the content of the meeting and recommend the 2DHB Maternal and Neonatal System Plan for approval by the 2DHB Boards.
Contributors	As noted in the HSC papers
Consultation	As noted in the HSC papers

Executive Summary

The Chair of the Health System Committee will provide an overview of the meeting agenda items and discussion.

The 2DHB Maternity and Neonatal System Plan (as amended as per the decisions made at Health System Committee) is attached as Appendix 1. The report to the Health System Committee is located in the folder for this Board meeting in the Resource Centre on Diligent.

The slides for presentations given at the meeting are located in the Resource Centre on Diligent, in the folder for the HSC meeting on 24 November 2021. The presentations were on:

- ***Item 2.1: 2DHB Maternal and Neonatal Health System Plan***
- ***Item 2.2 Commissioning in Localities***
- ***Item 3.1 Covid-19 Update***

Strategic Considerations

As noted in the HSC papers

Engagement/Consultation

As noted in the HSC papers

Identified Risks

As noted in the HSC papers

Attachment/s

1. Appendix 1 – 2DHB Maternity and Neonatal System Plan

HUTT VALLEY DHB

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

Appendix 1
2DHB Maternity and Neonatal System Plan

1 December 2021

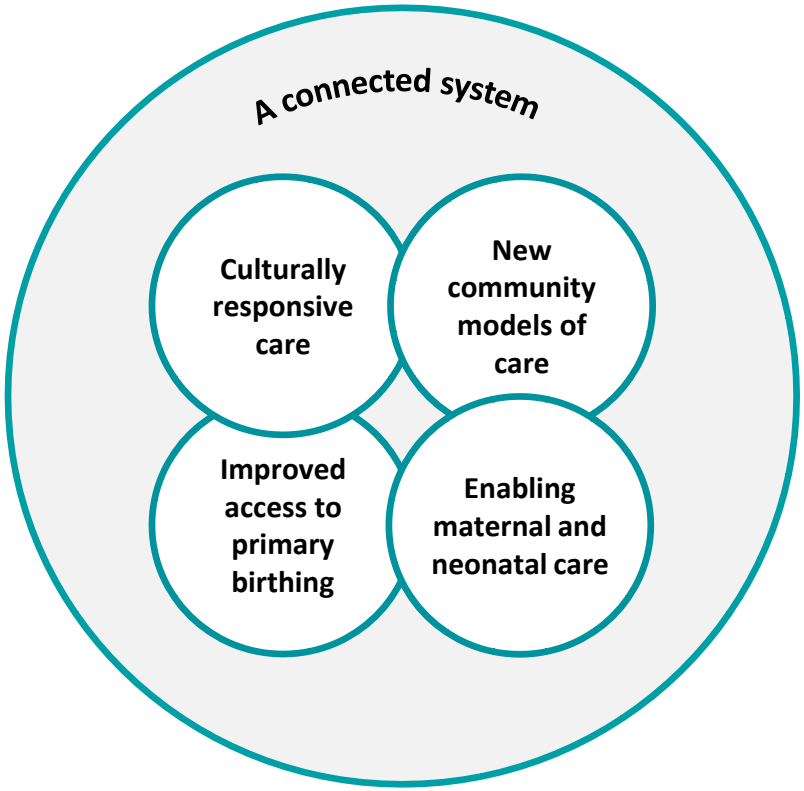
Endorsed by HSC on 24 November 2021 and recommended to the 2DHB Boards for approval

Contents

Introduction

Who is this Plan for?

This plan articulates a whole-of-system approach to improving maternal and neonatal care for all families in our region, with a pro-equity focus to improve outcomes for Māori and Pacific whānau & families, disabled women and babies with impairments.



Who are we serving?

- In 2020, **5,132 women** gave birth in 2DHB maternity facilities. 4,917 (96%) were mothers domiciled in the 2DHB region.
- **Māori women make up 22%** (1,140) of women giving birth in our region, and **Pacific women were 9%** (499) (of all known ethnicities). This is slightly higher percentages than the general population.

1,140 Māori

499 Pacific

3,591 Non-Māori, non-Pacific

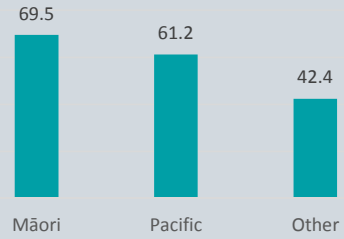
- **2,214 (45%) of women were first time mothers**. This is higher to the proportion of first time mothers nationally (approximately 41% in 2020).

What does the community look like in the future?

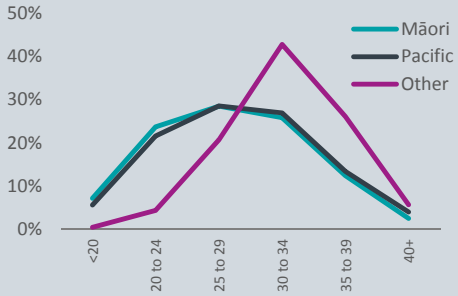
As there is a larger number of Māori mothers having children younger, current projections indicate there will be significant growth in the Māori population by 2030 than non-Māori. Pacific people will follow a similar trajectory.

- A **greater proportion of Māori and Pacific women give birth each year**. This further strengthens the need for a pro-equity approach.

2DHB birth rate per 1,000 of reproductive age



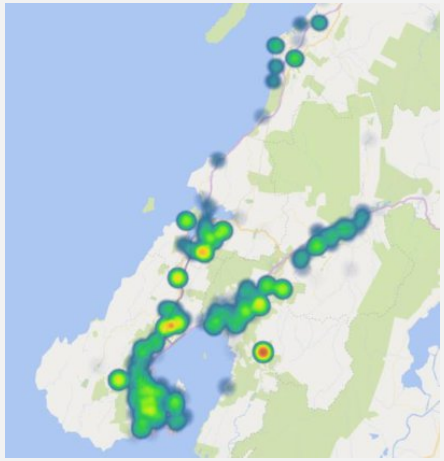
- Across our DHBs, our **younger mothers are more likely to be Māori or Pacific**. Younger mothers from other ethnicity have births later in life.



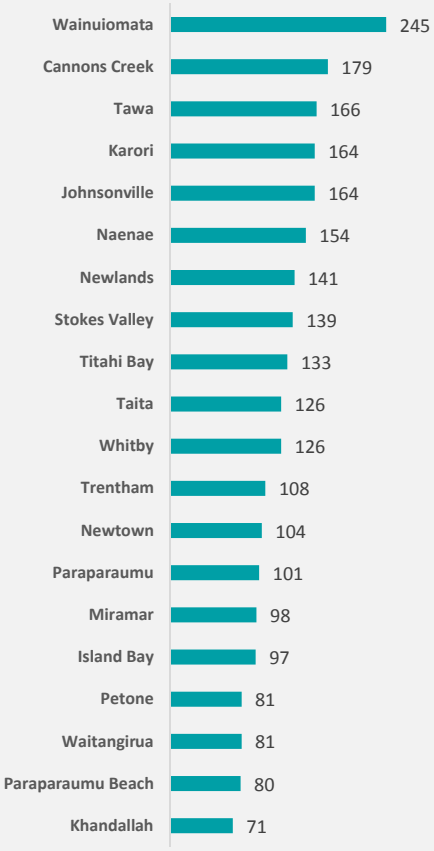
Where do women having babies live?

We have some suburbs with high volumes of mothers, which provides opportunities to create hubs in communities.

The top suburbs in 2018 were **Wainuomata** (245 mothers), **Cannons Creek** (179 mothers) and **Tawa** (166 mothers).



2DHB Top 20 suburbs where Mothers gave birth



Why is this important

The *Health System Plan 2030* says we need a maternal and neonatal model of care that supports all mothers, families and whānau, to have healthy babies and to provide the best start to life.

This approach is designed to improve outcomes, achieve equity, and make the experience of having babies better for families and whānau.

What will be different for me?

"I will know what to do when planning my pregnancy, having a child and/or caring for small children."

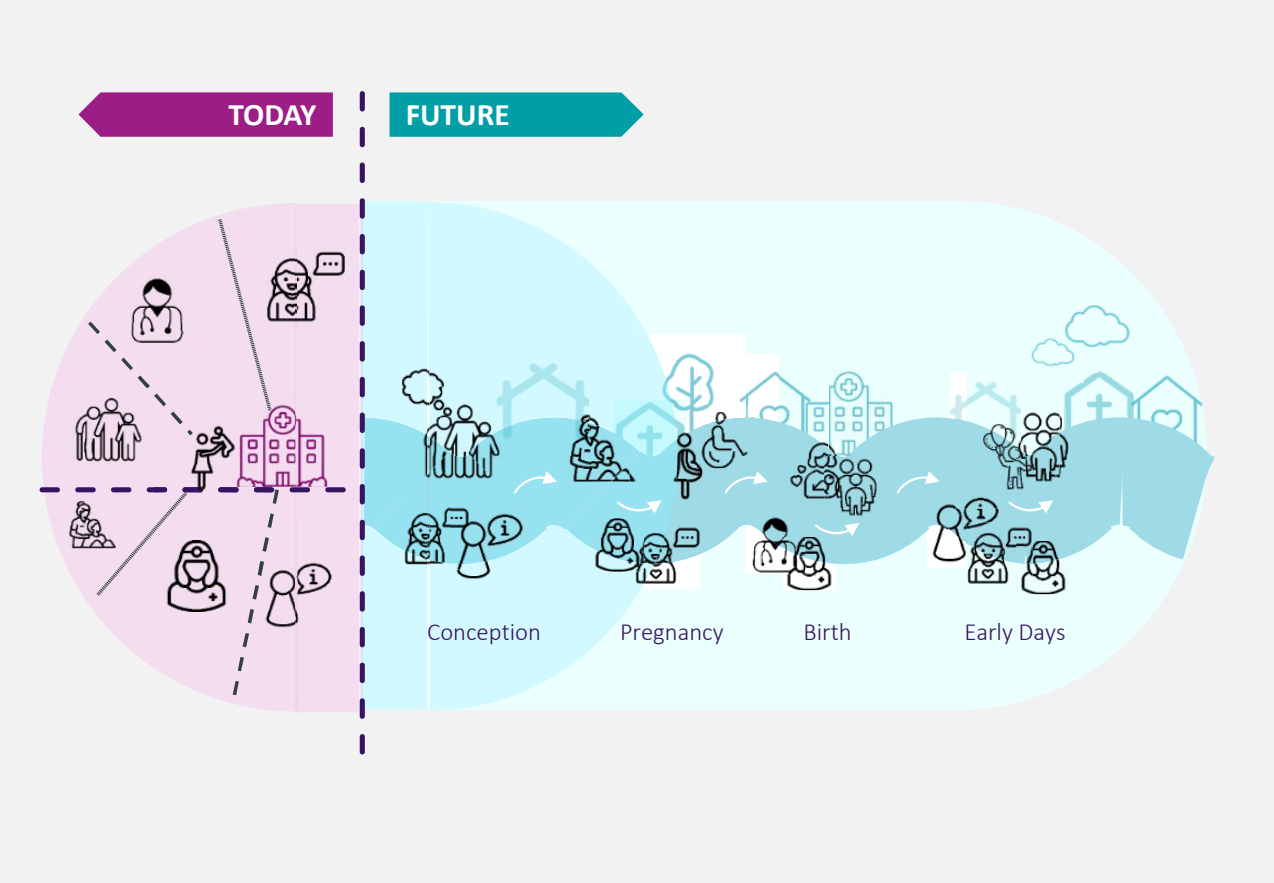
"I will have support to keep me and my family healthy."

"I will have access to a range of birthing options."

"I will have care that meets me where I am, to match my clinical, cultural and social needs."

- Health System Plan 2030

Our future state



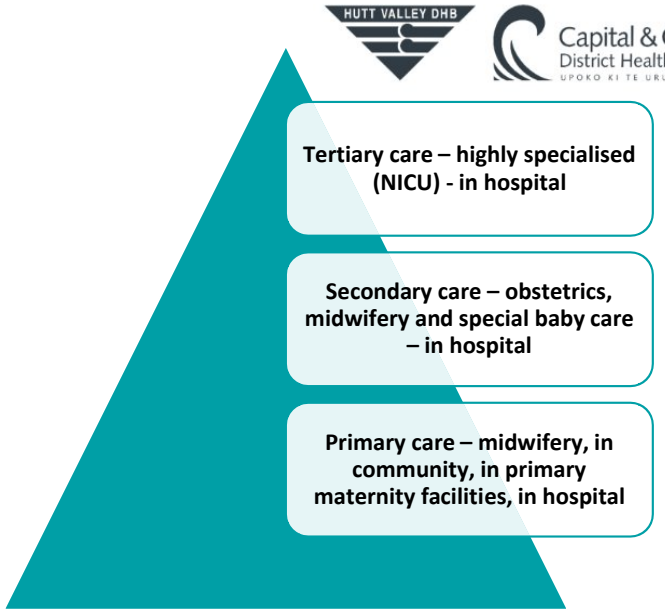
We are creating a future that:

- Is easy to learn, understand, and navigate.
- Is highly accessible via “any door”.
- Celebrates Māori and Pacific culture
- Enables good lives for disabled women and families with babies with impairments.
- Is full of individuals and services who reflect the community they serve and act as connectors.
- Is focused on a continuum of care from conception to 2 years old.
- Enables real choice that allows women and families to exercise their rights and agency.
- Meets people where they are, in the community.
- Moves from maternity as a journey towards hospital, **to** maternity as a journey within a community, with access to hospital as needed.
- Builds long-lasting trust and partnership with communities, families and providers throughout the region.

What services should be available across the maternal and neonatal continuum?

Women and families should have access to **safe and respectful** universal maternal and neonatal services from conception through the early years. The Ministry of Health specifies that all families should have access to **primary maternity** (including community midwifery care, and services at primary maternity facilities and hospitals) and **secondary and tertiary** level care (including midwifery, nursing, obstetric, neonatal and anaesthetic care, and care at hospitals).

The core service components of a high-quality, **universal continuum of maternal care** is outlined below. At any stage along the continuum, **specialist care** should be equitably accessible to those who have high clinical complexity, and **LMC midwifery and comprehensive social and cultural support** prioritised for those who have high social complexity.



Pregnancy
- Antenatal education
- LMC Midwife
- Labs and scans

Birth
- LMC Midwife
- Home birth, primary birth or hospital birth
- Inpatient care from midwives, nurses, specialists as needed

Postnatal
- LMC Midwife
- Breastfeeding support
- Maternal mental health (if needed)

Early Years
- Well Child Tamariki Ora
- Immunisation services

Primary care… Specialist care for mum and baby… Maternal wellbeing and mental health support… Social and cultural support…

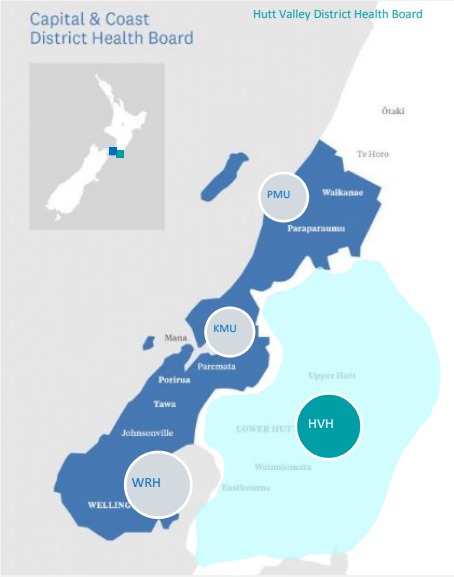
What care is currently available to families?

Who provides maternity care?

