PUBLIC

AGENDA

Held on Wednesday 2 June 2021
Location: **Wellington Regional Hospital, Level 11 Boardroom Grace Neil Block**
Time: 9:00am
Zoom: **876 5068 1844**

HUTT VALLEY AND CAPITAL & COAST DISTRICT HEALTH BOARDS CONCURRENT MEETING

	Item	Action	Presenter	Time	Min	Pg
1	**PROCEDURAL BUSINESS**					
1.1	Karakia		All members	9.00	15	2
1.2	Apologies	**ACCEPT**	Chair			
1.3	Public Participation - Nil	**VERBAL**	Public			
1.4	Continuous Disclosure 1.4.1 Combined Board Interest Register	**ACCEPT**	Chair			3
	1.4.2 Combined ELT Interest Register					7
1.5	Minutes of Previous Concurrent Meeting	**ACCEPT**	Chair			9
1.6	Matters Arising from Previous Concurrent Meetings	**NOTE**	Chair			14
1.7	Chair's Report and Correspondence	**NOTE**	Chair			
1.8	Chief Executive's Report	**NOTE**	Chief Executive			15
1.9	Board Work Plan 2021	**DISCUSS**	Chair			
2	**DHB Performance and Accountability**			**9.15**	**10**	
2.1	HVDHB March 2021 Financial and Operational Performance Report 2.1.1 Report	**NOTE**	Chief Financial Officer Director Provider Services Director Strategy, Planning and Performance			31 34
2.2	CCDHB March 2021 Financial and Operational Performance Report 2.2.1 Report	**NOTE**	Chief Financial Officer Director Provider Services Director Strategy, Planning and Performance			76 79
3	**Decision**			**9.25**	**10**	
3.1	Committee Membership and Terms of Reference	**APPROVE**	Chair			125
3.2	Te Hopai Lease	**APPROVE**	Chief Financial Officer			130
4	**Updates**			**9.35**	**10**	
4.1	HSC Update from meeting dated 26 May 2021	**NOTE**	Chair of HSC			136
5	**OTHER**					
5.1	General Business	**NOTE**	Chair			
5.2	Resolution to Exclude the Public	**ACCEPT**	Chair			137

NEXT BOARD MEETING:
7 JULY 2021, Zoom: 876 5068 1844, **Location:** Hutt Hospital, Level 1, Clock Tower Building, Auditorium Room

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

06/05/2021

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

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

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

CAPITAL & COAST AND HUTT VALLEY DISTRICT HEALTH BOARDS

Interest Register

EXECUTIVE LEADERSHIP TEAM

28 MAY 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
Declan Walsh *Director People, Culture and Capabilityn2DHB*	• Nil
Helen Mexted *Director, Communications and Engagement 2DHB*	• Director, Wellington Regional Council Holdings, Greater Wellington Rail • Board member, Walking Access Commission • Partner owns Mexted Motors (supplies/services vehicles for the CCDBH)
Dr Sisira Jayathissa *HVDHB Chief Medical Officer*	• Member of the Medicine Adverse Reaction Committee Medsafew (MOH) • Member Standing committee on Clinical trials (HRC) • Member Editorial Advisory Board NZ Formulary • Member of Internal Medicine Society of Australia and New Zealand • Australian and New Zealand Society for Geriatric Medicine • Writer NZ Internal Medicine Research Review • Clinical Senior Lecturer and Module convenor Clinical Skills module (Hutt campus), University of Otago • Company Director of Family Company Strik's Nurseries and Garden Shop 100&1 House and Garden Plans

Thursday, 27 May 2021

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

BOARD MEETING **PUBLIC**

HUTT VALLEY DHB / Capital & Coast District Health Board Ūpoko ki te Uru Hauora	**MINUTES** Held on Wednesday 5 May 2021 Location: **Hutt Hospital, Level 1, Clock Tower Building, Auditorium Room** Zoom: **876 5068 1844** Time: 9:30am
BOARD MEETING	**PUBLIC**

PRESENT

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

APOLOGIES

Vanessa Simpson
Keri Brown
Hamiora Bowkett – 2.20pm – 3.32pm
Josh Briggs – 12pm-2.30pm
Roger Blakeley – 9:30am – 12:05pm

IN ATTENDANCE

Hutt Valley and Capital & Coast DHB

Rosalie Percival	Acting Chief Executive Chief Financial Officer
Karla Bergquist	Executive Director Mental Health, Addictions and Intellectual Disability Services
Declan Walsh	Director People, Culture and Capability
Helen Mexted	Director of Communication and Engagement
Arawhetu Gray	Director Maori Health
Sally Dossor	Director, Office of the Chief Executive and Board Secretary
Saira Dayal	Clinical Leader Quality Service Improvement and Innovation
Meila Wilkins	Board Liaison Officer

BOARD MEETING **PUBLIC**

1 PROCEDURAL BUSINESS

1.1 KARAKIA AND MIHIMIHI

Kaumātua Hepetema Tairua, supported by his wife Mate, led the Boards in welcoming new Board Members Stacey Shortall, Ria Earp and Brendan Boyle.

The Board opened the meeting with a karakia.

1.2 APOLOGIES

As noted above.

1.3 PUBLIC PARTICIPATION: E TŪ – REGARDING CLEANING HOURS FOR CONTRACTED STAFF CONTINUOUS DISCLOSURE

E tū presented about contracting out of cleaning services and the employment arrangement of its members employed by CCDHB contractors, and in particular ISS. Izzy O'Neill, the spokesperson for E tū introduced 2 staff from ISS.

1.4 CONTINUED DISCLOSURE

1.4.1 COMBINED BOARD INTEREST REGISTER

The Boards **noted** the interests register and the folllowing additons were added:

(a) Ken Laban is a member of E tū.
(b) Dr Richard Stein is a member of the Executive Committee - Muscular Dystrophy Association (Central Region).

The Board **noted** that 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 Board **noted** Dr Chris Kalderimis was in attendance at the meeting.

The Boards **approved** the minutes (as amended) of Concurrent Board Meeting held on 7 April 2021 (public).

	Moved	**Seconded**	
HVDHB	Yvette Grace	Naomi Shaw	**CARRIED**
CCDHB	Sue Kedgley	'Ana Coffey	**CARRIED**

1.6 MATTERS ARISING FROM PREVIOUS CONCURRENT MEETINGS

The Chair discussed the actions and noted updates.

1.7 CHAIR'S REPORT AND CORRESPONDENCE

The Chair noted the Heath System reform, the Minister's updated letters of expectation dated 21 April 2021, and the key role in delivering on:

- Board accountabilities in the 2020/21 Annual Plan and the 2021/22 Annual Plan; and
- Supporting the 2 organisations though a significant period of change and transition.

1.8 CHIEF EXECUTIVE'S REPORT

The acting Chief Executive noted the Chief Executive's report and provided an update on key matters.

1.9 BOARD WORK PLAN 2021

The Board n**oted** the tight timing for the 2021/22 Annual Plan process, in light of the timing of the funding envelope (20 May 2021) and the statutory deadline to approve the Annual Plan. Noted that the timing is challenging, and that management will present the position at the 2 June 2021 Board meeting, and will propose delegations to the 2 FRAC committees to allow for final approval on 30 June 2021.

The Chair advised that management are reflecting on the Board work plan in light of the Health System reforms, and will report on progress on an updated work plan at the 2 June 2021 Board meeting.

2 DHB PERFORMANCE AND ACCOUNTABILITY

2.1 HVDHB FEBRUARY 2021 FINANCIAL AND OPERATIONAL PERFORMANCE REPORTREPORTS

This report was taken as **read.**

The Hutt Valley DHB noted:

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

(b) The DHB had a $1.1m surplus for the month of February 2021, being ($87k) unfavourable to budget

(c) The DHB year to date had a deficit of ($3.6m), being $1,522k favourable to budget

(d) The Funder result for February was $1.4m favourable, Governance $0.1m favourable and Provider ($1.6m) unfavourable to budget.

(e) Total Case Weighted Discharge (CWD) Activity was 6% ahead of plan.

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

Notes

- Our current forecast for year end is to be on budget (excluding Holidays Act and COVID-19 costs) year to date we are favourable to budget.
- Management noted that for planned care, the wait times are increasing and that action to improve the situation is a substantial piece of work. Decisions will be made as an ELT.