- **Lead Maternity Carer:** LMCs can be midwives, private obstetricians or GPs. LMC services are funded by the Ministry of Health through Section 88. LMC midwives provide continuity-of-care throughout pregnancy, birth and 4-6 weeks after baby is born. A key role of the LMC is to help women and families access additional care and support, and help women and families make informed choices.
- **Hospital midwives:** providing care in hospital to women who need antenatal care in hospital, and to women and babies during birth and postnatal stay, for women who birth in hospital.
- **Community Midwife Team:** operating out of both DHBs. These teams provide care for women who can't find a Lead Maternity Carer.
- **Obstetricians:** become involved in mothers care when she or her baby have more clinical needs. Women can choose to be cared for by a private obstetrician.
- **Neonatal Specialists:** Provide clinical support to babies who have additional clinical needs.
- **General Practitioners:** Many women see their GP when they first suspect they are pregnant. GPs may confirm pregnancy, provide initial pregnancy health assessment and advice, refer women for blood tests and scans, and refer women to midwifery care.
- **Community Health Service Providers:** Ora Toa, Taeaomanino Trust.

- **Well Child Tamariki Ora nurses:** Provide health and wellbeing assessments and support for children and whānau from birth to five years.
- **Lactation consultant:** DHB, Plunket, or privately funded support for women in the hospital and at home if needed.
- **Tohunga:** expert practitioners of specific cultural practices, e.g. rongoa and mirimiri practitioners.
- **Additional support:** acupuncture, massage, homeopathy, naturopaths.
- **Pregnancy ultrasound**: **Sonographers** use sound waves to create a picture of the baby in the uterus ("ultrasound scan"), to check baby's growth and development. The picture is checked by a **Radiologist** who interprets the picture and provides advice.
- **Pregnancy, birth and parenting educators**: Provide information to support parents to make informed choices during pregnancy, birth, and parenting.
- **Fertility services:** Publicly funded or private support for families who are having difficulty conceiving.

Where can and do people birth?



Birthing options

- **Home –** Home births are usually attended by an LMC midwife and backup midwife who support the woman, newborn and family. If there are complications at home, the midwife can refer the mother and/or baby for urgent care in hospital.
- **Kenepuru maternity unit (KMU)** is a midwifery-led primary birthing unit located in the Kenepuru Community Hospital at Porirua, a 20-minute drive (25km) from WRH. It has 2 birthing rooms and 6 single post-natal rooms.
- **Paraparaumu maternity unit (PMU)** is a midwifery-led primary birthing unit located at Kāpiti Health Centre, a 50-minute drive (55km) from WRH. It has 1 birthing room and 2 single post-natal rooms (with a shared toilet).
- **Wellington Regional Hospital (WRH)** has 12 delivery suites and 38 ante-natal and post-natal rooms. It has Level 3 Neonatal Intensive Care Unit (NICU) and a tertiary-level Maternal-Foetal Medicine service.
- **Hutt Valley Hospital (HVH)** has 8 delivery suites and 21 post-natal rooms It has Level 2 Special Care Baby Unit (SCBU).

Benefits of LMC midwifery care

Continuity of care improves safety and satisfaction with care with a trusted relationship through pregnancy, birth, and the newborn period.

Provide customised care to match the woman and families' needs and choices. Can provide birth care in a hospital, primary birthing unit, or at home

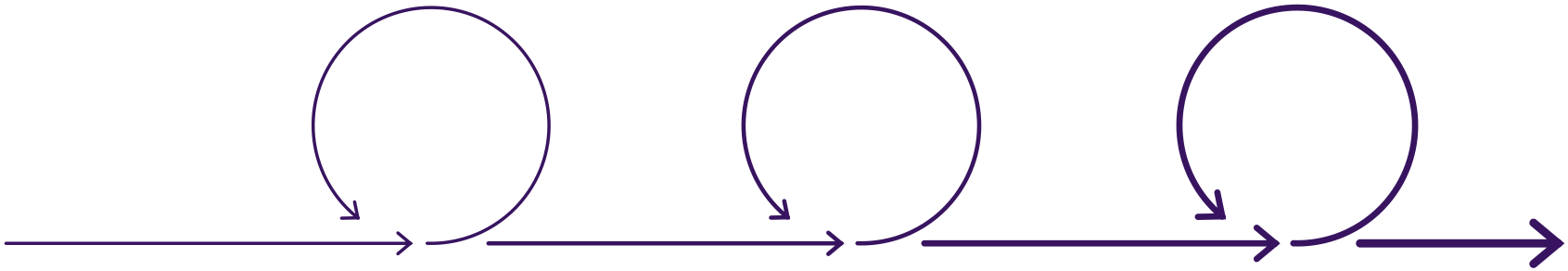
Where are we now?

Today's challenges	Our future state
Māori and Pacific women, babies and whānau and families are less likely to be able to access care that they are entitled to, from people and places they trust, and that meets their needs.	Māori wāhine, pēpi and whānau, and Pacific women, babies and family, can choose a range of maternity care from trusted Māori and Pacific providers in places that feel safe and familiar.
Disabled women, and families who have a baby with an impairment, are not always receiving enabling, respectful care.	All people, including disabled women and families who have a baby with impairments, experience responsive care that is enabling and respectful.
The current system is highly dependent on having an LMC to help navigate and access services.	Women and families who have greater care needs are supported early in their journey to access bespoke maternity care from providers who have Te Ao Māori, Pacific cultural, and clinical knowledge.
Not everyone who has birthed or received postnatal care in hospital requires hospital-level care.	Women and families are supported to receive maternity care at home and in the community, with access to specialist care when required.
People's birth and postnatal experiences in hospital services are not always positive, and maternity facilities struggle to provide adequate staffing to match demand.	Together, women and families and their advocates have the information and support to make informed choices that enable best outcomes.
The system is challenging to navigate and understand.	Women and families get care from connected and proactive providers during the first 1,000 days, especially when they have more complex care needs.
	Care is centred around supporting the wellbeing of the māmā, pāpā, pēpi and their whānau.

Endorsed by HSC on 24 November 2021 and recommended to the 2DHB Boards for approval

Creating the plan

We created this Plan with our community



Formed our Project Team and Advisory Group

Formed **Pro-Equity Project Team** with Equity Leads for Māori Health, Pacific Health and Disability.

Developed a stakeholder map, engagement and communications plan.

Formed an **Advisory Group** of 32 clinical, cultural, provider and lived experience experts.

Testing with Advisory Group and wider stakeholders

Advisory Group Hui: Provided an overview of Strategy aim and Design process. Tested and refined Design Principles. Got advice on other stakeholders to involve in testing priority areas.

Wider stakeholder Design Hui: Tested and refined priority programmes and actions with approx. 60 cultural, clinical, provider, community and lived experience experts.

Refinement and approval with Project Team and Advisory Group

Project team reviewed feedback from Advisory and Design Hui to refine the Plan.

Advisory Group Final Hui: Shared and tested the refined strategy (challenges, principles, actions) with Advisory Group.

Refined actions and prepare for Board review and implementation.

Board approval

Present to **Board** on 1 December for endorsement.

Project Team and Advisory Group Members

Rachel Pearce, Chair, GM Commissioning, Families and Wellbeing
Heather LaDell, Project Lead, Principal Commissioner Families and Wellbeing
Nikita Hunter, 2DHB Māori Health Equity Lead, Project Team
Michelle Graham, Disability Equity Lead, Project Team
Candice Apelu-Mariner, Pacific Health Equity Lead, Project Team
Victoria Parsons, Maternal and Child Health Commissioner, Project Team
Korena Wharepapa-Vulu, Māori Health Planning and Integration, Project Team
Sipaia Kupa, 2DHB Principal Advisor Pacific Health
Victoria Roper, Māori Midwifery Advisor
Fana Temese-To'omega, Pasifika Midwifery Advisor
Shannon Morris, Disability Equity Lead
Milly Carter, Te Atiawa partner
Natalie Kini, Ngāti Toa partner
Larissa Davidson, NET Māori
Joy Sipelli, NET Pacific
TeRina Michaela, Lived Experience Advisor
Dr Carey-Ann Morrison, Researcher and Lived Experience Advisor
Sieni Thetadig, Lived Experience Advisor

Melehina Kilino-Lapana, Lived Experience Advisor
Meg Waghorn, Chair, Hutt Maternity Action Trust
Orapai Porter-Samuels, Hutt LMC/ Hutt Maternity Action Trust
Vida Rye, BirthHub Wellington
Suzi Hume, BirthHub Wellington
Carolyn Coles, Director of Midwifery, CCDHB
Wendy Castle, Acting Director of Midwifery, HVDHB
Rose Elder, Obstetric Clinical Lead, CCDHB
Meera Sood, Obstetric Clinical Lead, CCDHB
Rosemary Escott, Nurse Manager, NICU CCDHB
Sagni Prasad, Nurse Manager, SCBU HVDHB
Cherie Parai, LMC Liaison, MQSP
Rachel Carian, LMC Liaison, MQSP
Noreen Roche, Charge Midwife Manager, Paraparaumu PMU
Jenny Quinn, Charge Midwife Manager, Kenepuru PMU
Shelley James, Service Manager, Women's & Children's Health, HVDHB
Simone Curran-Becker, Service Manager, Women's & Children's Health, CCDHB
Mal Joyce, General Manager, Children's Health, CCDHB

HUTT VALLEY DHB
Capital & Coast District Health Board
UPOKO KI TE URU HAUORA

What informs this kaupapa?

Te Tiriti o Waitangi

Strategies

- Taurite Ora
- Te Pae Amorangi
- Pacific Health Strategy GRW
- Our Vision for Change
- NZ Disability Strategy
- NZ Health Strategy

Insights

- First 1000 Days
- Māmā, Pēpi Tamariki Research Findings
- Creating enabling maternity care: dismantling disability barriers
- Wellington Primary Birthing Consultation and Feasibility Review

This plan builds on a substantial body of research, insights and analytics work that tells us what our community want and need in their maternal care system

2DHB Maternity & Neonatal Plan

Design Principles

Actions

Developing the 2DHB Maternity & Neonatal Plan

Endorsed by HSC on 24 November 2021 and recommended to the 2DHB Boards for approval

Living Te Tiriti o Waitangi principles

How this Plan lives Te Tiriti o Waitangi principles:

- **Tino rangatiratanga** provides for Māori self-determination and mana motuhake in the design, delivery and monitoring of healthcare services. The Plan included actions that create and invest in Hauora Māori leadership.
- **Equity** requires the Crown to commit to achieving health outcomes for Māori. The Plan adopts a pro-equity approach to prioritising actions that will deliver equitable outcomes for Māori.
- **Active Protection** requires the Crown to actively pursue and do whatever is necessary to ensure the right to tino rangatiratanga and to achieve equitable health and social outcomes for Māori. The Plan creates actions to devolve leadership and delivery to Māori.
- **Partnership** seeks to the Crown and Māori to work in partnership in the governance, design, delivery and monitoring of health services. In this Plan, Māori and iwi are recognised as co-designers and co-delivers of health care services for Māori.
- **Options** requires the Crown to provide for and provide resource for kaupapa Māori health services. This Plan provides action to ensure that maternal care is provided in culturally appropriate ways that recognise and support the expression of hauora Māori models of care.

Our pro-equity approach

Māori and Pacific mothers and babies and disabled women and families with babies with impairments experience worse outcomes *because the system fails to provide care that fits their needs.*

- In CCDHB and HVDHB, foetal and infant death rates are up to **6x higher for Pasifika babies/children** and up to **4x higher for Māori children** (see page 19).
- Wāhine Māori have statistically significant **higher rates of maternal mortality** than New Zealand European women (PMMRC, 14th Report, 2021).
- Certain groups are at higher risk of serious adverse outcomes. These include babies of **Māori, Pacific and Indian mothers; and babies of mothers aged less than 20 years** (PMMRC, 14th Report, 2021).
- A combination of issues, such as **discriminatory attitudes, limited skills and knowledge of healthcare professionals, resource constraints and limited availability of services**, prevent disabled women and women who have babies born with impairments from accessing maternity care that responds to their individual needs. (Creating enabling maternity care: research report. Imagine Better, 2021).

Alignment with health system transformation

This plan has been developed in the context of the imminent transformation of New Zealand's health system

The Plan 'gets ahead' of the reform by providing actions that bring to life key reform priorities. These include:

- **Te Tiriti-led approach:** Actions are led by Hauora Māori leadership, Māori health providers, iwi, hapū and Māori communities that reflect Māori health needs and invest sustainably in 'by Māori , for Māori approaches.
- **Locality-based approach:** Actions that emphasise integration and inter-professional teams in community-based hubs; rather than a proliferation of hospital based, DHB provided services.
- **More consistent, equitable access to specialist services:** Actions that smooth the pressure across our hospital services by delivering 'right care, right place' services, closer to home.
- **Co-commissioning with communities:** Commissioning approaches that defer to the experience and wisdom of the women and families who use services.
- **Alignment to Community Network approach:** Devolving integration and coordination to community-led hubs.

Current State

The current system has strengths

Every year, our maternal care system supports over **5,000 women** across the 2DHB region.

Our DHBs support and deliver a range of quality services including:

- primary maternity facilities at Kenepuru and Paraparaumu
- hospital-level care for mothers and babies at Hutt Valley Hospital and Wellington Regional Hospital
- specialised Maternal Foetal Medicine service supports a wider region, out of Wellington Regional Hospital
- commissioned services delivered in the community including antenatal education and breastfeeding support

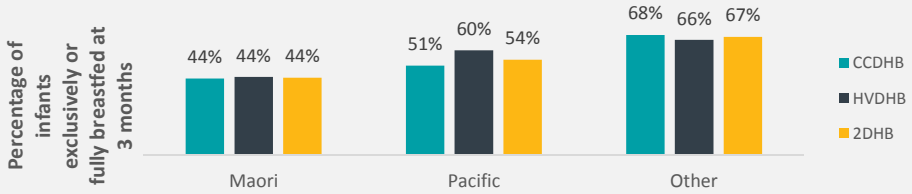
As a DHB we are refining our pro-equity commissioning approach and strengthening relationships with providers and partners across the community. We have some existing examples of great performance and effective innovation that this Plan seeks to adapt and scale.

Existing examples of great practice include:

- Innovative, **community-based** midwifery and obstetric services, including at marae.
- The early stages of **integrated service models** (hubs) across the First 1,000 Days, such as Ora Toa's Matua, Pēpi Tamariki model in Porirua.
- Pilot of **DHB support of LMC practice in the community**, to decrease the number of women relying on the Community Midwifery Team and increase utilisation at Kenepuru Maternity Unit.
- Kaupapa Māori, Pacific specific and youth-led **antenatal education options**.
- Well progressed Healthcare Homes and Community Health Networks which provides **infrastructure for community based hubs**.
- **Strong community providers** who are trusted faces for families in high needs communities.
- **Primary maternity** birthing facilities and services are valued.
- Some **growing Māori and Pacific midwifery** practices.
- **Progressive models of care** are already being considered and developed (transitional model of care).

But it is not producing equitable outcomes

Māori and Pacific babies are **less likely to be breastfed at 3 months**. The equity gap for **Māori** in our DHBs is significant – our breastfeeding rate for the total population is above the national rate; however, our rates for Māori are lower than the national average.



214 Māori babies were not breastfed at 3 months of age (42% of all babies not breastfed)

109 in CCDHB; 105 in HVDHB

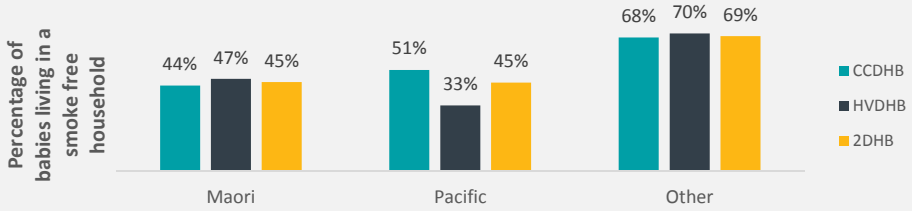
79 Pacific babies were not breastfed at 3 months of age (42% of all babies not breastfed)

52 in CCDHB; 27in HVDHB

520 babies of other ethnicities were not breastfed at 3 months

24% of all babies

Māori and Pacific babies are less likely to live in smoke free homes.



321 Māori babies did not live in a smoke free home (39% of all babies not in smoke free homes)

161 in CCDHB; 160 in HVDHB

148 Pacific babies did not live in a smoke free home (39% of all babies not in smokefree homes)

84 in CCDHB; 64 in HVDHB

562 babies of other ethnicities were not living in smokefree homes; 22% of all babies

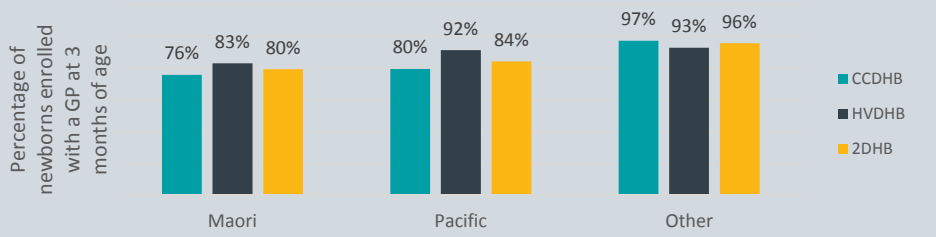
- There are "alarmingly **higher rates of maternal suicide that Māori whānau** are experiencing" (Source: PMMRC 14th report)
- **Foetal and infant death rates are up to 6x higher for Pasifika children** and **4x higher for Māori children**.
- For our 2DHB population, **Māori babies are more likely to be transferred to NICU** than babies of any other ethnicity.
- Rate of babies admitted to **NICU were highest for mothers who lived in Upper Hutt**.

	CCDHB			HVDHB		
	Maori	**Pacific**	**Other**	**Maori**	**Pacific**	**Other**
SUDI rate (2012 - 2016)	2.02	1.6	0.61	1.01	0	NA
Foetal death rate per 1,000 (2015)	4.1	12.6	5.9	3.3	4.7	8
Infant death rate per 1,000 (2015)	4.1	12.7	1.1	3.3	0	6
Registration with an LMC in first trimester (2018)	64%	42%	78%	43%	42%	%64

And not currently meeting needs across the continuum of care

"It was quite hard to find classes when I was pregnant… like there wasn't much out there that was time suitable for me anyway… There were none that I heard of with my second one, like there were none that were going on… and I would've loved to go to that cause my partner is a first-time dad, he doesn't know what to expect…"
Mother
(Māmā Pēpi Tamariki research)

Timely enrolment with primary care is important to ensure families are proactively reminded and supported to access core primary care services, such as immunisations. Māori and Pacific babies were less likely to have a GP at three months of age

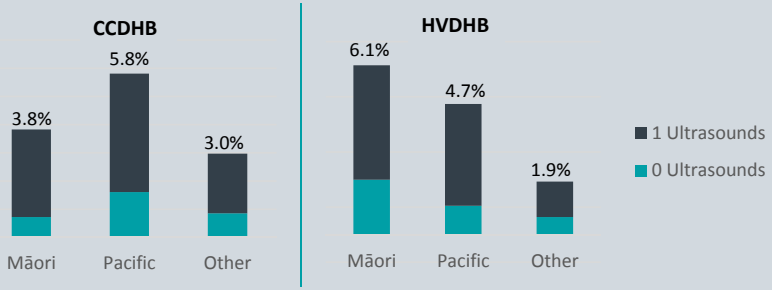


62 Māori babies had no GP at 3 months age (51% of all babies without a GP)
- 37 in CCDHB
- 25 in HVDHB

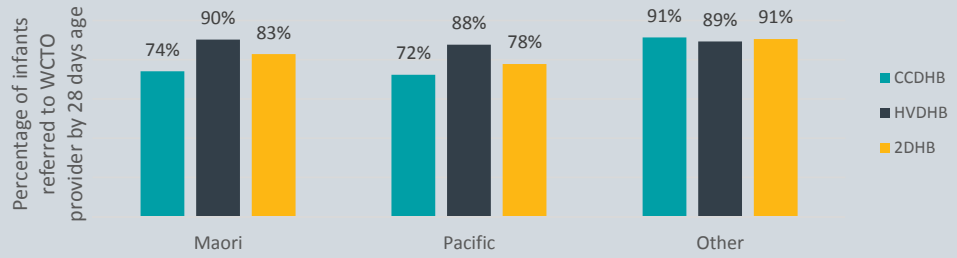
23 Pacific babies had no GP at 3 months age (39% of all babies without a GP)
- 18 in CCDHB
- 5 in HVDHB

40 babies of other ethnicities had no GP

On average, Māori and Pacific women access fewer scans in pregnancy than non-Māori , non-Pacific women



Māori and Pacific babies are less likely to be referred to a Well Child provider, especially if they live in the CCDHB area.



69 Māori babies were not referred to a WCTO provider by 28 days age (35% of all babies not referred)
- **48 in CCDHB; 21 in HVDHB**

40 Pacific babies were not referred to a WCTO provider by 28 days age (46% of all babies not referred)
- **32 in CCDHB; 8 in HVDHB**

119 babies of other ethnicities were not referred

21

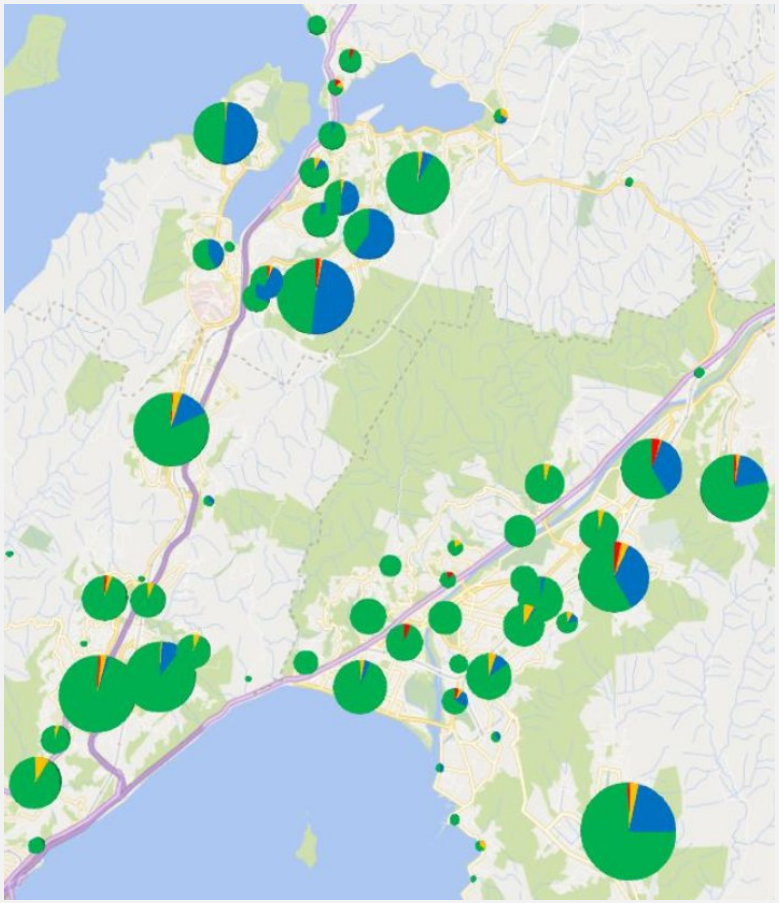
We know where the greatest need is

Each suburb is represented by a circle. The **size of the circles** reflects the volume of women having babies each year. The **blue shading represents women** with high social complexity.

Bigger circle = more birthing women

More blue in the circle = more social complexity need

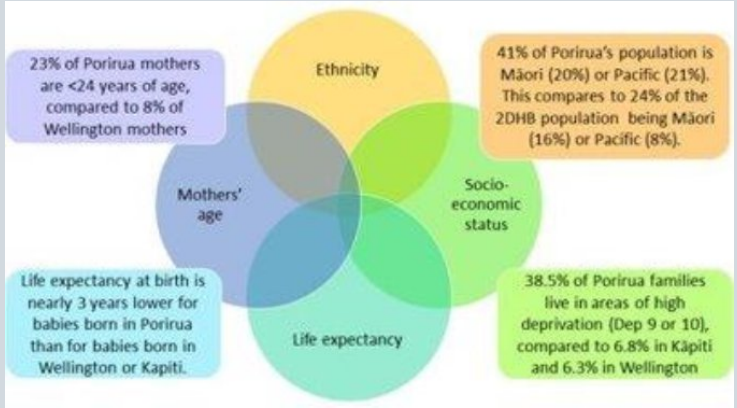
- **Wainuiomata, Naenae** and Eastern Porirua suburbs of **Cannons Creek and Waitangirua** are places with high number of births as well as a high proportion and volume of mothers needing social support.
- Clinical complexity was similar across all suburbs, with slightly elevated rates in Upper Hutt.



Intersectionality,

The concept of 'intersectionality' recognises the intersecting nature of systems of oppression. Ethnicity, socioeconmic status, gender, age, ability and nationality are not distinct, mutually exclusive entities. They overlap, combine and compound to impact on people's lives over a lifetime.

Intersectionality of risk factors for mothers and babies are disproportionately seen in some localities.



But the current investment does not follow where the need is greatest

Note: The analysis on this slide relates to CCDHB activity only. HVDHB does not contribute to the National Costing Collection, so detailed analytics is not possible for HVDHB activity at this time.

LMC funding

- There is a mix of Ministry of Health funded, District Health Board funded and privately funded care.
- LMC midwifery care is funded directly by central government. This funding cannot be accessed by DHBs who provide midwifery services to women who cannot find a community midwife.
- Therefore, **growing the community LMC midwifery workforce increases the government funding for maternity to our communities.**

Birthing costs

Normal, primary births cost less than secondary births (e.g., caesareans)

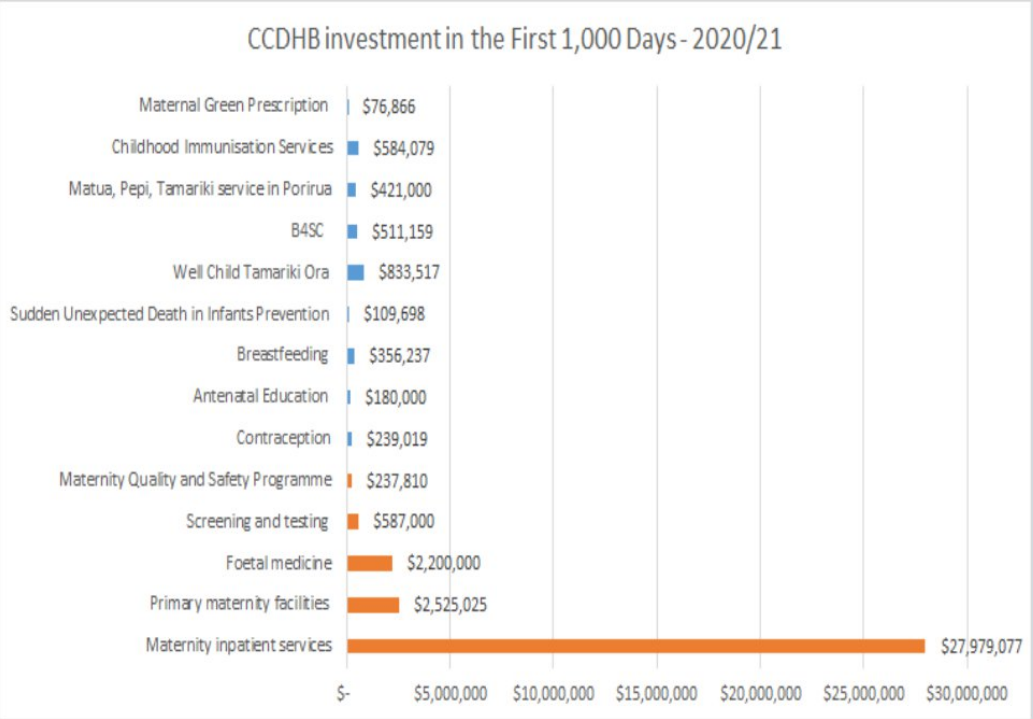
- **$1,295** is the cost of an uncomplicated vaginal delivery.
- **$5,159** is the cost of an uncomplicated caesarean.

Our maternity system is responsive to clinical complexity, but less responsive to the needs of women with social complexity. As a DHB, we spend more on clinical complexity than social complexity, even when women have both social and clinical complexity.

incl. NICU	excl. NICU
Mum with clinical *and* social complexity **$36,898.12**	Mum with clinical *and* social complexity **$2,076.90**
Mum with clinical complexity **$43,485.70**	Mum with clinical complexity **$2,992.83**
Mum no complexity **$2,038.41**	Mum no complexity **$1,417.87**

The graph below shows the range of investment across the maternal care continuum at CCDHB.

Approximately **three quarters of all CCDHB maternity funding goes toward maternity inpatient services.**



There are workforce challenges

What does midwifery care look like in 2020? How does it deliver to mothers' needs ?

- There are **240 DHB employed midwives** (including DHB employed Community Midwifery Team midwives).
- There are approx. **69 LMCs self-employed**, of whom **6 are Māori**, and **4 Pacific**.
- **LMCS attend roughly 3,500 of the 5,132 births across the DHBs**. This number has decreased significantly over the past 5 years due to LMC shortages, increasing demand for DHB provided midwifery care.
- The 2DHB Community Midwifery Teams (CMT) look after approximately 1,600 mothers per year. These women are looked after by a team of CMT midwives. Mothers attend a combination of home and hospital antenatal visits, birth at the hospital with support from a hospital midwife, and receive postnatal care from the CMT team.

Who is missing out on LMC care?

- **Each year, approximately 1,600 mothers won't be able to find an LMC.** In addition, many women report wanting a midwife that reflects their ethnicity. Of the 1,139 Māori mothers birthing annually, an estimated 839 of these Māori mothers will be unable to find a Māori LMC, as will 300 of the 499 Pacifica mothers.
- Only 10 LMCs are Māori or Pasifika midwives working in the community.