2.2 CCDHB JANUARY 2021 FINANCIAL AND OPERATIONAL PERFORMANCE REPORTS

This report was taken as **read.**

The Capital & Coast DHB Board noted:

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

(b) The DHB had a ($311k) deficit for the month of January 2021, being ($644k) unfavourable to budget before excluding COVID-19 and Holidays Act [2003]

(c) The DHB year to date had a deficit of ($27m), being ($8.8m) unfavourable to budget before COVID-19 and Holidays Act [2003]

(d) In the eight months we have incurred $11.5m additional net expenditure for COVID-19 and $5.3m against provision for Holidays Act [2003]

(e) This means that the DHB has an overall YTD deficit of ($10.2m) from normal operations (excluding COVID-19 and Holidays Act) being $8m favourable to our underlying budget**.**

Notes

- Management are confident that both DHBs will come in under the deficit (excluding Holidays Act and COVID-19)
- The Board noted the high number of vacancies carried and impact on the deficit.
- Year to date and the monthly position around nursing costs is offset in other areas.

	Moved	**Seconded**	
HVDHB	Dr Chris Kalderimis	Sue Kedgley	**CARRIED**

Notes

- Question asked about the audit and control environment and financial management controls.
- The Chief Financial Officer advised there are two 2 major lines of defence:
    - External audit work programme
    - Internal audit work programme (that is set on an annual basis)
- It is within the terms of reference for FRAC to review and identify gaps, and to report to the Board as required.
- Actions arising from the internal audit work programme are reported to FRAC and available in the FRAC papers on Diligent.

3 UPDATES

3.1 DSAC ITEMS FOR APPROVAL

The Board **approved**

(a) Item 3.1 on the agenda of the DSAC meeting dated 28 April 2021, 3DHB Alcohol and Other Drug (AOD) Model of Care and Priority Investment

	Moved	**Seconded**
HVDHB	Yvette Grace	John Ryall
CCDHB	‘Ana Coffey	Sue Kedgley

Notes

The Chair of the Disability Support Advisory Group:

- Reported that the Committee had travelled to the Wairarapa and thanked the WDHB for hosting the meeting.
- Acknowledged the high quality presentations and noted the value that they added to the papers;
- Outlined the information shared on the Wairarapa Services;

- Explained the concerns raised and discussion about the slow/delay in investment under Te Ara Oranga and noted the Committee agreed to write to the Ministry to raise its concerns about the delay. A copy of the letter will be circulated to the Board.
- Tristram Ingham noted that Sub Regional Disability Advisory Group had not approved the Annual Plan.

3.2 COVID-19 VACCINE ROLLOUT UPDATE

The Director Strategy, Planning and Performance presented.

The Board **noted** the successful delivery to date and moving to scale up the rollout as per the planned scheduling.

COVID Presentation.pptx

4 OTHER

4.1 GENERAL BUSINESS

Nil.

4.2 RESOLUTION TO EXCLUDE THE PUBLIC

	Moved	**Seconded**
HVDHB	Wayne Guppy	Yvette Grace
CCDHB	Sue Kedgley	Dr Chris Kalderimis

5 NEXT MEETING

2 June 2021, 9am, Zoom: 876 5068 1844, **Location:** Wellington Regional Hospital, Level 11 Boardroom Grace Neil Block

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 28 MAY 2021

Action Number	Date of meeting	Due Date	Assigned	Status	Date Completed	Meeting	Agenda Item #	Agenda Item title	Description of Action to be taken	How Action to be completed	Updates
20-P0011	3-Dec-20	TBC	Chief Financial Officer	In progress		Board - Public	1.3	PUBLIC PARTICIPATION – CCDHB STAFF PETITION, CAR PARKING	Management to bring to Board a paper on the long term Climate Emergency Response Plan.	Progress is being made on developing a 2DHB Sustainability Strategy for presentation to the Board first quarter 2021/22.	

Chief Executive's Report

Prepared by: Fionnagh Dougan, Chief Executive

1 Introduction

This report covers the period from 23 April 2021 to 21 May 2021.

2 COVID-19 Update

2.1 Current cases

Number of cases: 0
Number of days without cases, HVDHB: 183
Number of days without cases, CCDHB: 190

2.2 Managed Isolation Facilities

Number of COVID-19 cases in managed isolation: 0
Number of guests (as 21/05/21): 65

- Bay Plaza: 33
- Grand Mercure: 32

2.3 Testing statistics (to end 21/05/21)

	2DHB	HVDHB	CCDHB
Tests performed to date	164,716	42,597	122,119
People tested to date	108,763	29,294	79,369
Testing coverage	23.0%	19.5%	24.7%
Tests performed last week (15/05/21 – 21/05/21)	2,485	564	1,921

2.4 Testing statistics by ethnicity (to end 21/05/21)

	2DHB		HVDHB		CCDHB	
	Māori	Pacific	Māori	Pacific	Māori	Pacific
Tests performed to date	19,296	13,327	6,852	4,098	12,444	9,229
People tested to date	13,203	8,924	4,786	2,745	8,417	6,179
Testing coverage	21.0%	26.1%	18.3%	23.2%	23.0%	27.7%
Tests performed last week (15/05/21 – 21/05/21)	297	156	91	36	206	120

2.5 Vaccinations (to end 21/05/2021)

	2DHB	HVDHB	CCDHB
Total immunisations	47,870	15,264	32,606
Dose 1 total	30,731	10,527	20,204
Completed total	17,139	4,737	12,402
Group 1 people served	3,550	449	3,146
Group 2 people served	21,438	6,157	15,412
Group 3 people served	1,970	1,273	699
Group 4 people served	3,697	2,703	1,012

2DHB group	Coverage
Māori	7%
Pacific	9%
Asian	11%
Other	7%

3 Communications and Engagement

3.1 External engagement with partners and stakeholders

Our proactive engagement focus in May was largely focused around events and engagement for the COVID-19 vaccination programme, including openings of new community vaccination centres. We also hosted a number of Ministers and the Governor General for their vaccinations.

3.2 External communications and engagement – press releases and pitches

DHB	Subject	Outlet / Channel
2DHB	COVID-19	Highlighted Governor-General Dame Patsy Reddy and her husband Sir David Gascoigne receiving their COVID-19 vaccinations.
2DHB	COVID-19	Highlighted our first Pacific festival day for COVID-19 vaccinations.
CCDHB	Maternity / equity	Highlighted changes at Kenepuru maternity to improve the birth experience of Maori and Pacific mothers.

3.3 Health promotion campaigns

COVID-19 vaccination

Our COVID-19 vaccination programme continues to work efficiently and effectively as we move towards the end of vaccinating Group 2 and begin to prepare for Group 3, a significantly larger cohort.

Within our DHBs, as at Tuesday 18 May, 81% of staff at CCDHB and 78% at HVDHB have now received at least one dose of the COVID-19 vaccination, as well as large numbers of contractors and students based at our hospitals. Our staff have stepped up to protect each other and the people in our care.

Working through our PHOs, several new Community Vaccination Centres (CVCs) have opened in the past month, and more are expected to open prior to the end of June. We are confident that every person in our region will be able to be vaccinated in a place that is convenient for them, whether near their home, their work, or other amenities as a critical part of our programme.

Supporting our equity populations

Our communications and engagement is focussed on our equity populations: Māori, Pacific and Disabled people.

To support our Māori providers and the opening of their vaccination centres, we are producing a range of communications products to invite whānau in to the new Māori-run centres, and provide them with the information they need in a culturally appropriate way.

In late May, the first marae-based vaccination centre will open in Wainuiomata, and we are grateful to the marae trustees who have provided this space for us to use for the vaccination programme in 2021.

Our Pacific team, working alongside Pacific providers and PHOs, are organising Pacific Festival Days – block-booking for Pacific people at our CVCs. The first Festival Day in Lower Hutt on 19 May was very successful, with positive atmosphere and energy in the room.

Watch the Checkpoint (Radio NZ) story on our first Pacific festival day.

Our Disability team have created resources to allow disabled people to more easily access our CVCs, including informational posters, cards that can be given to CVC staff to outline specific needs, and a video walkthrough of a vaccination with NZSL interpretation and audio description. The video, which showed a wheelchair user receiving his dose of the vaccine, will help to demystify the process so that people know what to expect when they go to a vaccination site.