839 Māori mothers without a Māori LMC

544 Others without an LMC midwife

300 Pacific without a Pacific midwife

Supportive midwifery care matters

"There's a lot of information on parenting a blind child but not a lot on parenting as a Blind person. My midwife ended up finding another Blind mum in Christchurch who had done it blind and gave me her number. She gave me some tips and tricks and I felt really supported the whole way through."
Mother
(Creating Enabling Maternity Care)

"We are providing more and more care to women with very complex health needs that probably 20 years ago they were told that they couldn't have a baby. The focus has to be on the person… It is about fostering all the good things and looking at the individual."
CMT midwife
(Creating Enabling Maternity Care)

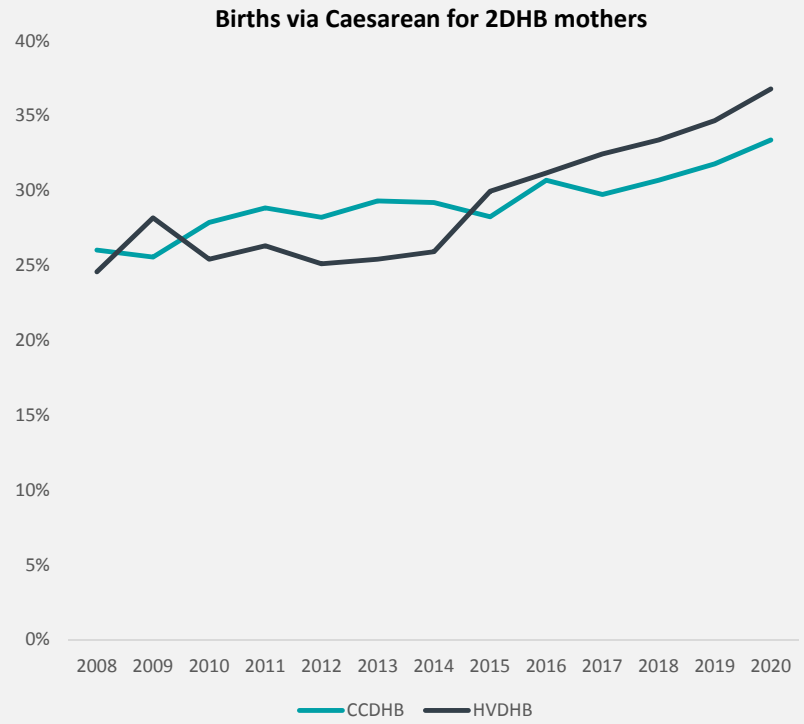
Women value midwifery care from a midwife who shares their culture

"Māori are more aware that it's not just that person that's pregnant... I think that just comes from being Māori."
Mother
(Māmā Pēpi Tamariki research)

"I know when I was pregnant with D, we did that whole look and find a midwife and we found one and she was very clinical and did everything that you needed to of a midwife, but I think with N (Māori midwife), you just felt a little more encompassed culturally and she was aware of all of that stuff."
Mother
(Māmā Pēpi Tamariki research)

And rising birth intervention rates

2DHB mothers have some of the highest rates of intervention including caesareans, and the rate of intervention is increasing. 33% of Hutt Valley and 31% of Capital & Coast mothers give birth via caesarean The national average is 27%.



Babies born in obstetric units, also had higher risk of admission to a neonatal intensive care unit, longer stay and recovery for mother and long-term health implications, as well as higher care costs
Davis et al (2011)

Research shows **women planning to give birth in an obstetric unit had higher rates of caesarean sections**, assisted deliveries and intrapartum interventions than in primary birthing units or at home.
Davis et al (2011)

Primary Birthing Units (*PBUs, also known as community birth centres*) have been found to have comparably lower intervention rates and similar neonatal wellbeing outcomes, higher breastfeeding rates and low postpartum haemorrhage rates.
Davis et al (2011)

Amongst women who birthed across CCDHB facilities in 2017, breastfeeding rates on discharge were significantly higher for women who gave birth at a Primary Birthing Unit.
Davis et al (2011)

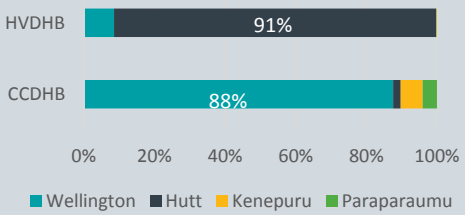
People do not always access birth care at the clinically appropriate level

Number of available beds at DHB funded maternity services

- Hutt Hospital: **17 postnatal beds**
- Wellington Regional Hospital: **26 antenatal and postnatal beds**
- Paraparaumu Maternity Unit: **2 postnatal beds**
- Kenepuru Maternity Unit: **6 postnatal beds**

While many mothers choose to birth at a hospital, under current policy parameters **1682 mothers who do birth in hospital, do not have a choice but to birth at hospital** due to inability to get LMC care to provide birth care at home or at primary maternity unit.

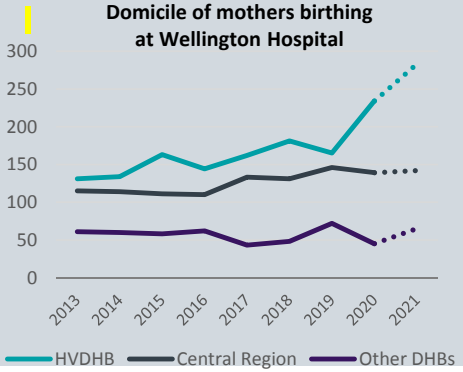
Births by Facility for 2DHB mothers



Women giving birth at our DHBs' hospitals have a slightly **longer length of stay than the national average**. Both CCDHB and HVDHB have an average LOS of 2.1 days, compared to the national average of 1.9 days.

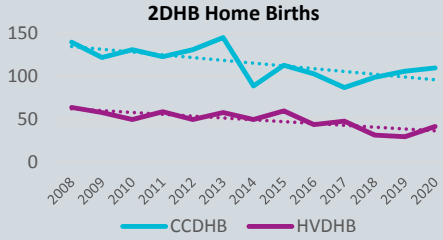
CCDHB mothers are most likely to give birth in Wellington Hospital, however an increasing number of affluent, middle aged non- Māori and non-Pacific Hutt Valley mothers are choosing to birth at Wellington Hospital. This increase is most notable in 2020 and is forecast to continue in 2021.

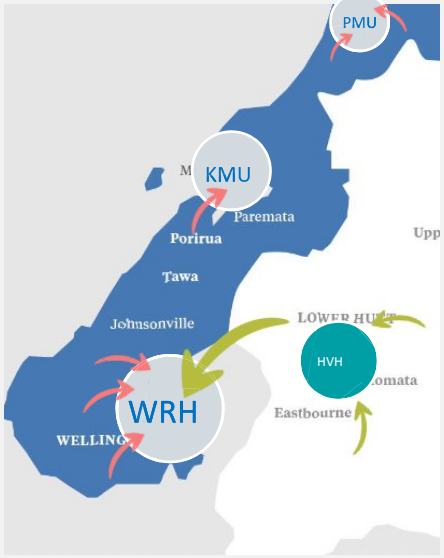
Domicile of mothers birthing at Wellington Hospital



In 2020, 152 mothers in the 2DHB region gave birth at home (3% of all births, which is lower than some other regions). Over time, the rate of home births has been decreasing.

2DHB Home Births

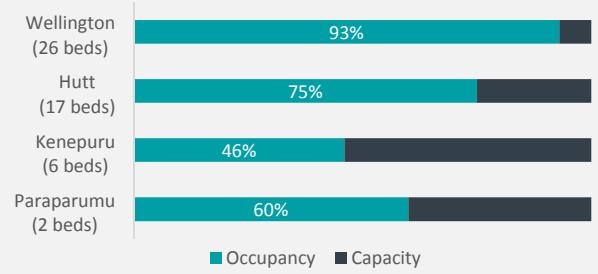




Who is birthing outside of their DHB?

- Since 2019 there has been a significant increase in the number of women who live in HVDHB who are birthing at WRH. These women are more affluent, non-Māori and non-Pacific mothers.
- Mothers who birth at KMU are primarily from Cannons Creek and Linden.
- PMU primarily had mothers birthing there who lived locally. HVH primarily had mothers from Naenae and Taita.

2DHB Birthing Facility Occupancy



- This is one factor contributing to the **imbalance in the distribution across the 2DHB facilities**, with some facilities such as KMU and PMU with capacity, while WRH experiencing frequent overcapacity and staffing shortages.

Endorsed by HSC on 24 November 2021 and recommended to the 2DHB Boards for approval

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What maternity care do mothers and families want?

Where do mothers want to receive maternity care?

- **Midwifery care close to home:** Most women and families prefer to receive antenatal and postnatal care at home or close to home.
- **Community birth options:** There is demand for alternatives to hospital birthing locations.
    - A 2014 study (Dixon et al.) shows that, for Māori women who were clinically good candidates for birth in any setting, 44% would prefer to **birth at home or in a primary birth unit**. It has also been identified that Māori women make greater use of primary birthing facilities.
    - In 2018 a survey of the consumers and midwives about a potential Wellington Primary Birthing Unit:
        - 70 percent of pregnant consumers agreed they would use a Primary Maternity Unit
        - 73 percent of all consumers said they would use the unit for self/family/whānau/organisation
        - 91 percent agreed they would be 'interested', in transferring to a primary birthing unit for postnatal care
        - About two-thirds of consumers said they would want a birth and postnatal environment that was relaxed, restful, comfortable, homelike and pleasant. They said they wanted support and privacy in a less rushed, less clinical environment that would result in less interventions.

Continuity of care and choices

"Our women struggle to find an LMC, and if they do have an LMC, it's not a consistent one, they get different ones throughout their pregnancy…and then when it comes to giving birth, they think they can birth at Kenepuru but they have to go to Wellington Hospital…"

Health care provider, Taeaomanino Trust (Evaluation of Antenatal Education Services Report)

Help with gaining knowledge and confidence

"A lot of them don't know what information is out there, you know, so I just sit with them and talk about what things they can learn about when they are pregnant."

Health care provider, Taeaomanino Trust (Evaluation of Antenatal Education Services Report)

Consistent support

"We see them here at hospital and at home, for that continuity and we support them through that and then once the midwifery side is finished there are the other providers like Plunket and we would support that transition so they can continue that support, to their GP, or other specialists, and so not just run away – make sure somebody else is there, whether that is a medical person or a social service person."

CMT midwife (Creating Enabling Maternity Care)

Actions

Overview and objectives

1. Culturally responsive care

a. As the indigenous people of Aotearoa, Māori experience care that is reflective of their indigenous knowledge and is culturally responsive and safe.

b. Pacific families access care and services that is culturally responsive and safe.

2. Improved access to primary birthing

a. Women and families can choose community models of birth and postnatal care.

b. Women and families who birth in hospital have support to experience a healthy normal birth.

3. Enabling maternal and neonatal care

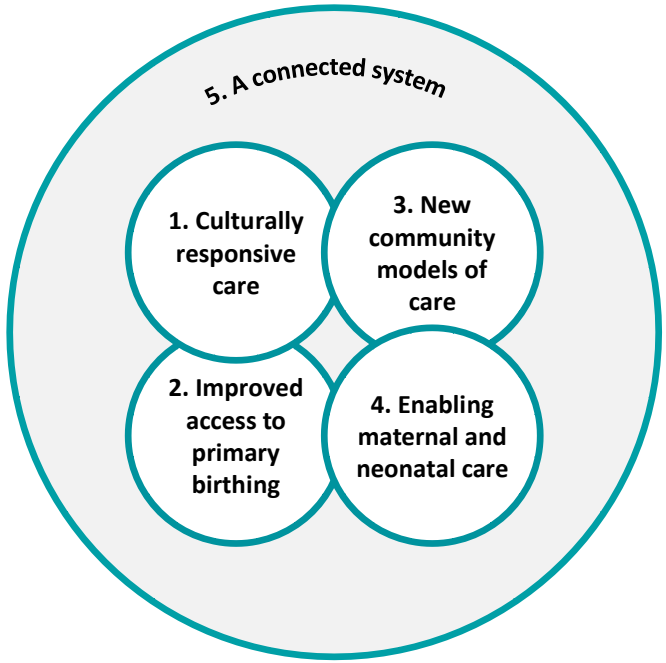
Disabled women and families with children with impairments receive accessible and inclusive care that enables good lives.

4. New community models of care

Mothers, fathers, families and whānau access a range of care connected within their community from trusted faces in trusted spaces.

5. A connected system

We deliver a connected continuum of maternal and neonatal care, at the right level, as close to home as possible, keeping families together.



Culturally responsive care

1 Trusted faces in trusted places
4 Intensify for those who need it most
6 Connected, proactive providers
7 Whānau centred

Programme objectives

A. As the indigenous people of Aotearoa, Māori experience care that is reflective of their indigenous knowledge and is culturally responsive and safe.
B. Pacific families access care and services that is culturally responsive and safe.

Hauora Māori leadership

Establish Hauora Māori leadership role which enables, supports and enhances indigenous knowledge and cultural responsiveness throughout the maternal and neonatal system of care. Support recruitment and retention of Māori workforce within maternity and neonatal care. Provide a work environment that is culturally safe and skilled in the cultures and healthcare needs of both workforce and families.

Actions:
1. Establish and resource new Hauora Māori leadership role by February 2022.
2. Recruit into Hauora Māori leadership role by April 2022.

Pacific Health leadership

Establish Pacific health leadership role which enables, supports and enhances Pacific cultural knowledge and cultural responsiveness throughout the maternal and neonatal system of care. Support recruitment and retention of Pacific workforce within maternity and neonatal care. Provide a work environment that is culturally safe and skilled in the cultures and healthcare needs of both workforce and families

Actions:
1. Establish and resource new Pacific leadership role by February 2022.
2. Recruit into Pacific leadership role by April 2022.

Workforce support and education programme

People who work within maternity and neonatal spaces, including managers, in the community and in facilities, have education and support to gain the skills and confidence to provide culturally safe care.

Actions:
1. Suite of mandatory and progressively stepped cultural responsiveness training and resource library is developed and implemented by June 2022.
2. Develop complaint and resolution pathway to support staff when they witness or experience culturally unsafe practice or behaviours, by June 2022.
3. Evaluation and audit of skills, knowledge and practice is developed and implemented by September 2022.

Grow the Māori and Pacific maternity workforce

Increase the maternity workforce that holds specific clinical and cultural skills and knowledge including:
Safe sleep, breastfeeding, kaiāwhina, mātauranga Māori, birthing tikanga, hapū wananga, mental health.

Actions:
1. Co-develop package of support to recruit and retain Māori and Pacific LMC midwives by April 2022.
2. Include support for new peer support and professional roles in hapū whānau service specification by March 2022.

Support indigenous, traditional and cultural birthing knowledge and practice

Enable the sharing, access to and growth of Indigenous, traditional and cultural birthing knowledge and practices.

Actions:
1. Establish Indigenous, Traditional and Cultural Birthing Knowledge and Practice Advisory Group by May 2022.
2. Include advice from Advisory Group in mandatory Cultural Responsiveness education by June 2022.
3. 2DHB policy and guideline developed to increase access to Indigenous, traditional and cultural birthing knowledge and practices by June 2022.

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Improved access to primary birthing

1 Trusted faces in trusted places
2 Enabling and respectful
3 Right-level care, closer to home
5 Informed choices
7 Whānau centred

Programme objectives

A. Women and families can choose community models of birth and postnatal care.

B. Women and families who birth in hospital have support to experience a healthy normal birth.

Increase access to primary maternity facilities

Actions:

1. Articulate a 2DHB configuration of primary maternity facilities that increases access to community-based primary birth and postnatal services, by March 2022.
2. Develop a business case for investment in additional primary maternity inpatient birthing and postnatal services; and capital improvements at existing PBUs (KMU and PMU) by June 2022.
3. Contribute to Master Site Plan to consider medium-to-long term facilities needs for maternity at Kenepuru by June 22.

Increase utilisation of current primary maternity units

Increase utilisation of existing primary maternity facilities by ensuring they are fit for purpose and enable holistic, whānau-centred and safe care.

Actions:

1. Lead a design process with families to finalise short-term improvements to Kenepuru by June 2022.
2. Consider staffing models at Kenepuru and Paraparaumu to include support staff (e.g. healthcare assistants) by June 2022.

Enable home birth choice and knowledge

Homebirth is promoted and resourced as a viable option and women are given the choice, support, resources and pathways to enable this.

Actions:

1. Factual information about homebirth is included in Pepe Ora by April 2022.
2. Support LMC midwives to offer homebirth option for place of birth by providing a package of education, resources, and consumable supplies (e.g. birth pools/liners) for midwives and Kaiāwhina is developed by April 2022.

Define physiological pathway care for women birthing in hospital

Define a pathway and develop environments that promote birth without unnecessary intervention at our hospitals.

Actions:

1. Building on current "Optimising Birth" initiatives, develop a physiological birth pathway and guidelines for midwifery-led care to achieve a physiological birth without unnecessary intervention, in hospital, by April 22.
2. Develop normal-birth promoting environments within hospital maternity wards, according to physiological birth promotion principles and involving service users and community providers, by June 22.
3. Include access to birth support from Kaiāwhina (date TBD).

New community models of care

1 Trusted faces in trusted places
2 Enabling and respectful
3 Right-level care, closer to home
4 Intensify for those who need it most
6 Connected, proactive providers
7 Whānau centred

Programme objective

Mothers, fathers, families and whānau access a range of care connected within their community from trusted faces in trusted spaces.

Enable development of community Hapū Whānau Maternity Hubs

Commission and develop a network of connected Hapū whānau Hubs that provide a continuum of services for the whole family, for the first 1000 days and beyond. The hubs are formed by partnering with, investing in and co-locating existing community services including LMCs, primary health and specialist services.

Actions:
1. Create a service specification for hapū whānau hubs, that builds on existing services, strengths and assets in the community by March 2022.
2. Implement a minimum of 2 iwi-led or supported Hapū whānau hubs by June 2022.
3. Enable access to specialist care closer to home including the potential for a mobile outreach clinic and telemedicine, co-located with other integrated services in the community (e.g. hubs and PBUs) by December 2022.
4. Enable access to holistic comprehensive support to meet a range of social needs (e.g. Kaimahi, social work, specialist midwifery and cultural support) by December 2022.

Kaiāwhina model of care

Develop a model of care for maternity-specific Kaiāwhina support for pregnant, birthing, and postnatal mothers and families that would provide wellbeing support and health navigation support throughout women and families' journey from conception to early years.

Actions:
1. Include Kaiāwhina within Hapū Whānau Hub service specification by March 2022.
2. Co- develop with families, cultural and clinical experts, a maternity-specific Kaiāwhina model of care and capability and support framework by June 2022.

Community Midwifery Team new model of Care

Improve access to continuity-of-care maternity care closer to home for women unable to access community LMC midwifery. Establish a well aligned and resourced team who provide culturally responsive and enabling, continuity of care.

Actions:
1. Create a new continuity of care model of care for HV and CCDHB CMTs by March 2022.
2. Implement a new model of care by September 2022.

Maternal wellbeing and mental health model of care

Improve support for wellbeing and access to appropriate services so mothers and fathers can indicate that they are experiencing distress and get appropriate support, at any time across the perinatal period. This includes support for loss, bereavement, birth trauma, and post-diagnosis of babies with impairments.

Actions:
1. Create specialist perinatal wellbeing role to support emotional wellbeing and mental health of families across the 2DHBs by September 2022.
2. Develop a package of education and resources for non-clinical roles (e.g. chaplains, kaumātua) to support families experiencing distress by September 2022.
3. Include support for emotional wellbeing in Hapū whānau Hub service specification by March 2022.

Support LMCs to enter and stay in practice

Develop a package of support for LMC midwives in the 2DHB region to enter and stay in practice including support for providing homebirth and birth in primary maternity facilities care.

Actions:
1. Co-develop and implement a package of support for new and returning to service LMC midwives by April 2022.
2. Fund clinic space for LMC midwifery practices in high needs areas by June 2022.

Enabling maternal and neonatal care

2 Enabling and respectful

4 Intensify for those who need it most

6 Connected, proactive providers

7 Whānau centred

HUTT VALLEY DHB

Capital & Coast District Health Board
UPOKO KI TE URU HAUORA

Programme Objective

Disabled women and families with children with impairments receive accessible and inclusive care that enables good lives.

Establish this role… **…to enable these actions**

Disability equity leadership

Establish Disability leadership role which enables, supports and enhances Enabling Good Lives principles throughout the maternal and neonatal system of care. Includes leading workforce education and support, review of policies, clinical pathways, environments, and resources for families.

Actions:

1. Establish and resource new disability role by February 2022.
2. Recruit into disability leadership role by April 2022.

Breastfeeding pathways are disability and impairment positive

All women who aspire to breastfeed receive effective, accessible and inclusive lactation support, including disabled women and mothers of babies with impairments.

Actions (dates TBD):

1. EGL education mandated to all DHB-funded breastfeeding support providers in 2DHB region.
2. Update all breastfeeding pathways and guidelines, according to EGL principles.
3. Develop specific resources to provide practical accommodations with breastfeeding for disabled mothers and families with babies with impairments.

Antenatal education is enabling

All antenatal education curricula is reviewed against Enabling Good Lives principles. Resources are developed for specific needs (e.g. mobility needs in birth, or families who have an antenatal diagnosis).

Actions (dates TBD):

1. EGL education offered to all antenatal and parenting educators in 2DHB region (date TBD)
2. Antenatal and parenting education curriculum is reviewed and recommendations consistent with EGL update (date TBD).

Disability advocacy and support service available for maternal and neonatal Care

Kaiāwhina-type role developed to support disabled women and families with a baby with impairments, to ensure environments are enabling, provide support to healthcare providers, and develop care plans that extend from the neonatal period through to children's services.

Actions:

1. Establish and resource new role/s by April 2022.
2. Disability support service available to families by June 2022.

Information is gathered that can drive further improvement

Care, outcomes and experiences of disabled women and families with babies with impairments is collected, evaluated and creates ongoing improvement.

Actions:

1. Disability Equity Advisor role established on Maternity Quality Safety Programme Governance Groups by April 2022.
2. Guidelines for gathering and evaluation of information related to disability in maternity and neonatal space are developed by MQSP (date TBD).

Policies and guidelines are enabling

Review all 2DHB maternity and neonatal policies and guidelines to ensure rights based language and EGL principles are evident.

Ensure all resources developed reflect intersectional realities.

Actions (dates TBD):

1. Priority maternity and neonatal policies are reviewed and updated to reflect EGL principles.
2. All 2DHB policies and guidelines are reviewed with a Disability Equity lens as they come up for review.

Workforce support and education programme

People who work within maternity and neonatal spaces, including managers, in the community and in facilities, have education and support to gain the skills and confidence to provide care in line with Enabling Good Lives principles.

Actions (dates TBD):

1. Suite of mandatory and progressively stepped cultural responsiveness training and resource library developed and implemented.
2. Measures for evaluating and auditing skills, knowledge and practice, with consideration of an accreditation system are implemented.
3. Clinical coaches available to all workforce.

A connected system

1 Trusted faces in trusted places
2 Enabling and respectful
3 Right-level care, closer to home
4 Intensify for those who need it most
5 Informed choices
6 Connected, proactive providers
7 Whānau centred

Programme objective

We deliver a connected continuum of maternal and neonatal care, at the right level, as close to home as possible, keeping families together.

Resources for families

Women, families and providers have the information they need to access the care they need, and to make decisions about their care, throughout the 2DHB region.

Actions:

1. Extend the Pēpe Ora online network of resources to include the Hutt Valley, by April 2022.
2. Expand Pēpe Ora to include information about how to make informed choices, by March 2022.
3. Ensure Pepe Ora is highly accessible and visible to women and families, by March 2022.
4. Include links to Pepe Ora in platforms used by providers including Health Pathways by March 2022.

Integrated Network of Right place-Right care Services

Connected network of care from community to specialist services. Support people to access levels of care based on needs and preferences, and integrated clinical governance is provided across the system.

Actions:

1. Contribute to the Master Site Plan to determine medium-to-long-term maternal and neonatal facility needs at Hutt, Wellington and Kenepuru Hospital sites, by June 2022.
2. Develop Right Place-Right Care pathways of care guidelines to maximize the ability for families to access care at the optimal level for their needs, as close to home as possible, by April 2022.
3. Integrate clinical governance structures across 2DHB system, including Maternity Quality and Safety Programme (MQSP) by June 2022.

Safe sharing of clinical information across the continuum of care

Select a maternity clinical information system that can be implemented across the 2DHB maternal and neonatal system, so that providers and families have access to complete clinical information across the continuum of maternal and neonatal care, to maximise safety and continuity. (This also brings the 2DHBs into compliance with Ministry of Health expectations.)

Action:

1. Develop a maternity clinical information system procurement and implementation plan by June 2022.

Whānau-friendly policies and support

Remove barriers for families and whānau to stay together throughout the maternal and neonatal inpatient journey.

Actions:

1. Involve consumers in updating all maternity and neonatal unit policies regarding support people presence to support birthing people, including strategies to minimise separation in a COVID environment, by February 2022.
2. Involve families in facility redesign/improvement work to ensure that family-friendly spaces are created, by June 2022.
3. Fund an extension to existing travel and accommodation support for families who have to travel to access inpatient maternity or neonatal care for extended periods, by April 2022.

Enabling access to high-quality pregnancy ultrasound

Remove barriers for women to access appropriate and adequate-quality scans, either in the community or in the DHB.

Actions:

1. Provide access to free ultrasound morphology scans for women who would otherwise be unable to access them, by April 2022.
2. Develop clinical governance framework to ensure uniform, high quality for all pregnancy related ultrasound services. Improve sonographers training to pick up impairments by June 2022.

New models of care for newborns requiring extra support

Implement new models of care to support babies to minimise unnecessary separation from mother and whānau, minimise unnecessary hospitalisation, and improve post-discharge support.

Actions:

1. Develop plan to implement new national Transitional Model of Care in Hutt Hospital and Wellington Hospital, to keep mothers and babies together whilst providing additional neonatal specialist input as required, by June 2022 (NB there are facilities redevelopment implications).
2. Adopt and implement Model of Care to support babies in the community who are requiring extra support but do not (or no longer) require hospitalisation, by April 2022.
3. Create a lactation support service for families who have a baby in Hutt Special Care Baby Unit (SCBU), or have been discharged from SCBU by April 2022.

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Change principles

Strategic approach

Pro-equity

- Project Aim
- Project Team with Māori, Pacific and Disability Equity Leads

Human-Centred

- Engaged design experts from ThinkPlace
- Focused on experiences of women and families

Insight-driven

- Builds on existing knowledge about what is and isn't working in the system.

Bias toward action

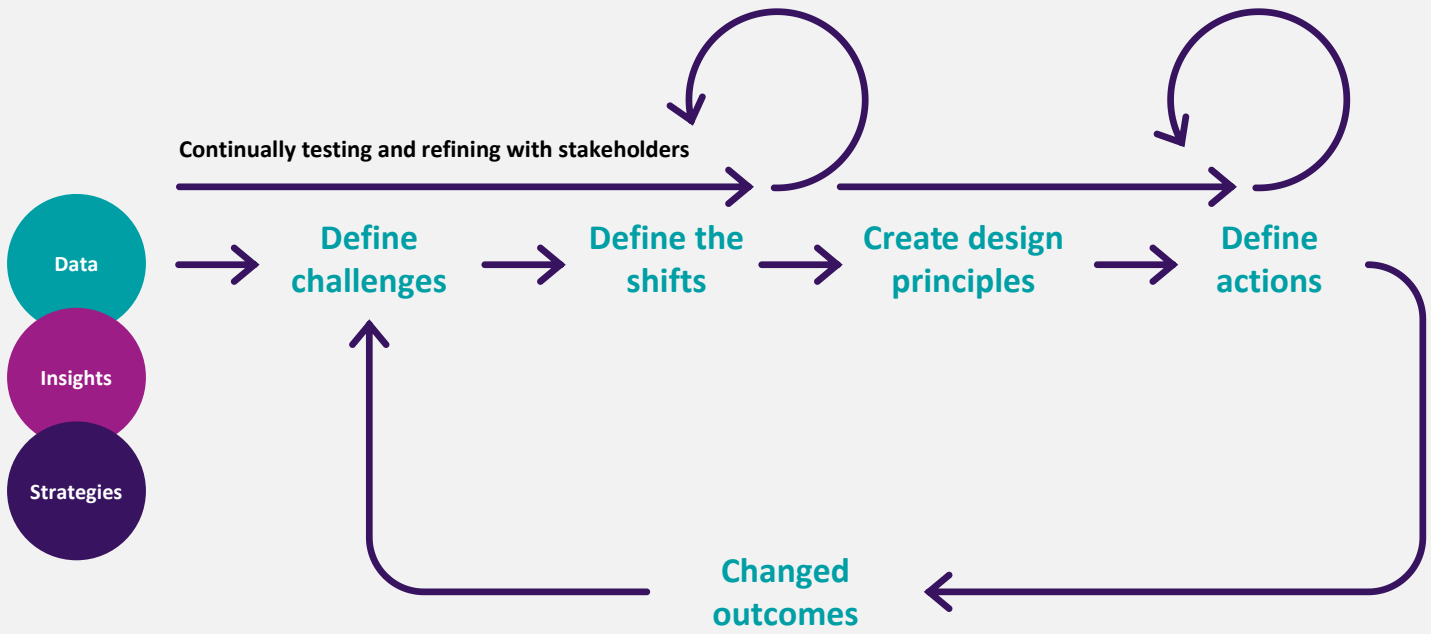
- Defines concrete actions to create change

Relationship building

- Prioritises building trust throughout the system.

Iterative

- Tests and refines using an Advisory Group and wider stakeholders who represent the people who are in the system.
- Tests thinking early and often.



The steps to design this Plan have taken us from: making sense of the data, insights, and strategies; to defining challenges; understanding the shifts required, outlining the design principles to guide decision making; defining the actions to make change; defining the outcomes that will be measurably changed, which ultimately will address the challenges we face today.

Understanding our challenges

1

Māori and Pacific women, babies and whānau and families are less likely to be able to access care that they are entitled to, from people and places that they trust, and that meets their needs.

Māori and Pacific women are less likely to have continuity-of-care midwifery care, and less likely to have the support they need to give birth to full term healthy weight babies.

"They'll go, 'here's a list of midwives, find a midwife.' Then this poor woman is left to negotiate this whole thing, often not hearing back from any services, they'll say, 'well no one got back to me, they got back but couldn't see me in the end.' I don't think that women are being served well from the very first point of contact in their pregnancy." CCDHB - MĀMĀ, PĒPI, TAMARIKI RESEARCH. DNA: 2019

2

Disabled women, and families who have a baby with an impairment, are not always receiving enabling respectful care.

The workforce is not educated or trained to provide enabling or respectful care to disabled women and babies born with impairments.

"I contacted a lot of LMCs very early on, I mean at this stage I was probably only five weeks pregnant and a lot of them didn't feel confident in taking me on, so it wasn't a case of they didn't have space – it was that they felt they didn't have the skills they needed to support me in pregnancy." Creating enabling maternity care: research report. Imagine Better: 2021.

Understanding our challenges

3

The current system is highly dependent on having an LMC to help navigate and access services.

LMC shortages means more women are not receiving continuity-of-care midwifery care, are missing out on care they are entitled to, and are not receiving intrapartum care from a midwife they know and trust.

Across the 2DHBs there is a decreasing number of LMCs, and particularly scarce Māori and Pacific LMCs.

The type of birth and care you can access is dependent on the LMC you can access and requires high effort from the women and their family to engage.

Approx. 1,600 women per year are unable to access an LMC midwife and receive their care through the 2DHB community midwifery team. These women are unable to choose to birth at a primary maternity unit or at home.

Refer to "The maternity workforce" data story on page 23 for more information.

4

Not everyone who has birth or postnatal care in hospital requires hospital-level care.

There are rising rates of birth interventions in hospital, with risks for mothers and babies and less satisfactory birth experiences, and few women in the 2DHB region have access to out-of-hospital birthing and postnatal care.

Current research and evidence supports physiological birth outside of the hospital but birthing in hospitals is common for women across the 2DHBs, and intervention rates in hospital are increasing

Refer to data story on page 24-25 for more information.

Understanding our challenges

5

People's birth and postnatal experiences in hospital services are not always positive, and maternity facilities struggle to provide adequate staffing to match demand.

An increasing number of women and families are choosing to birth in the Wellington Regional Hospital, which is experiencing capacity issues.