The video, released to mark New Zealand Sign Language week, was viewed more than 10,000 times on social media platforms, and shared by Unite Against COVID-19, the Ministry of Health, and many other DHBs. Watch the video walkthrough of a vaccination and Read the audio description.

Vaccinate Greater Wellington

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

The website is the hub for information about our local vaccination rollout, and is complementary to the Unite Against COVID-19 website. It is regularly updated with information about who we are vaccinating and how people can book, with news stories, video content and other information about the vaccination rollout in the region.

Our weekly pānui currently goes to more than 600 subscribers each week, and contains the latest updates and stories from our programme. People can subscribe to this newsletter online.

Aged residential care rollout

We have now delivered the first dose of the vaccine to residents and staff at all 46 of our aged residential care facilities across the region, and are underway with second dose delivery.

This part of our programme has been worked through in partnership with community pharmacy vaccinators. Being able to deliver vaccinations on-site to this group of at-risk people has been greatly appreciated by residents, who have spoken publicly in the media about their excitement at being vaccinated.

Read about the 101-year old who was one of the first aged residential care residents vaccinated in our region.

Measles campaign

Activity continues with promoting awareness of the need to be immunised against measles if you are in the 15-30 year old age group. The number of vaccinations being delivered continues to rise but is expected to peak in the next month or so as the COVID-19 vaccine rolls out to the wider public.

Kapiti Youth Service has been busy with outreach by visiting Paraparaumu College filming vox pop interviews with students. The resulting video is insightful and worth the watch. You can see it here https://drive.google.com/file/d/1T8jLjKtnODLwHD4g7XLe-ZSkmzJeXCVn/view

An interesting mix of answers, with some students being quite savvy about the risks associated with contracting measles, and others being genuinely surprised that it is a serious illness. These activities are good for modifying messaging and knowing where and who to target.

Bowel Screening

The bowel screening programme has been running at CCDHB for just over 6 weeks and currently all systems and processes are working well.

1,598 people have been invited to take part over this time, and so far 341 definitive results have been received and tested by the NSBP laboratory. Participation rates won't become meaningful until the programme has been running for at least 6 months.

Of these definitive results, 21 have been positive – meaning a positivity rate of 6% which is comparable with what other DHBs have seen in the early stages of bowel screening.

Of the positive tests, 2 have been for Maori participants, 3 for Pacific, 2 for Asian, and 14 for European.

Patients with positive tests have been referred by their GP via our new e-referral processes, and our bowel screening team then pre-assess the patients and decide next steps. Our team has currently performed 1 colonoscopy and 6 more are booked in at our new Kenepuru facility.

The giant bowel which debuted in Kenepuru mid-April also graced the atrium at Wellington Regional Hospital for two days earlier this month. It kept the team busy, attracted a lot of attention, resulted in a number of kits being expedited for people who met the criteria for being screened earlier than their next birthday, which is when invitations are sent out.

Disability Team Resources

As outlined above, the Disability team has produced an excellent walkthrough of the vaccination process as the first in its series of video resources for vaccination centres, but with underlying messages for anyone providing health services.

You can see Stewart Sexton navigating the process in his wheelchair, with NZSL team member Shannon Morris signing. The video has been widely shared and the team is getting great feedback.

Disability team educator, Michelle Graham is producing another video looking at people with various disabilities navigating their way around the hospital to help health care teams and services see the sorts of accommodations they can make to improve access.

3.4 Social media views and stories

CCDHB impressions	HVDHB impressions	RPH impressions
Facebook: 78,121 Twitter: 5,230 LinkedIn: 19,077	Facebook: 135,919 Hutt Maternity Facebook: 10,903 Twitter: 4,006 Instagram: 4,888 LinkedIn: 23,966	Facebook: 6,157

3.4.1 Top social media posts


Capital & Coast District Health Board (CCDHB)
last Tuesday
Happy International Nurses Day!
Our nurses devote their careers to the health and wellbeing of our patients and their whānau. From the cradle to the end of life, in hospitals and in many community settings, nurses are working to provide the care people need.
"I want to thank you, each and every one of you for the great work you do," said 2DHB chief nursing officer Chris Kerr (pictured below, centre of front row). ... See More
151
13
13


Hutt Valley District Health Board
about 2 weeks ago
Today is International Day of the Midwife!
We would like to acknowledge and thank our midwifery teams who work hard in our hospital and community to provide essential support and care for pēpē, parents and whānau.
"Hospital midwives, community midwives and Lead Maternity Carers (LMCs) continue to provide exceptional care to all in changing circumstances," says Karen Ferraccioli, Director of Midwifery at Hutt Valley DHB. ... See More
Skin to Skin
229
32
11

3.5 Website page views and stories

CCDHB	HVDHB	RPH	MHAIDS
91,204 page views	25,126 page views	21,503 page views	9,548 page views

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

Top five webpages CCDHB

- Login to the DHB
- Careers with CCDHB
- Wellington Regional Hospital
- After hours and emergency care
- COVID-19 Community based assessment centres (CBACs)

Top five webpages HVDHB

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

Top five webpages RPH

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

Top five webpages MHAIDS

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

3.5.1 Website stories and releases

Supporting Maori and Pasifika through the joy of childbirth

Kenepuru Community Hospital's maternity unit is working collaboratively with lead maternity carer (LMC) service Te Ao Marama Midwifery Tapui Ltd as part of work to provide an improved experience for well Māori and Pasifika women who give birth in Porirua.

"The Kenepuru maternity unit is a primary birthing facility where well women birth under the care of their LMC. Te Ao Marama Midwifery Tapui Ltd is a group of experienced Māori and Pasifika midwives who provide team care to mothers, pēpi, and whānau," said Capital & Coast DHB Director of Midwifery Carolyn Coles.

"The service has a kaupapa of improving birth outcomes for Māori and Pasifika whānau in the Porirua region and provides antenatal, labour, birth, and postnatal care for wāhine and pēpi."

With two birthing rooms and six postnatal beds, Kenepuru maternity has seen more than 165 women give birth in the past year – most of whom stay up to 48 hours.

Kenepuru is a busy maternity unit where LMCs and DHB staff work collaboratively to give women a safe and positive birthing experience. Care is led by midwives, women have single rooms, and partners are able to stay to provide much-needed support.

"We have also recently received approval to appoint an extra member of staff 24/7, and we anticipate recruiting fully to these roles by 31 May 2021.

"Having a baby should be a joyful event. Working closely with Te Ao Marama Midwifery Tapui Ltd and other community-based LMCs means the Kenepuru maternity unit will strive to make this a reality while improving outcomes for wāhine, pēpi, and whānau of Porirua."

3.5.2 New website banners

3.6 Internal Engagement and Communication

3.6.1 Intranet page views and stories

CCDHB	HVDHB
502,481 page views	98,805 page views

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

3.6.2 Staff posters

3.6.3 Top intranet stories

Ka pai tō mahi: Meet our latest Kia Ora Hauora interns

Meet the rangatahi helping to shape the future of our health system.

Te Kura Kaupapa Māori o Te Ara Whanui tauira Ngaraukura Opetaia-Rapana, Taita College student Ava-Rose Solomon-Wichman, Wainuiomata High School student Rachel Tamihere, and St Patrick's College Silverstream student Sebastian Watson, completed Rangatahi ki te Ao internships at Hutt Hospital in April.

The internships are a collaboration between Hutt Valley DHB and Kia Ora Hauora, which is a national Māori health workforce development programme established in 2009 to increase the overall number of Māori working in the sector.

Kia Ora Hauora interns, from left to right, Te Kura Kaupapa Māori o Te Ara Whanui tauira Ngaraukura Opetaia-Rapana, 16, Taita College student Ava-Rose Solomon-Wichman, 16, Wainuiomata High School student Rachel Tamihere, 17, and St Patrick's College Silverstream student Sebastian Watson, 17.

The group spent part of their school holidays learning about all sorts of medical services they might one day want to make into a career here at the DHB.

Ava-Rose, from Ngai Tahu and Ngati Ruanui, particularly enjoyed learning about dentistry and respiratory physiology.

"The lady I had was really enthusiastic helping the patients," Ava-Rose said. "She let me do the tests and sit in on two of her appointments."