Some women and families are choosing to bypass Hutt Valley Hospital Maternity facilities due to perceptions around the quality and safety of the service.

"I felt was there was no empathy for mothers; new, new mothers. First time mother. They were willing to get rid of her the next day. I don't understand why I had to advocate for her, just to have a couple more days."
CCDHB - MĀMĀ, PĒPI, TAMARIKI RESEARCH. DNA: 2019

6

The system is challenging to navigate and understand.

It takes a lot of effort for individuals and families to access separate services throughout the maternal, neonatal and early years' time, and people don't always feel involved in decisions about their care.

Families really appreciate when they can get multiple services through a provider who is trusted and already known to them.

Families who don't engage in maternity services are sometimes blamed for "Not Attending" and end up missing out on care they are entitled to.

"They have had really bad experiences with conversations or experiences they've had, or whoever they wanted was unavailable, so they just thought, well, I'm not going to bother."
CCDHB - MĀMĀ, PĒPI, TAMARIKI RESEARCH. DNA: 2019

Developing principles for change

These principles are statements that can be used to guide and inform decision making now and in the future. Together, they describe the direction of change.

They have been informed by current strategies, evidence, insights and the voices of service users and providers, to help us to imagine what better maternity and neonatal care could look like.

Endorsed by HSC on 24 November 2021 and recommended to the 2DHB Boards for approval

Principle 1: Trusted faces in trusted places

The principle and what it means

Māori wāhine, pēpi and whānau, and Pacific women, babies and family, can choose a range of maternity care from trusted Māori and Pacific providers in places that feel safe and familiar.

Trusted faces means… people who are known and familiar. People will engage and respond more effectively to people they feel they can trust, especially those from their own communities.

Family means… extended family of a Pacific person. Family is an important value for Pacific people. In some Pacific cultures, "fanau" refers to the immediate or nuclear family, children, or birthing.

Trusted places means… the environments people receive care are familiar to them, close to home or in places they go regularly.

Choose means…
People know what they are entitled to and have the option to engage with something, they have agency over this interaction, it is not forced.

A range of maternity care means… access to primary care as well as specialist care, and it also means having respectful care.

The strategic shift

FROM: Clinical and hospital-based services that aren't easily accessed or affirming for Māori, Pacific or disabled communities.

TO: Well-known and easy to access clinical and cultural services that are designed specifically to proactively cater to the unique and intersectional needs of Māori, Pacific and disabled community.

FROM: Mothers and whānau experiencing care that makes them feel judged, unheard and unvalued.

TO: Mothers and whānau receiving care that is mana enhancing, kind and makes them feel understood and valued.

The rationale

Strategies:
- Taurite Ora,
- Te Pae Amorangi,
- Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020 to 2025

Insights:
- Feedback from Advisory Group and Stakeholders,
- *CCDHB – Māma, Pēpi, Tamariki Research* – DNA

Existing successful initiatives:
- Hapū Wananga
- Anofale Fa'atupu Ola Pacific
- Te Ao Mārama

Principle 2: Enabling and respectful

The principle and what it means

All people, including disabled women and families who have a baby with impairments, experience responsive care that is enabling and respectful.

Disabled means… a person who experiences loss of opportunities to take part in society on an equal level, as a result of negative interactions that take place between a person with an impairment and the barriers in her or his environment.". *

Enabling means… people are informed, can access the highest level of care, and participate actively in all relationships. *

Impairments means… an injury, illness or congenital condition that causes or is likely to cause a difference of function. *

Responsive means… responding to requests for accommodation to enable equitable care to happen. *

Respectful means… people feel their mana and dignity is maintained by those providing care.

***** https://www.enablinggoodlives.co.nz/about-egl/egl-approach/principles/

The strategic shift

FROM: Services aren't accessible or affirming for disabled people and are delivered by a workforce who are not trained or educated in delivering enabling care.

TO: Well known, accessible and inclusive services from a workforce who are disability aware.

FROM: Parents and whānau who have babies born with impairments, or have a disability themselves, don't get the appropriate support or response from the workforce.

TO: Disabled parents and every baby that is born with impairment is cherished and the workforce knows how to respond and accommodate them.

The rationale

Strategies:
- Enabling Partnerships: Collaboration for effective access to health services. Sub-Regional Disability Strategy 2017 – 2022. Wairarapa, Hutt Valley and Capital & Coast District Health Boards

Insights:
- Feedback from Advisory Group and Stakeholders,
- *Creating enabling maternity care: dismantling disability barriers: Mums and babies' experiences at the 3DHB research report April 2021.* Dr Carey-Ann Morrison, Imagine Better Ltd.

Existing successful initiatives:
- Enabling Good Lives education
- Twenty-one gifts partnership

Principle 3: Right-level care, closer to home

The principle and what it means

Women and families are supported to receive maternity care at home and in the community, with access to specialist care when required.

At home and in the community means… antenatal and postnatal care is delivered in the community, and coordinated through maternity hubs in specific, high needs areas, and community place of birth and postnatal care options are trusted and accessible.

Specialist care means… care from a range of professionals e.g., obstetricians, neonatologists, lactation consultants, kaiāwhina, mirimiri practitioners, and others.

Right level means… care is delivered at the right intensity to meet the person's clinical, social and cultural needs, with wellbeing-focused primary care being the norm.

The strategic shifts

FROM: Most people who give birth are accessing hospital-level care, even if they would be good candidates for community birth and inpatient postnatal care.

TO: People are able to access community birth and inpatient postnatal care, and hospital care is predominantly for women and babies who require specialist care

FROM: People travel far from home, bypassing closer services, to birth at Wellington Regional Hospital.

TO: People in Hutt Valley have a range of trusted options for place of birth and postnatal care, and only access Wellington Regional Hospital if they require tertiary-level specialist care.

FROM: Facilities are often far away from people's homes, clinical, and do not feel welcoming to mothers and their whānau.

TO: Places which are closer to home, make mothers and whānau feel comfortable, and their diversity and uniqueness celebrated.

The rationale

Strategies:
- CCDHB Health System Plan 2030;

Insights:
- Feedback from Advisory Group and Stakeholders,
- Maternity analytics: Report for Capital and Coast and Hutt Valley District Health Boards. 21 June 2020. Synergia
- Primary Birthing Unit: Capital and Coast District Health Board. Integrity Professionals

Existing successful initiatives:
- Keneperu Maternity Unit
- Paraparaumu Maternity Unit
- Supporting LMC practices

Principle 4: Intensify for those who need it most

The principle and what it means

Women and families who have greater care needs are supported early in their journey to access bespoke maternity care from providers who have Te Ao Māori, Pacific cultural, and clinical knowledge.

Te ao Māori means… a Māori worldview.

Pacific cultural means… Pacific worldviews across distinct Pacific cultures.

Clinical means… knowledge held by midwives, social workers, obstetricians, nurses, and other health professionals.

Supported early means… engaging with people proactively to ensure if they need a Kaiāwhina/navigator/resources.

Bespoke means… services designed in a different way than the status quo.

The strategic shift

FROM: Gold standard continuity of care maternity care is mostly accessed by people with less-complex social needs, and people with the highest complexity of social needs are more often missing out

TO: Specific and bespoke continuity-of-care maternity care is delivered to those who have with greater social needs

FROM: Reliance on LMC midwives to provide comprehensive wrap-around continuity of care and ensure people get access to all the care they require

TO: Well-resourced community providers with expert kaiāwhina who are able to connect hapū māmā and whānau to a range of providers and services to fit their needs

FROM: It is difficult to access culturally specific knowledge and care, and people's cultural practices and wishes are not always respected

TO: Indigenous knowledge and traditional Māori and Pacific practices and practitioners are visible and respected and easily accessible for people and whānau

The rationale

Strategies:
- CCDHB Health System Plan 2030;
- Taurite Ora,
- Te Pae Amorangi,
- Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020 to 2025

Insights:
- Feedback from Advisory Group and Stakeholders,
- data on who is missing out on LMC care (who is receiving CMT care, by ethnicity location and social complexity)
- *Creating enabling maternity care: dismantling disability barriers: Mums and babies' experiences at the 3DHB research report April 2021.* Dr Carey-Ann Morrison, Imagine Better Ltd.
- *CCDHB – Māma, Pēpi, Tamariki Research* – DNA
- First 1000 Days Partnership Project Report [DRAFT 21 August 2019]

Existing successful initiatives:
- New antenatal education services targeting young mums in Kāpiti, Māori and Pacific mothers in Porirua and Lower Hutt
- Matua Pēpi Tamariki Service

Principle 5: Informed choices

The principle and what it means

Together, women and families and their advocates have the information and support to make informed choices that enable best outcomes.

Together means… decision making is a collective, whānau inclusive process.

Advocates means… people who are supporting the women e.g., midwives, GPs, kaiāwhina.

Information and support means… people have access to unbiased, plain English guidance to know their options and make decisions.

Outcomes means… both clinical outcomes for mother and babies and cultural outcomes e.g., being able to integrate traditional practice into the journey.

The strategic shift

FROM: People are not always feeling included in the key decisions made about their care, and don't have the information or health literacy to advocate for themselves.

TO: People receiving care and their advocates receive information in a way that makes sense to them, outlining the full range of options and support pathways so they are able to make informed choices about their care.

FROM: Services are not configured to deliver evidence-based best practice such as continuity of care, closer to home care and accessibility.

TO: Services that enable gold standard, continuity of care, provided in places closer to people's homes, that align with the 2DHB accessibility charter.

The rationale

Strategies:
- CCDHB Health System Plan 2030;
- Taurite Ora,
- Te Pae Amorangi,
- Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020 to 2025

Insights:
- Feedback from Advisory Group and Stakeholders,
- *Creating enabling maternity care: dismantling disability barriers: Mums and babies' experiences at the 3DHB research report April 2021.* Dr Carey-Ann Morrison, Imagine Better Ltd.
- *CCDHB – Māma, Pēpi, Tamariki Research* – DNA
- First 1000 Days Partnership Project Report [DRAFT 21 August 2019]

Existing Successful initiatives:
- Pēpe Ora
- New antenatal education services providing education on Te Ao Māori and Pacific worldviews, alongside pregnancy and birthing physiology

Principle 6: Connected, proactive providers

The principle and what it means

Women and families get care from connected and proactive providers during the first 1,000 days, especially when they have more complex care needs.

Connected means… providers are linked up, coordinated and have integrated communication channels which enable them to collaboratively care for people.

Proactive means… providers meet families where they are and actively listen to and respond to their needs, including connecting them to other sources of support and care if needed.

First 1,000 Days means… Babies are enabled to get the best start to life from the day the baby is conceived, up until 2 years of age.

Complex means… when mothers have more distinct needs, both clinical (e.g., diabetes) and/or social needs (e.g., distressing family dynamics).

The strategic shift

FROM: Relying on individuals to navigate and engage with multiple discrete providers and services who only work on specific sets of needs or time periods.

TO: Providers and advocates that are proactively connecting and linking with one and other to provide holistic care for mothers and babies from pre-conception through the early years of family life.

FROM: A fragmented array of providers who are under resourced and not working together in unison.

TO: A unified and connected range of providers who refer to and from each other, guiding the mother, her whānau and pēpi to someone they know and trust.

The rationale

Strategies:
- CCDHB Health System Plan 2030;
- Taurite Ora,
- Te Pae Amorangi,
- Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020 to 2025

Insights:
- Feedback from Advisory Group and Stakeholders,
- *Creating enabling maternity care: dismantling disability barriers: Mums and babies' experiences at the 3DHB research report April 2021.* Dr Carey-Ann Morrison, Imagine Better Ltd.
- *CCDHB – Māma, Pēpi, Tamariki Research* – DNA
- First 1000 Days Partnership Project Report [DRAFT 21 August 2019]

Existing successful initiatives:
- Maternity Hubs – Wairoa
- Matua, Pēpi, Tamariki

Endorsed by HSC on 24 November 2021 and recommended to the 2DHB Boards for approval

Principle 7: Whānau-centered

The principle and what it means

Care is centred around supporting the wellbeing of the māmā, pāpā, pēpi and their whānau.

Supporting means… showing manaaki to the whānau of the person they are caring for.

Wellbeing means… healthy behaviours and relationships, and safe families.

Whānau means… people who the māmā sees as important in the journey of her and her pēpi. This could include immediate family and wider community members.

The strategic shift

FROM: An individual, biomedical perspective which only takes into account the mother and baby they are caring for.

TO: A broader perspective and understanding that includes and welcomes whānau into the journey and works with them to get the best outcomes for all involved, including māmā and pēpi.

FROM: Funding providers to provide care only to mothers and babies, rather than to everyone in the family

TO: Funding providers to assess the whole family's wellbeing (e.g. smokefree, immunisations, dental care, education).

The rationale

Strategies:
- CCDHB Health System Plan 2030;
- Taurite Ora,
- Te Pae Amorangi,
- Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020 to 2025

Insights:
- Feedback from Advisory Group and Stakeholders,
- *CCDHB – Māmā, Pēpi, Tamariki Research* – DNA
- First 1000 Days Partnership Project Report [DRAFT 21 August 2019]

Existing successful initiatives:
- Whānau Ora

Appendix

Advisory Group Tapa Cloth and words of encouragement References

Gifts from our Advisory Group: Tapa Cloth and words of encouragement

Endorsed by HSC on 24 November 2021 and recommended to the 2DHB Boards for approval

References

- CCDHB Mama Pēpi Tamariki Research Findings. DNA (2019)
- CCDHB Primary Birthing Unit Report. (2018)
- First 1000 Days Partnership Project. Hutt Valley District Health Board (2019)
- Creating enabling maternity care: dismantling disability barriers. Mums and babies' experiences at the 3DHB. Research Report (2021)
- Place of birth and outcomes for a cohort of low-risk women in New Zealand: A comparison with Birthplace England. Dixon et al. (2014)
- Synergia Maternity Analytics Report for Capital and Coast and Hutt Valley District Health Boards (2020)
- Evaluation of Antenatal Service Report
- Planned place of birth in New Zealand: does it affect mode of birth and intervention rates among low-risk women? Davis, et al. (2011)
- Enabling Good Lives principles. https://www.enablinggoodlives.co.nz/about-egl/egl-approach/principles/
- Hutt Maternity Quality and Safety Programme Annual Report. (2019)
- Hutt Valley District Health Board Women's Health Services External Review (2018)

APPENDIX 2 – Health System Committee (HSC) update and items for approval from Committee meeting dated 24 November 2021

Health System Committee - Public

24 November 2021

2DHB Maternal and Neonatal System Plan

Action Required

Health System Committee notes:

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

(b) a whole of system approach, defining care and experience across the maternal care service continuum has been adopted to develop the above. This has created specific interdependent actions that need to be implemented in order to realise the shifts outlined in the strategy.

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

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

(e) DHB leads are of the view that it is possible to drive many of the initiatives within existing resources (refer to high level action plan, section 8) by December 2022.

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

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

The Health System Committee endorses:

(a) the 2DHB Maternal and Neonatal System Action Plan to 2DHB Boards.

Strategic Alignment	This initiative is aligned with Taurite Ora, Te Pae Amorangi, 3DHB Pacific Health, and Wellbeing Plan, the NZ Disability Strategy, CCDHB's Health System Plan 2030 and HVDHB's Our Vision for Change.
Authors	Heather LaDell, Principal Commissioning Manager, Families and Wellbeing Rachel Pearce, General Manager, 2DHB Commissioning, Families and Wellbeing
Presented by	Fionnagh Dougan, Chief Executive Officer Rachel Haggerty, Director, Strategy, Planning and Performance
Purpose	This paper supports the presentation of the 2DHB Maternal and Neonatal System Plan
Contributors	Not applicable
Consultation	This plan is the outcome of a strategic design process including stakeholder engagement (refer to Engagement and Consultation section below)

Report to the Health System Committee on 2DHB Maternal and Neonatal System Plan dated 24 November 2021.