The sixteen-year-old said the dental staff were also brilliant.

"They were very enthusiastic and energetic towards us students, which made me enjoy being there."

Kia Ora Hauora is supported by district health boards and the Ministry of Health. The organisation aims to increase Māori employment in DHBs to reflect their local population by 2025.

That would mean increasing the amount of Māori staff at Hutt Valley DHB from about seven percent to about 17 percent.

Ava-Rose saw the programme advertised at Taita College. Her auntie works at Hutt Valley DHB, and her nan is a nurse.

"I was nervous applying; not being good enough because I don't know much about the medical side of things.

"But I thought it would be a good experience and good to have an understanding about the different medical careers like nursing and doctors," she said.

Staff who were enthusiastic about their jobs played a big part in attracting the students.

"I would 100 per cent recommend it to anyone else - it's better than spending your holidays just sitting at home.

"It was amazing. I loved it and would do it again."

Special thanks to Allied Health, Scientific and Technical Associate Director Paul Rigby, Director of Midwifery Karen Ferraccioli, Associate Director of Nursing Claire Jennings and Toi Ora Māori Health who organise the week long schedules and host the rangatahi.

Previous Kia Ora Hauora interns Imajyn Kamoto, left, and Tyla-Jade Robb, completed the programme in October, 2020.

Last October, Hutt Valley teens Imajyn Kamoto, 18, and Tyla-Jade Robb, 16, completed Kia Ora Hauora internships during their school holidays.

At the time, Imajyn said she particularly enjoyed learning about dentistry in the community, the hospital's audiology department, and the role of theatre nurses.

Imajyn, who was in her final year at Naenae College at the time, is now studying nursing.

See here for more information about the Kia Ora Hauora Māori health workforce development programme.

Aniva helps grow Pacific health careers

Aniva is a Pacific-run leadership programme which helps advance participants' health careers, build their understanding of working cross-culturally and advocating, as well as connect them with a wider Pacific health sector network.

Several of our 2DHB people have undertaken the programme and say it has potential to help make the change the healthcare system needs.

"Being empowered through this leadership training enables Pacific Nurse Leaders to be confident change agents and strong advocates for quality initiatives that will reduce disparities and bring about equity for Pacific people as well as the Pacific workforce," says Agnes McKay of CCDHB's Pacific Health Unit. "This programme will not only help you develop your leadership skills, but also give you the confidence and credentials to progress in your career."

"Having Pacific health professionals in leadership roles would help tip the balance of equity and help shape the health system," agrees Aniva graduate registered nurse Frances Pedro. "It has given me a greater perspective on issues for Pacific populations, and where I am placed to address equity within the health system."

The course was developed to help address the significant shortage of New Zealand health and disability workers with an understanding of Pacific health perspectives and Pacific culture. Importantly, the course is also free to eligible participants, and can be fitted around existing jobs.

Participants analyse their work and community for health disparities affecting Pacific people, before being encouraged to think practically of innovative ways to improve service, and most importantly, to take leadership in implementing these changes to reduce the disparity. Agnes says the knowledge she gained helped her transition into her role as the Pacific Health Unit's specialty clinical nurse.

"In the ten months that I have been in this role, I have managed to make changes in the processes in the unit, formulate a Pacific cultural awareness guideline, and undertake a review of the Pacific Health Unit policies," she says.

Other initiatives Agnes has undertaken as a result of the programme include formulating a Pacific Cultural Resource Package for use on wards, and developing cultural awareness programmes for nursing students."Leadership is taking responsibility to lead by example and developing the confidence to advocate and implement positive changes," she says. "Aniva has contributed greatly to my confidence as a Pacific nursing leader."

Thanks to the DHB COVID-19 vaccination teams

Over the past six weeks, thousands of HVDHB staff, alongside contractors and students working in our hospitals, have stepped up to be vaccinated for COVID-19. In doing so we have taken a big step to protect ourselves, our whānau and the people we care for.

With three weeks left in our DHB vaccination programme, we have now vaccinated nearly 80% of all HVDHB staff. This is a fantastic effort and one we should all be proud of.

We couldn't have achieved this without the hard work of our administrators and vaccinators in the vaccination clinic teams. HVDHB staff have brilliantly been involved in the rollout at both Ropata Health, and at the Capital & Coast DHB clinics.

At the end of this month, our on-site COVID-19 vaccination clinics will close and responsibility for COVID-19 vaccination will transfer to Occupational Health. They will run a reduced number of clinics to cater for second doses, new staff and those who weren't able to be vaccinated during this initial phase for any reason.

As we move towards the broader public rollout through Community Vaccination Centres in the coming weeks, please take this opportunity to talk to your friends, whānau and communities about the importance of vaccination.

As health workers, we are trusted advisors to the people who know us. By getting vaccinated ourselves, we have taken the first step – now, it is time to use our voices to ensure the rest of our region joins us.

Rotuman language week

Rotuma is a Fijian dependency, consisting of Rotuma Island and nearby islets with seven major districts. The two peoples are closely linked but have their own language, culture and identity. More Rotuman people live on mainland Fiji than on Rotuma, while thousands more are spread across the world.

Previously part of Fijian language week, Rotuman language week has been celebrated in its own right since 2020.

3DHB desktop engineer Paulo Kupuri (pictured right) is one of our Rotuman staff at CCDHB along with Ricco Panapasa (left) and Ravai Henderson (centre). Fidelis Vena is one of our Rotuman employees at Hutt Valley DHB, and Tausie and Sunita Munivai work at Masterton DHB. We all speak the language, some more than others. But we do try with every opportunity.

The Rotuman community in the Greater Wellington Region is planning celebrations during the language week in Wellington at Te Papa. There will be storytelling dances and song, and dignitaries in attendance.

Events like this offer an opportunity for younger Rotuman people to connect with their culture and language - although such celebrations are on a smaller scale here than in Fiji, where dance troupes can number 100 people.

Dancers for this year's Rotuman Language week include CCDHB's orthopaedic booking clerk Ricco Panapasa, Fidelis Vena CNE Medical, Hutt Valley DHB. Learning the meanings to the lyrics has helped Ricco broaden his understanding of both the language and dance.

The Rotuman community is teaching its people, young and old, the language and culture using different media platforms like follow-along video resources.

"It's important to celebrate our language and identity. Hopefully, with the various language workshops being run in Auckland and here in Wellington, our people and the younger generation will, in time, be able to speak our Rotuman language with confidence," says Paulo.

Traditions

"At Christmas, Rotumans have a tradition called Fara, which aims to spread the joy of Christmas. Family members and friends form 'Fara groups', and go around visiting other Rotuman homes, spreading the Love and Joy of Christmas, playing music and dancing on the lawns – even if the people inside are asleep! The 'Fara' group is rewarded with food and drinks and are showered with perfume and talc powder. This goes on every day of the festive season. It's so much fun!"

There are different ceremonies for occasions of joy (weddings), well-being (post-surgery/ first time returning from abroad) and even the passing of a family member and unveiling of tombstones. These occasions are usually followed by a feast cooked mostly in an earth oven (Koua).

Concurrent Board Information

2 June 2021

March 2021 Financial and Operational Performance Reports – Hutt Valley DHB

Action Required

The Hutt Valley DHB Board notes:

(a) The DHB had a $1.9m deficit for the month of March 2021, being ($117k) unfavourable to budget

(b) The DHB year to date had a deficit of ($5.6m), being $1,4m favourable to budget,

(c) The DHB year to date deficit excluding $0.7m unfunded COVID-19 Costs and $2.1m Holidays Act provision was a deficit of ($2.8m), being $4.2m favourable to budget,

(d) The Funder result for March was $1.4m favourable, Governance $0.1m favourable and Provider ($1.6m) unfavourable to budget;

(e) Total Case Weighted Discharge (CWD) Activity was 7% ahead of plan.

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

Executive Summary

There are ongoing costs due to the COVID-19 response into the 20/21 financial year. Uncertainty remains around how much of the DHB COVID-19 response costs will be funded in 20/21. The Ministry have asked DHBs to separately report unfunded net COVID-19 impacts for 20/21, these being considered outside our responsible deficit and budgets. They have also advised that ongoing provisions for the liability due to Holidays Act remediation are to be reported separately to the base budget.

Excluding the COVID-19 net expenses and the Holidays Act provision the DHB's result for the nine months to 31 March 2021 is a ($2.8m) deficit, versus a budget deficit of ($6.99m).

- Additional net COVID-19 related expenditure above funding, year to date is $0.7m.
- The monthly provision for increasing Holidays Act liability is $227k and year to date the impact on the result is $2.1m

For the nine months to 31 March 2021 the overall DHB year to date result, including COVID-19 and Holidays Act costs is a ($5.6m) deficit compared to a budget deficit of ($6.99m)

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

- **Hospital** activity was high in both ED attendances, discharges and caseweights for all services with flow on the diagnostic and community services. As we head towards winter this peaks – our winter bed plan to increase capacity by using every available space over the winter months is in development with the first draft due late April.
- The ability to discharge patients within 6 hours remained a challenge with 83% able to move through the ED within 6 hours. The expectation to improve long waits in ED for patients to see speciality services is supported by our work in the Assessment Planning Unit (APU) which continues to provide assessment space for patients requiring review from Medical, General Surgery and Gynaecology specialities. Despite hospital occupancy pressures in March 21, the team assessed 36% more patients compared to March 20 with an average length of stay of 26 hours.
- Planned care – the delivery of Specialist assessments or Treatment within 120 days continues to be a major challenge. While the total March planned care target at 98.6 % was met we are behind target for the additional elective volumes. This is due in part to the impact of acute demand but also limited capacity in the private sector. A revised plan is in development that includes use of Saturday morning lists. We are liaising weekly with the Ministry planned care team seeking support and advice as we lead out our system improvement project aimed at making progress around all aspects of managing elective flow.
- **Funder** key areas of performance with a focus on core services and achieving equity. We are responding to the needs of our children.
  - In 2019, 6% of preschool children were overdue annual examination, which show improved performance from the previous year when 16% were overdue. There was also significant improvement in Māori and Pacific children's dental health, with a 14% increase in Māori and Pacific who had caries free teeth at age 5.
  - Concern regarding the ongoing decline in performance in diabetes services has been discussed with PHOs. TeAHN has committed to moving practices to pro-active planning, working at an individual patient level.
  - We are developing sustainable strength and balance programmes to improve our response to frailty, particularly for Māori and Pacific older peoples.
  - We are improving our data to inform the development of initiatives to reduce falls. We are participating in a Regional Equity forum to improve equitable outcomes for dementia.
  - We are strengthening primary care with more specialist support, embedding telehealth models of care that started during COVID-19, and continuing the roll out of the Health Care Homes to help keep older people healthy and well in the community.

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 191 below plan with additional costs in outsourced personnel for roles employed by CCDHB for MHAIDs and IT.
Financial	Planned deficit for HVDHB $10.6 million with no COVID-19 or Holidays Act provision impacts included.

Governance	The FRAC committee is accountable for scrutinising the financial and operational performance on behalf of the board, and reporting back to the board on issues as identified by the committee.

Engagement/Consultation

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

Identified Risks

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

Attachments

3.1.1 Hutt Valley DHB March 2021 Financial and Operational Performance Report

Monthly Financial and Operational Performance Report

For period ending
31 March 2021

Reported in May 2021

Contents

Section 1

Financial and Performance Overview and Executive Summary

Executive Summary

- There are ongoing costs due to the COVID-19 response into the 20/21 financial year. Uncertainty remains around how much of the DHB COVID-19 response costs will be funded in 20/21. The Ministry have asked DHBs to separately report unfunded net COVID-19 impacts for 20/21, these being considered outside our responsible deficit and budgets. They have also advised that ongoing provisions for the liability due to Holidays Act remediation are to be reported separately to the base budget.
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- For the nine months to 31 March 2021 the overall DHB year to date result, including COVID-19 and Holidays Act costs is a ($5.6m) deficit compared to a budget deficit of ($6.99m)
- Key underspends are in the funder demand driven costs including Aged Residential Care (ARC) and Other Health of Older People (Other HoP). Mental health contacts are also underspend due to timing of contracts.
- Capital Expenditure was $6.2m year to date with $27.9m remaining including projects that are delayed and funding will be transferred to next financial year.
- The DHB has a positive cash Balance at month-end of $24.6 million with an equity injection for deficit support received in October 2020 of $35m. Overall the DHB cash balance is better than was budgeted for this point in time due to delayed capital spend. We are expecting an equity injection for capital in relation to two capital projects approved for MoH funding (TWA replacement and the Maternity upgrade projects). The equity injection is now expected in 2021/22 to line up with forecast expenditure.

Executive Summary (continued)

- **Hospital** activity was high in both ED attendances, discharges and caseweights for all services with flow on the diagnostic and community services. As we head towards winter this peaks – our winter bed plan to increase capacity by using every available space over the winter months is in development with the first draft due late April.
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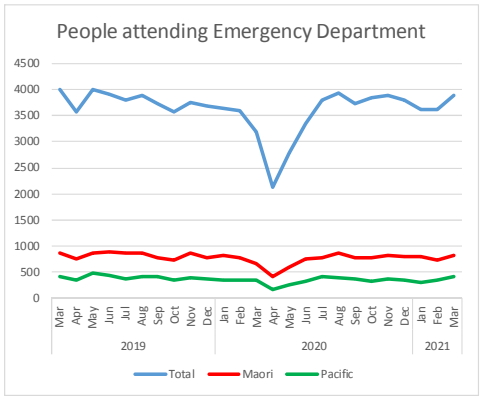
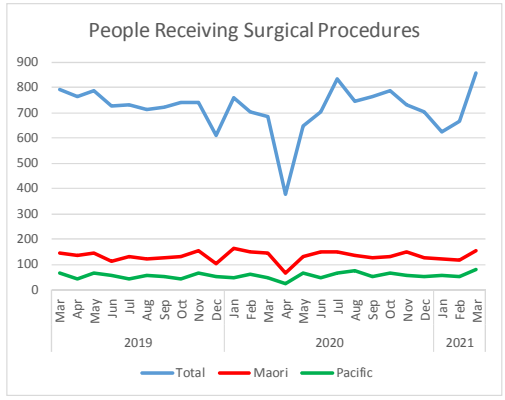
  - We are strengthening primary care with more specialist support, embedding telehealth models of care that started during COVID-19, and continuing the roll out of the Health Care Homes to help keep older people healthy and well in the community.

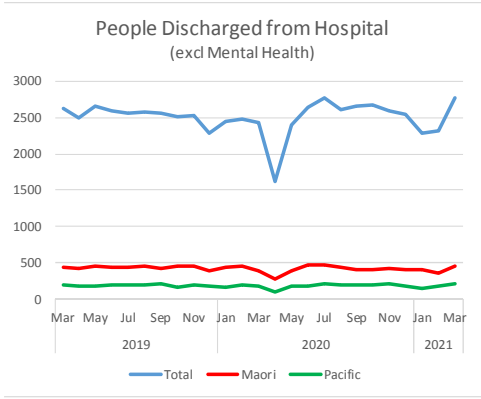
Performance Overview: Activity Context (People Served)

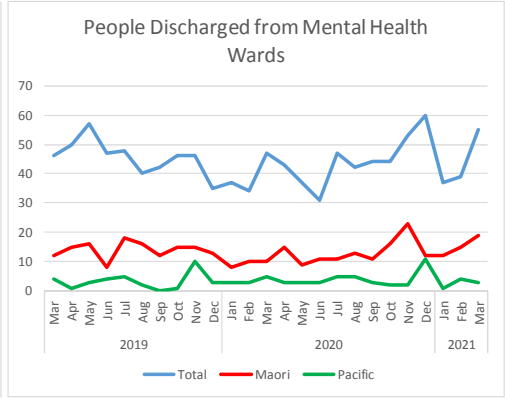
The numbers below count individuals once and are based on Hutt Valley DHB being the DHB of Service. Our services have returned to delivering services to our population without the restrictions due to COVID-19. Services continue to take necessary precautions. March was busy in all services

People attending ED	**3,886**	815 Maori, 403 Pacific
People receiving Surgical Procedures	**856**	154 Maori, 79 Pacific
People discharged from Hospital (excl Mental Health)	**2,786**	451 Maori, 204 Pacific
People discharged from Mental Health wards	**55**	19 Maori, 3 Pacific