APPENDIX 2 – Health System Committee (HSC) update and items for approval from Committee meeting dated 24 November 2021

Executive Summary

In July 2021 the Executive Leadership Team selected eleven priorities, including development of a 2DHB Maternal and Neonatal Health System Plan. This paper provides an update for the HSC on the design process that has culminated in a 2DHB Maternal and Neonatal System Plan, and seeks HSC's endorsement of this ahead of the 1 December 2021 Board meeting.

The Plan articulates a whole-of-system approach to improving maternal and neonatal care for all families in our region, underpinned by a pro-equity approach to improve outcomes for Māori and Pacific whānau and families, and disabled women and babies with impairments. The planning process was underpinned by a research and discovery approach to define a framework intended to prioritise what high quality care looks like across the care continuum. We identified the gaps in the current state; and articulated the actions required to deliver consistent high quality care for all families going forward.

The Plan outlines over 50 actions that have been developed in partnership with the community and clinicians and reflects what they believe will make a meaningful change for all women and families having babies across the 2DHB region. The suite of inter-dependent actions will improve all families' experience and support more equitable outcomes for Māori, Pacific and women with disabilities and babies born with impairments. The Plan has been informed by current strategies, evidence, insights and the voices of service users and providers, to help us imagine what better maternity and neonatal care could look like.

The actions are spread across specific domains:

- Culturally responsive care
- Improved access to primary birthing
- Enabling maternal and neonatal care
- New community models of care
- A connected system

There is a mix of resourcing required to fully implement the Action Plan (refer to section 9 of this paper), including:

- actions we can take now within existing resources;
- recommended investment priorities from 2022/23; and
- longer term capital requirements.

Section 8 of this paper outlines a high level implementation plan, focussing on what is achievable within existing resources using a pro-equity approach which means starting in the "culturally responsive care" and "enabling maternal and neonatal care" domains.

Section 9 of this paper outlines the actions that will require additional funding, and indicates some of the funding avenues the Project Team is yet to explore to secure this funding. However, it is likely that some of these actions will need to be considered in the context of 2022/23 budget setting processes.

Strategic Considerations

Service	If endorsed, this Action Plan will both DHBs' women's health services to implement changes to their staffing models and service delivery.

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People	Recommendations include establishing new roles as well as reconfiguring existing service, including both DHBs' Community Midwifery Teams.
Financial	There are activities described that can be delivered within existing, endorsed budgets/revenue streams, and additional recommendations that are recommended for investment consideration in 22/23.
Governance	The 2DHB ELT has been the oversight group for this work.

Engagement/Consultation

Patient/Family	The Lived Experience Advisory Group who guided the development of the Plan included Māori and Pacific mothers and mothers of children with impairments. In addition, the strategy built on insights work recently commissioned to better understand the experiences of Māori, Pacific and disabled mothers and mothers of children with impairments
Clinician/Staff	A broad range of clinicians contributed to the development of the Plan including: Midwifery, Obstetrics, Neonatology, Ultrasound, Service Managers, Charge Midwives, Primary Maternity Unit managers, Disability Team, Māori Health, Pacific Health, Allied Health, Perinatal Mental Health, Lactation Consultant.
Community	A broad range of community leaders and partners contributed to the development of the Plan including: Hutt Maternity Action Trust, Birth Hub, and Hutt Families for Midwives; Iwi partners and providers, LMC midwives, breastfeeding supporters, antenatal education providers.

Identified Risks

Risk ID	Risk Description	Risk Owner	Current Control Description	Current Risk Rating	Projected Risk Rating
	Not applicable				

Attachment/s

1. Appendix 1 – 2DHB Maternal and Neonatal System Plan

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1 Why develop a maternal and neonatal health system strategy and action plan?

The 2DHB Boards have endorsed a proposal to make maternity and the First 1000 days a priority for development of a plan for improvement and investment. This has been done in recognition that investment at the beginning of life has lifelong health benefits to individuals and at a population level. Conversely, a failure to invest in equitable outcomes drives financial and social costs that have a compounding impact across the lifespan.

This builds on CCDHB's *Health System Plan 2030,* and it is based on the premise that drawing on the strengths of the community, adopting pro-equity approaches, and bringing more services out of the hospital and into the community, creates an environment where both service users and providers of care can thrive.

If we do not act to realise changes in the maternal care system, we will continue to see:

- Inequitable outcomes across the life course for Māori and Pacific whānau and families, and for disabled women and children with impairments
- Shrinking midwifery workforce
- Rising rates of unnecessary intervention including caesarean sections
- Overburdened hospital services
- Dissatisfaction with choices available

2 Who will the Plan deliver improvements for?

The 2DHB Maternal and Neonatal System Plan articulates whole-of-system improvements in maternal and neonatal care for all families in our region, underpinned by a pro-equity focus to improve outcomes for Māori and Pacific whānau & families, and disabled women and babies with impairments.

The Plan will also drive improvements for providers of maternity and neonatal care, with additional support and education, supporting growth of community-based and out-of-hospital providers, create more innovative models of care, and enhance interprofessional practice.

3 Why adopt a Pro-Equity approach?

Māori and Pacific mothers and babies and disabled women and families with babies with impairments experience worse outcomes because the system fails to provide care that fits their needs.

- In CCDHB and HVDHB, rates of foetal and infant death are up to 6 times higher for Pasifika babies/children and up to 4 times higher for Māori (see Action Plan, page 20).
- Wāhine Māori have statistically significant higher rates of maternal mortality than New Zealand European women (PMMRC, 14th Report, 2021).
- A combination of issues, such as discriminatory attitudes, limited skills and knowledge of healthcare professionals, resource constraints and limited availability of services, prevent disabled women and women who have babies born with impairments from accessing maternity care that responds to their individual needs (Creating enabling maternity care: research report. Imagine Better, 2021).

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4 What does a high quality continuum of maternal care look like?

Women and families should have access to safe and respectful universal maternal and neonatal services from conception and right through the early years. The Ministry of Health specifies that all families should have access to primary maternity (including community midwifery care, and services at primary maternity facilities and hospitals) and secondary and tertiary level care (including midwifery, nursing, obstetric, neonatal and anaesthetic care, and care at hospitals).

Women and families should be able to access a connected continuum of safe, evidence-based maternal and neonatal services from providers and facilities that are known and trusted. The majority of care can be supported in the community and delivered by community providers, with access to specialist and inpatient care when required. Avoiding unnecessary hospitalisation also reduces the risk of unnecessary interventions.

5 What was our approach to developing the Plan?

This design process represents gold standard pro-equity planning, commissioning and engagement. Highlights of the process include:

- **End to end Pro-Equity approach** including equity analytics; a Pro-Equity project aim; a Project Team with equity leads for Māori Health, Pacific Health and Disability; Pro-Equity approach to investment and implementation.
- **Human-Centred Design** process including utilising design experts ThinkPlace, and focusing on experiences of women and families.
- **Insight-Driven,** building on existing knowledge about what is and isn't working across the system and working with lived experience advisors to develop the strategy and actions.
- **Bias toward Action,** defining concrete actions to create change
- **Building engagement and trust,** utilising an Advisory Group and wider stakeholders to test and refine challenges, the desired future, design principles, and specific priorities for action**.**

Throughout the design sprint process we worked based on the advice of our Advisory Group, and through focused design hui we connected with over 50 cultural, clinical, provider, community and lived experience experts.

6 What are we currently doing that works well?

As DHBs we are refining our pro-equity commissioning skills and strengthening relationships with providers and partners across the community, and are well placed to adapt and scale existing successful initiatives and approaches. Some examples of innovation and great performance across the current continuum of services in our region include:

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- Examples of innovative, community-based midwifery and obstetric services, including at marae.
- Delivering through integrated service models (hubs) across the First 1,000 Days, such as Ora Toa's Mātua, Pēpi Tamariki model in Porirua.
- Examples of the DHB supporting LMCs to practice in the community, for example CCDHB supporting the creation of Te Ao Marama. This group of five LMCs working in Porirua is already decreasing pressure on DHB services and the Community Midwifery Team, and increasing utilisation of Kenepuru Maternity Unit.
- Kaupapa Māori, Pacific specific and youth led antenatal education options.
- Well progressed HealthCare Home model and Networks which provide great infrastructure for hubs.
- Strong community providers who are trusted faces for families in high needs communities.
- Primary maternity birthing facilities and services are valued.
- Some growing Māori and Pacific midwifery practices.
- Progressive models of care are already being considered and developed (e.g. transitional model of care).

7 What are the key service gaps and challenges in our current system?

While all components of the continuum of maternal and neonatal health services are present in our 2DHB region, the consultation and design process identified barriers for some women and families accessing the following components of the care continuum:

- Information about options for care (eg fit for purpose websites, apps), especially for women in the Hutt Valley
- LMC midwifery care, especially for Māori and Pacific families
- Access to scans at appropriate times, especially for Māori and Pacific women
- Early and adequate social and cultural support
- Birth care in homelike environments.
- Breastfeeding support, especially for families using the Special Care Baby Unit (SCBU) facility.
- Out-of-hospital support for babies who need extra care
- Enabling care for disabled women and babies with impairments across the care continuum

The design process synthesised the challenges in 6 key areas:

1. Māori and Pacific women, babies and whānau and families are less likely to be able to access care that they are entitled to, from people and places that they trust, and that meets their needs.
2. Disabled women, and families who have a baby with an impairment, are not always receiving enabling respectful care.
3. The current system is highly dependant on having an LMC to help navigate and access services.
4. Not everyone who has birth or postnatal care in hospital requires hospital-level care.

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5. People's birth and postnatal experiences in hospital services are not always positive, and maternity facilities struggle to provide adequate staffing to match demand.
6. The system is challenging to navigate and understand.

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8 How does the Plan and set of actions describe and provide a response to these gaps and challenges?

The project team and our stakeholders synthesized the evidence, insights, and voices of service users and providers to identify the key shifts that need to occur in order to transform the maternal and neonatal health system to deliver better outcomes.

As a result, seven design principles were developed that can be used to guide and inform decision-making now and in the future. Together, these seven design principles describe the future direction.

1. **Trusted faces in trusted places**: Māori wāhine, pēpi and whānau, and Pacific women, babies and family, can choose a range of maternity care from trusted Māori and Pacific providers in places that feel safe and familiar.
2. **Enabling and respectful**: All people, including disabled women and families who have a baby with impairments, experience responsive care that is enabling and respectful.
3. **Right-level care, closer to home**: Women and families are supported to receive maternity care at home and in the community, with access to specialist care when required.
4. **Intensify for those who need it most**: Women and families who have greater care needs are supported early in their journey to access bespoke maternity care from providers who have Te Ao Māori, Pacific cultural, and clinical knowledge.
5. **Informed choices**: Together, women and families and their advocates have the information and support to make informed choices that enable best outcomes.
6. **Connected, proactive providers**: Women and families get care from connected and proactive providers during the first 1,000 days, especially when they have more complex care needs.
7. **Whānau centred**: Care is centred around supporting the wellbeing of the māmā, pāpā, pēpi and their whānau, and their whakapapa.

Actions (page 28 – 34 of Appendix 1)

The maternal and neonatal system is complex and co-dependent. Multiple changes executed in a coordinated way will be required to deliver change. The Plan therefore articulates the most powerful next steps (actions) we can take on the pathway toward that desired future. The actions described below were confirmed by over 60 stakeholders as being relevant to the challenges and likely to make meaningful change.

They are:

- Culturally responsive care
- Improved access to primary birthing
- Enabling maternal and neonatal care
- New community models of care
- A connected system

APPENDIX 2 – Health System Committee (HSC) update and items for approval from Committee meeting dated 24 November 2021

9 Implementation approach

We will create a (fixed term) Maternal and Neonatal System team to drive the implementation of the Plan. It is anticipated this team will be in place between January and 30 June 2022. The team would be comprised of:

- 1 FTE Change and Programme Manager
- 0.5 FTE Senior Advisor, Communication and Engagement
- 1 FTE Programme Coordinator

The following high level implementation approach is achievable within existing resources. A pro-equity approach has been taken to the creation of the implementation plan; we will start in the "culturally responsive care" and "enabling maternal and neonatal care" domains.

Action/s (refer page 28 – 34 of Appendix 1)	Indicative timeframe for completion
Culturally responsive care	
Fund and recruit to the new Hauora Māori leadership role	April 2022
Fund and recruit the new Pacific leadership role	April 2022
Workforce support and education programme, including the development of a resource library and training package for all professionals across the continuum	Sept 2022
Grow the Māori and Pacific workforce	Requires longer term investment
Support indigenous, traditional and cultural birthing knowledge and practice	June 2022
Enabling maternal and neonatal care	
Fund and recruit to the new Disability equity leadership role	April 2022
Breastfeeding pathways are disability and impairment positive	June 2022
Antenatal education is enabling	June 2022
Information is gathered than can drive further improvement	June 2022
Policies and guidelines are enabling	June 2022
Workforce support and education programme	June 2022
Disability advocacy and support for maternal and neonatal care	Requires longer term investment
New community models of care	
Enable the development of Hapu Whānau hubs	Specification developed by March 2022. Fully commissioning will require longer term investment.
Kaiāwhina model of care development	June 2022
Community Midwifery Team new model of care	Sept 2022
Support LMCs to enter and stay in practice	July 2022
Perinatal wellbeing and mental health model of care	Requires longer term investment
Improved access to primary birthing	
Increase access to primary maternity facilities	June 2022
Increase access to utilisation of current primary maternity units	June 2022
Enable home birth choice and knowledge	June 2022

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Define a physiological pathway of care for women birthing in hospitals	June 2022

Report to the Health System Committee on 2DHB Maternal and Neonatal System Plan dated 24 November 2021.

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A connected system	
Resources for families	April 2022
Integrated Network of right place, right care services	June 2022
Safe sharing of clinical information across the continuum of care	June 2022
Whānau friendly policies and support	June 2022
Enabling access to high quality pregnancy and ultrasound	June 2022
New models of care for newborns requiring extra support	Requires longer term investment
Progress further investment bids	Requires longer term investment
Stakeholder and relationship management including Hub development	Requires longer term investment
Community and staff facing communications and engagement activities	Requires longer term investment

10 Funding Implications

A detailed resourcing plan is being developed, including a description of recommended investment priorities for 2022/23 and longer term capital requirements.

10.1 We can progress a significant number of actions within existing resources, particularly the pro-equity actions.

The level of activity and progress achievable within existing resources is largely driven by:

- The 2020/21 2DHB Board decision to invest in "Equity – Mothers and Babies". While this funding was largely allocated last year to address cost pressures across our Well Child Tamariki Ora providers, significant increases in Well Child Tamariki Ora Crown Funding Agreement has freed over $300k across the 2DHBs in 20212/22.
- Increased investment in our DHBs' midwifery leadership has created more capacity to lead transformational change. In particular, the creation of the following Associate Director of Midwifery roles:
    - Equity and Workforce;
    - Primary; and
    - Secondary.

10.2 Fully realising strategic shifts across the service continuum will require additional investment for new and expanded services

The following actions are not able to progressed within existing resources. The Maternal and Neonatal System team will endeavour to identify new, alternative approaches to funding these areas, including critically reviewing the investment within provider arm services. However, these will need to be considered in the context of 2022/23 budget setting processes.

These new investments would deliver the changes that are most visible to our communities and staff – holistic Hapu Whānau hubs; LMC support; and Kaiāwhina/advocate roles to shift the way care is delivered for Māori, Pacific and women with disabilities.