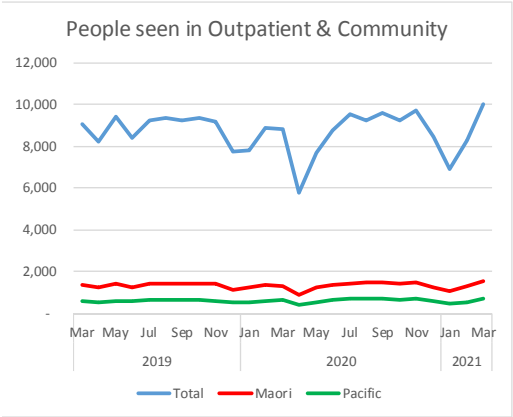


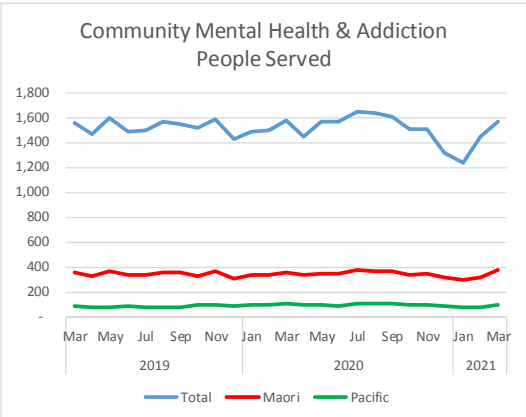


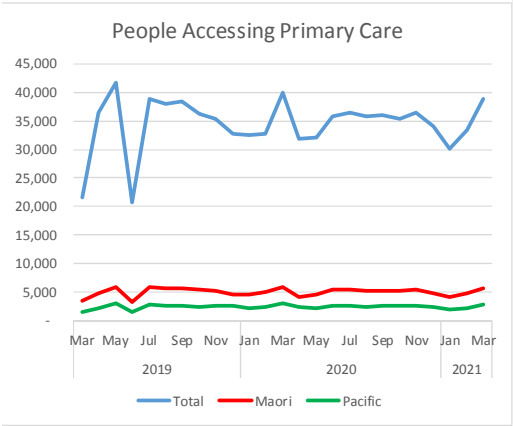


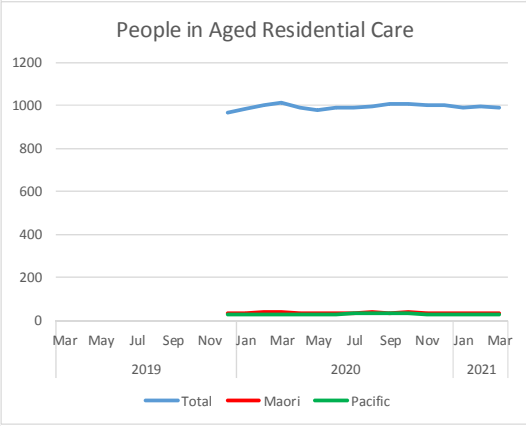
Performance Overview: Activity Context (People Served)

People seen in Outpatient & Community	**10,035** 1,527 Maori, 707 Pacific
Mental Health and Addiction Contacts	**1,565** 373 Maori, 94 Pacific
Primary Care Contacts	**38,789** 5,685 Maori, 2,766 Pacific
People in Aged Residential Care	**989** 35 Maori, 26 Pacific









Financial Overview – March 2021

YTD Operating Position	YTD Provider Position	YTD Funder Position	YTD Capital Exp
$5.6m deficit	$11.0m deficit	$4.7m surplus	$6.2m
Against the budgeted deficit of $7.0m.	Against the budget deficit of $8.1m.	Against the budget surplus of $0.9m.	

YTD Activity vs Plan (CWDs)	YTD Paid FTE	Annual Leave Accrual
7% ahead	1,846	$20.6m
387 CWDs ahead PVS plan for February. IDFs were 20 CWD over budget for the month	YTD 212 FTE below annual budget of 2,058 FTE. Note: The MHAIDS & ITS restructures and change of employer contributed 148 FTE to this variance	This is an increase of $0.7m on prior period.

Hospital Performance Overview – March 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
83%	1,239	1,093	100%
12% below the ED target of 95%, Similar to March 2020.	Against a target of zero long waits a monthly decrease of 26.	Against a target of zero long waits a monthly decrease of 31	We have achieved the 62 day target this month. The 31 day target was achieved at 87%

YTD Activity vs Plan (CWD)	YTD Standard FTE	Serious Safety Events
7% ahead	1,834	3
387 CWDs ahead PVS plan for February. IDFs were 20 CWD over budget for the month	203 below YTD budget of 2,037 FTE. Month FTE was 188 under budget and downwards movement from February of 7 FTE.	An expectation is for nil SSEs at any point.

Section 2

FUNDER PERFORMANCE

Executive Summary – Funder

- Overall the funder has a positive variance of $1,401k for the month and $3.781m year to date, with revenue for IDFs being ahead of budget by $1.4m due to wash-ups from last year and increased volumes for the current year. In addition COVID-19 revenue, which is offset by costs also means we are ahead of revenue by a total of $4.98m YTD.
- Aged residential care costs are $181k favourable for the month. Other Health of Older People costs are favourable $586k for the month and $1,796k YTD. The implementation of the frailty model will be supported by this underspend.
- Mental Health costs are unfavourable ($229k) for the month, favourable $1,043k YTD, reflecting timing of contracts which will be rectified with the acute care continuum funding.
- The COVID-19 Vaccine programme is progressing well and in line with MoH targets. There is a strong focus on equity for Māori and for our Pacific and Disability communities.
- In this report we have also highlighted the below key areas of performance with a focus on our core services and achieving equity. We are responding to the needs of our children.
    - HVDHB has recently reviewed its investment in its WCTO providers (Te Rūnanganui o Te Atiawa and the Pacific Health Service), to correct the level of WCTO activity the DHB purchases from our providers and ensure equity in price and volume.
    - ARC is the highest cost care option and ARC expenditure is going down against our population suggesting we are supporting more people to live at home for longer. Our main lever to continue to reduce demand is to continue to scale our health of older people programme and ensure alternatives such as community Home Care Support Services, and community organisations to support frail elderly at home for longer.
    - We actively look at flow through our CAMHS services, and have been provided with some specific training from Werry Workforce on this to assist us in managing flow within our teams as effectively as possible.
    - A range of strategies are in place to mitigate acute demand in both community and hospital settings:
        - Community initiatives to manage in-flow: we are developing our community responses to population drivers alongside approaches to maximise the productivity and efficiency of our hospital system, for example early supported discharge.
        - Hospital initiatives to improve in-hospital flow: we are exploring our short and medium term options for expansion of bed and theatre capacity this will increase the timeliness of flow through our emergency department. The options are being developed within the context of the Hospital Network programme.