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Action area	Investment required
Enabling maternal and neonatal care	
Disability advocacy and support for maternal and neonatal care	This is a new, FTE based service that will require additional funding
New community models of care	
Enable the development of Hapu Whānau hubs	Additional investment will be required to commission new services.
Support LMCs to enter and stay in practice	Funding would also be required to support LMCs with clinic space.
Perinatal wellbeing and mental health model of care	Funding is required for additional maternal mental health services.
Increase access to primary birthing	
Define a physiological pathway of care for women birthing in hospitals	Kaiāwhina birth support will require new, additional investment
A connected system	
Safe sharing of clinical information across the continuum of care	Will require change management and CAPEX investment to implement
Whānau friendly policies and support	Additional investment required for travel and accommodation support.
Enabling access to high quality pregnancy and ultrasound	New, additional investment required to increase ultrasound access.
New models of care for newborns requiring extra support	Additional investment is required for new community based services for babies requiring additional support and for lactation support for SCBU babies.

10.3 To fully optimise primary birthing, capital investment is required

It is possible to develop a business case this financial year, for Health New Zealand consideration for implementation after 1 July 2022. The business case would be seeking investment in both upgrades to existing primary maternity facilities and the potential development of a new primary maternity facility/services.

11 Implementation Opportunities

The Plan has been developed in the context of the imminent transformation of New Zealand's health system and 'gets ahead' of the reform by proposing actions that bring to life key reform priorities. These include:

- Te Tiriti-led approach: Actions are led by Haoura Māori leadership, Māori health providers, iwi, hapū and Māori communities that reflect Māori health needs and invest sustainably in 'by Māori, for Māori approaches.
- Locality-based approach: Actions that emphasise integration and location of interprofessional teams in community-based hubs; rather than a proliferation of hospital based, DHB provided services.
- More consistent, equitable access to specialist services: Actions that smooth the pressure across our hospital services by delivering 'right care, right place' services, closer to home.

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- Co-commissioning with communities: Commissioning approaches that defer to the experience and wisdom of the women and families who use services.
- Alignment to Community Network approach: Devolving integration and coordination to community-led hubs.

12 Implementation Risks

Risk	Mitigation Strategies
The risk that the strategy is partially funded leading to an inability to realise system change and strategic shifts across the continuum of care.	• Working collaboratively across SPP teams to identify all possible funding opportunities including within provider arm and the mental health and addictions portfolio.
Not delivering on community expectations, reducing community trust and credibility in the maternal care system.	• Communications and engagement role has been identified as part of the implementation team. • Actions related to community and provider information sharing, including websites and apps. • If fully funded, a strategic shift toward delivery in community supporting people to connect with 'trusted faces in trusted places'.
Failure to lead change (clinical, operational and community)	• Maternal and neonatal health system team established to lead the programme of work. • Appointment to high quality candidates within the new midwifery leadership structure. • Shared Maternity Quality Safety Programme to strengthen 2DHB oversight and leadership across clinical delivery.
Ambitious pace	• Equity Lead roles prioritised. • Change and Programme Management Lead roles funded. • New Associate Director Midwifery roles will provide additional professional leadership.

13 Next steps

The 2DHB Maternal and Neonatal System will be presented to the 2DHB Board on 1 December 2021.

The Project Team will provide an update to the Advisory Group before the end of the calendar year.

Detailed implementation planning and recruitment to new roles will commence immediately after the Christmas and New Year break.

END OF REPORT.

Board Decision – Public

1 December 2021

Delegations for the 2021/22 summer break in Board schedule	

Action Required

Capital & Coast District Health Board agrees to:

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

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

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

Hutt Valley District Health Board agrees to:

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

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

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

Presented by	Rosalie Percival, Chief Financial Officer 2DHB
Purpose	This paper seeks agreement from the Boards to put in place delegations for the period from 2 December 2021 to 15 February 2022.
Contributors	Mathew Parr, Acting Chief Financial Officer 2DHB and Sally Dossor, Board Secretary

Executive Summary

1. The final Board meeting for 2021 is on 1 December 2021 and then there is a break in the Committee and Board meeting schedule until the first Board meeting of 2022, which is on 16 February 2022.
2. While ELT have taken practical steps to ensure that decisions requiring Board approval have been made in advance of this period it is prudent to put in place delegations to ensure continuity of decision-making over this period, particularly in the context of continued planning to respond to Covid-19.
3. Delegations over this period will ensure that projects and programmes requiring Board approval are not delayed due to the break in the Board and Committee schedule. As is customary for delegations of this nature, any decisions made under the delegations in this paper will be tabled at the first Board meeting of 2022 for noting and ratification.

Strategic Considerations

Governance	The delegations support operational requirements over the summer period

Board Information – Public

1 December 2021

Disability Support Advisory Committee (DSAC) Items for Board Approval and Noting from Committee meeting dated 24 November 2021

Action Required

The Boards note:

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

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

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

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

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

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

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

Item 2.3 – MHAIDS Service Performance Update

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

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

Item 2.4 – 3DHB Mental Health and Wellbeing Strategy update

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

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

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

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

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

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

Strategic Alignment	Annual Plans, Te Pae Amorangi, Taurite Ora and Sub Regional Disability Strategy 2017-2022, Pacific Health and Wellbeing Strategy for the Greater Wellington Region. Suicide Prevention Postvention Annual Action Plan 2021/2022.
Endorsed by	Fionnagh Dougan, Chief Executive Disability Support Advisory Committee
Presented by	'Ana Coffey, Chair Disability Support Advisory Committee
Purpose	Gain Board approval for decisions endorsed by DSAC, noting any discussions or areas of concern, and provide an update on the meeting of the Committee.
Contributors	As noted in the DSAC papers
Consultation	As noted in the DSAC papers

Executive Summary

The Chair of the DSAC will provide an overview of the meeting agenda items and discussion. The papers can be located on the DHB websites or in the DSAC Diligent Book for 24 November 2021. The slides for the presentations are located in the Resource Centre on Diligent.

Strategic Considerations

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

Engagement/Consultation

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

Identified Risks

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

Attachment/s

n/a

Board Information – Public

1 December 2021

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

Executive Summary

The Delta outbreak has changed the way the government and health sector are having to respond to managing COVID in Aotearoa. Nationally, regionally and locally the health sector is planning for the management of sustained COVID outbreaks in our communities. The current delta outbreak in Auckland, and beyond its borders, highlights the challenges our health system will have managing a sustained community outbreak with increasing rates of hospitalisation and increased pressures on our community providers to assist people with COVID to isolate at home.

The government has communicated that while public health measures such as vaccination, contact tracing, social distancing, mask wearing, and testing will play a key role in managing community outbreaks, lockdowns will play a decreasing role in the management of COVID in our communities. The Government's Traffic Light system sets the framework for the health system's planning for the management of COVID in our community. Maximising rates of vaccination remains at the heart of this strategy. We continue to work to reach and increase vaccine rates across our priority populations, while refining our preparedness planning.

Each DHB has been asked to ensure that they now have developed plans for managing both a surge and sustained cases of COVID in the community and our hospitals. A nationally consistent approach to assessing DHB resilience preparedness was rolled out by the Ministry of Health. DHBs were asked to assess their readiness for this next phase and identify their priority areas for action. We submitted to the Ministry of Health a 2DHB view of our priority areas of work and have put in a work programme to deliver against those priority areas.

Over the past two years we have continuously reviewed and updated our COVID readiness plans, our focus is now about ensuring we can deliver across the priority areas identified in our future resilience plan. This paper updates the Boards on the body of work that is underway to address the priority areas, as part of our next stage of COVID preparedness.

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

In addressing these priority areas we will:

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

There will be funding requirements to ensure our COVID Response Team has sufficient capacity to implement the COVID Community Care programme, our DHB provider arms to have the resources and facilities that they need to provide COVID related care, and sustained funding for our PHOS and NGOs to deliver the community testing, vaccination programme, COVID Community care and the manaakitanga programme.

Strategic Considerations

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

Engagement/Consultation

Patient/Family	ELT has agreed a dedicated communications and engagement approach will be critical to the success of this work and a dedicated resource is being put in place to ensure regular and frequent updates to all stakeholders.
Clinician/Staff	
Community	

Identified Risks

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

Preparedness work

We have existing COVID preparedness plans both across our Public Health, Provider and Community teams. They are continuously reviewed and updated. For our Hospitals the CCDHB and HVDHB Business Continuance Plans (our resurgence plans) were updated in September and are our current operating plans. These provide a framework for what is required at various alert levels according to the COVID-19 National Hospital Response Framework. The National Community Response Framework is in its final stages of preparation.

Our planning is now focused on responding to the change in national direction; moving from an elimination to a resilience strategy.

Modelling

Modelling plays an important role in our planning. We are working with the nationally developed models to understand the potential demand under different scenarios. The national models have two main limitations:

- they do not fully account for ethnicity making it hard to understand where to prioritise support for priority communities and the increased risk of hospitalisation for some communities
- they work to a 52 week average making it impossible to understand peak(s) in demand as they flow through the primary, community, secondary and tertiary health systems

With the guidance of a Data Governance Group SPP analytics is layering in 2DHB information such as vaccination rates, weightings for different levels of social interaction and co-morbidity, to refine and inform the model outputs. Outputs for this information are provided by ethnicity, locality and PHO provider. At a macro level the model estimates numbers of potentially infected people and gives an indication of the numbers that may need care in the community, hospital and intensive care. The model works to a moderate set of assumptions and gives us an indication of what the worst case scenarios might be.

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

Currently the 2DHB modelling shows:

1. There may be two peaks of COVID-19 in our system. The first and highest peak may occur about 50 days after the first five cases in the community and last for approximately one month. The second and lower peak may occur four months later, but will be of longer duration and is expected to last for up to three months, which will test the resilience of our health system.
2. Achieving and maintaining a 90% + vaccination coverage has a material impact on both community and hospital demand and in particular for Maori, Pacific and other localities with vaccination rates that are currently lower than this.
3. Distribution of clinical and manaakitanga support cannot be managed on a one size fits all approach. The primary and community systems will be invested in to ensure local capacity to manage COVID in the community is able to surge easily and safely in response to demand.
4. We are still working through the implications this has on existing physical and human resource associated with inpatient beds, HDU and ICU at peak demand; what is certain is that there will be a significant impact on planned care during the peak period(s).

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

Hospital & Specialist Resilience

Planning for the increase in COVID cases requiring specialist care is a key focus of the resilience planning. There are four critical parts:

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

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

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

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

Community and Public Health Response

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

The planning for COVID Community Care model includes a strong manaakitanga component. This integrated model is being supported by work programmes in; manaakitanga, the clinical care

continuum including escalation to hospital level care. Manaakitanga is the support for individuals and families who are managing at home, when COVID positive. Any welfare requirements will be coordinated by the manaakitanga response and resourced by MSD after the first 48 hours.

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

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

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

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

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

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

Priorities for next phase of preparedness

Our priorities

As part of the nationally-led COVID resilience planning we have identified a number of priorities to ensure we are ready for the next phase of COVID. They include:

- Maintaining the momentum for pro-equity vaccination and ensuring sufficient capacity for testing for our communities
- Ensuring our 2DHB work force and community providers are supported to be fully vaccinated as per the Mandatory Vaccination Health Order
- Strengthening the work we are doing with our Maori, Pacific and Disability community providers to enable them to be a key part of our overall response
- Setting up the end-to-end ‘care in the community model’ to address the patient care continuum from:
    - How we assess and support those who are COVID sick at home

- Those that are unable to isolate at home and need access to supported isolation (SIQ)
- Triage/ Assessment and support for those who require specialist review and care in community /virtual
- Admission for those who become so unwell they need to be hospitalised
- Discharge from hospital care back to community

- Working with our welfare partners to ensure there are appropriate measures in place to support people with COVID and their close contacts to stay safely in the community
- Managing our hospitals' ability to deal with resurgence and increasing numbers of cases requiring hospitalisation and/or intensive care
- Ensuring sustainable staffing for Regional Public Health, our COVID Response team, clinical and administrative workforces and enhanced leadership, clinical governance, training and support.
- Ensuring we have the technology available to enable a sustained response, in particular to support care in the community.
- Developing the clinical governance model to support the above
- Working across our region and other tertiary providers to ensure robust decision making and transfer processes whilst maximising tertiary capacity.

We have a programme of work that spans all aspects of all these priorities and is governed by a working group across ELT to ensure integration.

We continue to work at the regional and national level to seeking funding and support for this work. As the planning progresses there has been refinement of the funding needs and phasing. Most of the funding is operational (and workforce related). Where possible the executive is identifying the hiring decisions can be made to assist planning and resourcing our COVID readiness, while also ensuring continued focus on business as usual and our transition to Health NZ. We have also identified the COVID–related community provider commissioning arrangements that can be extended to 30 June 2022.

The identified capital for facilities and infrastructure works is a 'pull forward' of the funding needs already identified for the hospital network development and already signalled to the Ministry in our discussions for future capital intentions. We updated the boards at our November meeting about this. Since that meeting further work has been undertaken to refine a proposed capital works programme which would support additional beds, ICU and other facility improvements to support our COVID readiness. We continue to liaise with the Ministry about accessing early funding for this work.

In support of our hospitals' ability to deal with resurgence and increasing numbers of cases requiring hospitalisation and/or intensive care – our focus is on interface processes for Triage/ Assessment and support for those who require specialist review and care in community /virtual and working with our regional partners around tertiary referrals and care processes.

Managing the Implications of the Mandatory Vaccination

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

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

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

The coverage of the Order is broad, and in most cases will apply to a large number of workers employed by DHBs and other public and private health care settings, no matter the role or job they undertake.

The Order covers employees, contractors, service providers, casuals, students, temps, volunteers and others who 'work' as an employee or service provider in setting where healthcare is provided.

The Order sets out the obligations for employers and employees. For Employers there are PCBU responsibilities such as providing fact sheets on vaccination to employees and also significant privacy requirements to address. We have worked through an implementation plan to ensure we meet the obligations in the Order.

As at 24 November 2021 we have the following vaccination levels:

	First dose	Both doses	Unknown / unvaccinated
CCDHB	97%	94%	92 people
HVDHB	98%	95%	32 people

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

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

To support service continuity each service has undertaken their own risk assessment and have business continuity plans in place to help mitigate the impact of losing staff who have not been vaccinated. The areas that were are working closely with are Maternity, Eating Disorders (residential services) and community home care providers.

Preparedness coordination and oversight

A governance structure is in place to ensure that we can align and coordinate the work that is occurring across all areas. Work is occurring at pace and decisions need to be made quickly as new policies and advice is developed nationally, and we respond to the change in COVID response management. This oversight group meets frequently to ensure timely decision making and operates similarly to our Incident Management Team approach (based on the CIMS model) that we have activate for alert levels 3 and 4 (and other emergency scenarios).

Performance Monitoring

Data remains critical to the success of our response. We will continue to report on the overall effectiveness of the programme such as vaccine levels, testing and other public health initiatives. We will also expand our measures and reporting to monitor progress against these new priorities.

We will continue to adjust our models and assumptions as new and improved information comes to hand.

Communications and Engagement

The high level communications and engagement approach has been agreed. The executive team are working together to both inform and engage with our partners, stakeholders, providers, stakeholders, staff, and the public on our preparedness work. We continue to engage with our communities, groups, and leaders in designing and implementing solutions for our key priorities such as developing the care in the community solutions.

Capital and Coast DHB and Hutt Valley DHB

CONCURRENT Board Meeting

Meeting to be held on 1 December 2021

Resolution to exclude the Public

The Boards agree that the public be excluded from the following parts of the proceedings of this meeting, namely:

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

TABLE

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

HVDHB Financial and Operational Performance Report – October 2021	As above	As above
2DHB Hospital Network	As above	As above
FRAC items for Board Approval from meeting dated 26/11/2021	As above	As above
MCPAC update from meeting dated 26/11/21	As above	As above
People and Culture Report	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.