Funder Financial Statement – March 2021

DHB Funder (Hutt Valley DHB)
Financial Summary for the month of March 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										
38,586	37,970	616	34,735	3,851	Base Funding	341,312	341,727	(415)	312,612	28,700	455,083	455,637	(554)	416,816	38,267
2,730	2,341	389	3,144	(414)	Other MOH Revenue	24,816	21,067	3,748	24,889	(73)	31,941	28,090	3,851	38,006	(6,065)
95	36	60	(24)	119	Other Revenue	612	320	292	285	327	719	427	292	619	100
9,697	9,229	468	8,315	1,382	IDF Inflows	84,411	83,057	1,355	77,543	6,868	112,366	110,742	1,624	102,280	10,087
51,107	**49,575**	**1,533**	**46,169**	**4,938**	**Total Revenue**	**451,151**	**446,172**	**4,980**	**415,328**	**35,823**	**600,109**	**594,895**	**5,213**	**557,721**	**42,388**
					Expenditure										
386	416	30	383	(3)	DHB Governance & Administration	3,500	3,740	240	3,448	(53)	4,652	4,987	335	4,597	(55)
22,042	21,033	(1,009)	19,624	(2,418)	DHB Provider Arm	189,698	189,271	(427)	180,518	(9,180)	252,874	252,577	(297)	241,131	(11,744)
					External Provider Payments										
2,948	3,109	161	2,307	(640)	Pharmaceuticals	30,573	29,195	(1,378)	27,999	(2,575)	40,729	38,866	(1,863)	37,365	(3,365)
4,353	4,369	16	4,244	(109)	Laboratory	39,482	39,318	(164)	38,046	(1,436)	52,537	52,424	(113)	50,903	(1,634)
2,583	2,541	(42)	2,427	(157)	Capitation	23,448	22,872	(576)	22,072	(1,377)	31,072	30,495	(576)	29,563	(1,509)
1,071	1,235	164	939	(132)	ARC-Rest Home Level	10,330	10,917	588	8,665	(1,665)	13,956	14,543	588	11,877	(2,079)
1,903	1,920	17	1,522	(381)	ARC-Hospital Level	16,289	16,968	679	14,175	(2,114)	21,925	22,604	679	19,154	(2,772)
2,126	2,712	586	3,363	1,238	Other HoP & Pay Equity	22,513	24,306	1,793	25,761	3,248	30,471	32,442	1,970	35,134	4,663
1,318	1,089	(229)	830	(488)	Mental Health	8,735	9,778	1,043	6,408	(2,327)	12,170	13,045	875	9,580	(2,590)
499	482	(17)	500	1	Palliative Care / Fertility / Comm Radiology	4,450	4,336	(114)	4,343	(107)	5,895	5,782	(114)	5,788	(107)
1,023	1,357	335	1,793	770	Other External Provider Payments	14,622	12,202	(2,419)	11,082	(3,540)	18,809	17,332	(1,477)	19,220	411
9,293	9,151	(143)	8,594	(699)	IDF Outflows	82,817	82,355	(462)	74,444	(8,373)	110,284	109,807	(477)	101,298	(8,985)
0	0	0	0	0	Provision for IDF Wash-ups	0	0	0	43	43	0	0	0	0	0
49,544	**49,413**	**(131)**	**46,527**	**(3,017)**	**Total Expenditure**	**446,457**	**445,259**	**(1,198)**	**417,003**	**(29,454)**	**595,375**	**594,905**	**(470)**	**565,610**	**(29,765)**
1,563	**162**	**1,401**	**(358)**	**1,921**	**Net Result**	**4,694**	**913**	**3,781**	**(1,674)**	**6,369**	**4,734**	**(9)**	**4,743**	**(7,889)**	**12,623**

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 favourable $610k to budget for the month and ($415k) year to date, reflecting the various changes for Capital Charge impacting both Income and expenditure for the DHB.
- Other MoH revenue is favourable $389k for March and $3,748k year to date, including COVID-19 funding and Planned Care.
- IDF inflows are $468k favourable for the month driven by current month volumes and favourable $1,355k year to date..

Other MOH Revenue Variance	MTH $000's	YTD $000's
In- Between Travel (prior years)	0	(314)
In- Between Travel (2020/21)	11	39
Capitation Funding	18	377
Planned Care	64	579
COVID-19 Funding	426	4,087
COVID-19 Funding - RPH	(127)	(1,146)
Crown funding agreements		
B4 School Check Funding	72	123
Hospice - Cost Pressure funding	12	106
More Heart and diabetes checks	(5)	(75)
Additional School Based MH Services	(10)	(88)
Maternity Quality and Safety Programme	11	95
Rheumatic Fever Prevention Services	(9)	(55)
Well Child/Tamariki Ora Services	(84)	(36)
Other CFA contracts	(10)	(55)
Year to date Variance $000's	**389**	**3,748**

Expenditure:

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

External Provider Payments:

Pharmaceutical costs are favourable $161k for March and unfavourable ($1,378k) YTD, reflecting a combination of passing rebates back to the provider arm and seasonal variations in March. We have received $1,670k for increased pharmaceutical costs due to COVID-19.Capitation expenses are ($46k) unfavourable for the month, offset by changes to revenue.

Aged residential care costs are $181k favourable for the month.

Other Health of Older People costs are favourable by $586k for the month and favourable $1,796k YTD.

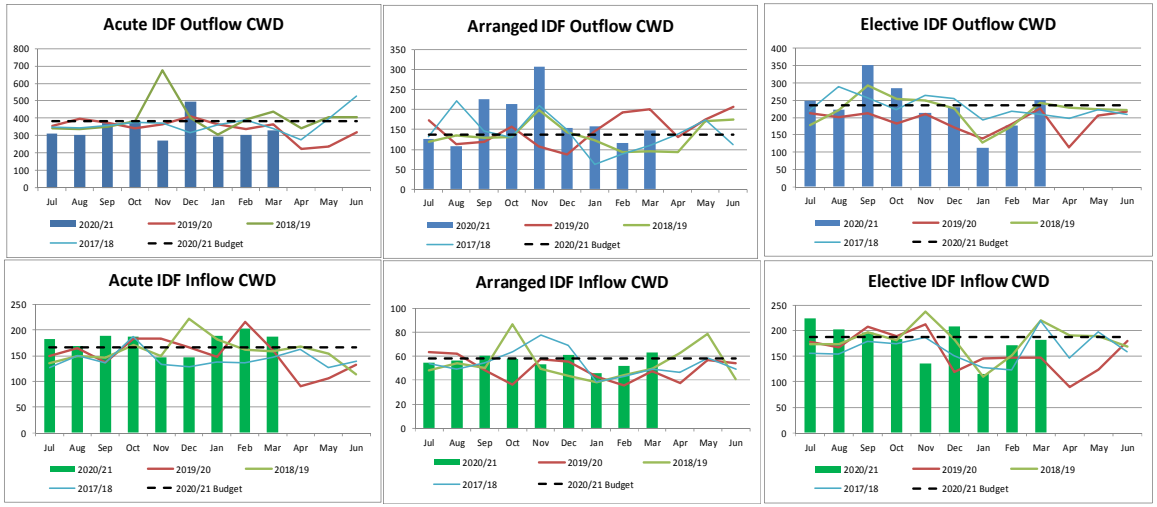
Mental Health costs are unfavourable ($229k) for the month, favourable $1,043k YTD, reflecting timing of contracts.

Palliative Care, Fertility and Community Radiology costs are unfavourable by ($17k) for the month.

Other external provider costs are favourable to budget $507k for the month.

IDF Outflows are unfavourable ($143k), due to Current Year Wash-up payments for volumes.

Inter District Flows (IDF)



IDF Wash-ups and Service Changes March 2021			
IDF Outflows $000s	Variance to budget		
	Month	YTD	Forecast
Base	(0)	(2)	(2)
CCDHB - Advance Care Planning	(5)	(45)	(60)
	-	-	
Wash-ups			
2020/21 Outflows	(138)	(550)	(550)
2020/21 PHO	-	(133)	(133)
2020/21 FFS	-	14	14
2019/20 Wash-ups	-	254	254
IDF Outflow variance	(143)	(462)	(477)

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

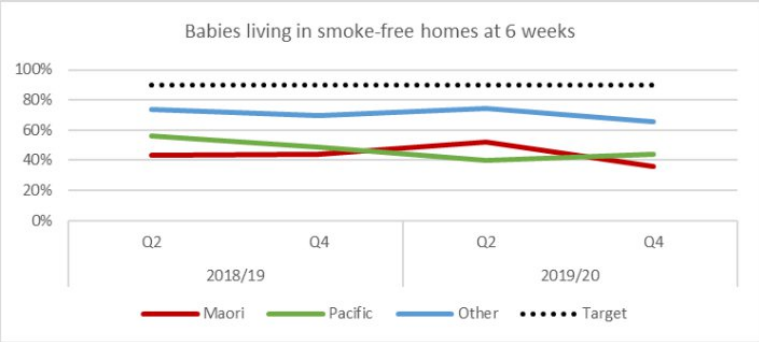
IDF inflow (revenue):

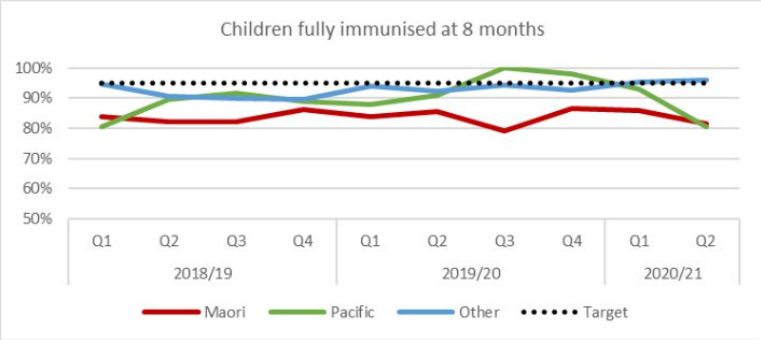
- Based on the data available, overall IDF inflows are over budget YTD by $1,355k. Inflows for other services $1,061k and inpatient $86k over budget. Inpatient inflows are under budget mainly in Orthopaedics, Rheumatology and Gastroenterology.

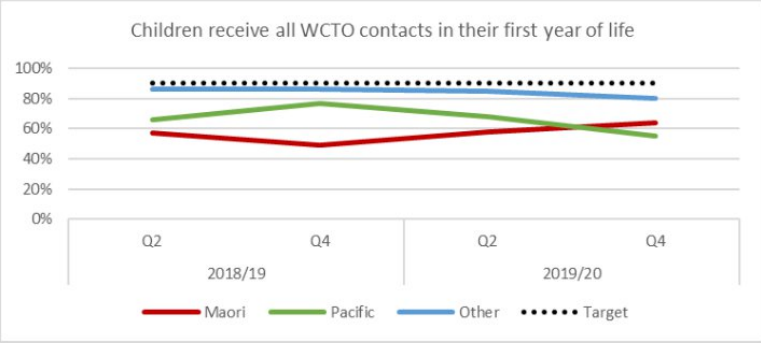
IDF Outflow (expense):

- Based on the data available, overall IDF outflows are over budget by ($462k) year to date mainly due to Inpatient outflows being over budget by ($550k). Inpatient outflows are mainly over budget in Neonates, elective Cardiology and Vascular Surgery at Capital Coast.

Commissioning: Families & Wellbeing







What is this measure?

- 90% of children living in smokefree homes at 6 weeks
- 95% of children fully immunised at 8 months
- 90% of children receiving all WCTO contacts in the first year of life

Why is this important?

- The early years of life set the foundation for lifelong health and wellbeing:
- Reducing infant exposure to smoking requires an integrated approach between maternity, community and primary care and a focus beyond maternal smoking to the home and whānau environment.
- Immunisation rates at age 8 months are a measure of timely protection against whooping cough, among other vaccine-preventable diseases.
- The WCTO programme is a package of universal health services offered free to all New Zealand families/whānau for children from birth to 5 years.

How are we performing?

- The proportion of children living in smoke-free homes at 6 weeks is consistently below target for all groups, and is significantly lower for Māori (36%) and Pacific (44%). Rates have been decreasing overall.
- Immunisation coverage for Māori and Pacific 8-month olds has been decreasing. An additional 16 Māori and 6 Pacific babies needed to be vaccinated to reach the target of ≥95% in Q2.
- The proportion of children who received all WCTO checks in their first year of life is lower for Māori and Pacific compared to non-Māori, non-Pacific (64% and 55% respectively).

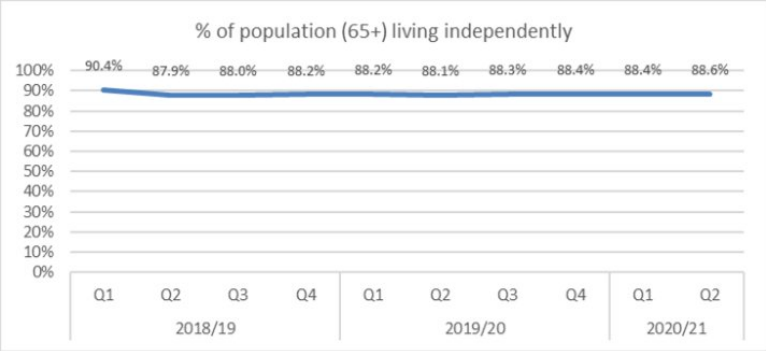
What is driving performance?

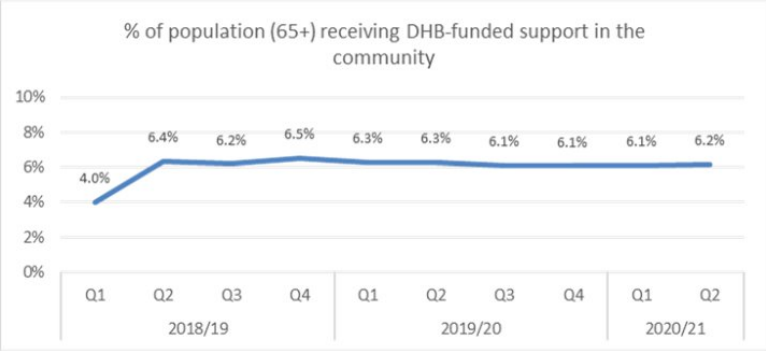
- Engagement with the full set of WCTO visit in the first year of life is challenging; on average performance for HVDHB is slightly below the national average (74%).

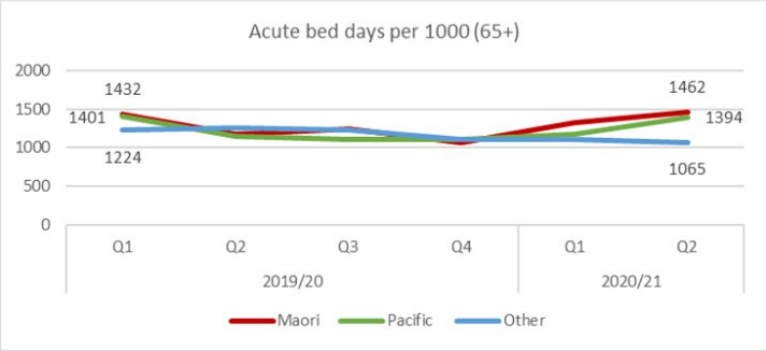
Management comment

- HVDHB continues to progress work promoting the relationship between the Hapū Māmā smoking cessation service and maternal and child services provided in secondary care.
- Work is underway to identify the factors contributing to the high number of children on the Outreach Immunisations Service (OIS) register and how both primary care and the OIS provider can be supported to reach families with children still needing vaccinations.
- HVDHB has recently reviewed its investment in its WCTO providers (Te Rūnanganui o Te Atiawa and the Pacific Health Service), with a view to validate or correct the level of WCTO activity the DHB purchases from our providers.

Commissioning: Primary & Complex Care







- **What is this Measure**

  Older people & frailty
  - % of population living at home
  - % supported to live at home
  - Acute bed day rate per 1000 (65+)
- **Why is it important**
  - A significant pressure on HVDHB's health system over the next 15 years is its ageing population.
  - We can support older people to maintain their independence through prevention and early intervention activities using a range of community-based supports. These investments can improve quality of life for individuals, and reduce demand on costly health services that have limited capacity.
- **How are we performing**
  - 89% of older people (65+ years) are living at home without support.
  - 6% of older people (65+ years) received DHB-funded support in the community to live at home.
  - Acute bed days for 65+ year olds are decreasing but are higher for Māori and Pacific.
- **What is driving Performance**

We are looking to localise investments for frailty that are showing an impact on acute demand management, including:

- **Community Health of Older People Initiative (CHOPI):** Geriatricians and Nurse Practitioners support primary care practitioners with advice and same day home visits to avoid hospital admission. Cost of $928 per person saving $5,500 for each admission averted.
- **Acute Health of Older People (AHOP):** Inpatient care model moving frail people through the system faster from ED (90 mins quicker) and reduced LOS
- **Early Supported discharge (AWHI):** Patients are supported home sooner through a restorative model. In 2019/20 525 bed days were saved at a saving exceeding $1m.
- **Community Acute response Services (CARS):** Prototyped in Kapiti to support primary care in avoiding ED presentations using ambulance diversion. This cost effective initiative for frailty management. Marginal cost savings are $60,000.

- **Management Comment**
  - Our main lever to reduce demand is to invest in community HCSS and community organisations to support frail elderly at home for longer. This funding has been stable for the last three years and allows for in-between travel and pay equity. Investment in HCSS is required in order to support people to remain at home for longer. ARC is the highest cost care option and ARC expenditure is going down against our population suggesting we are supporting more people to live at home for longer

Commissioning: Mental Health & Addictions

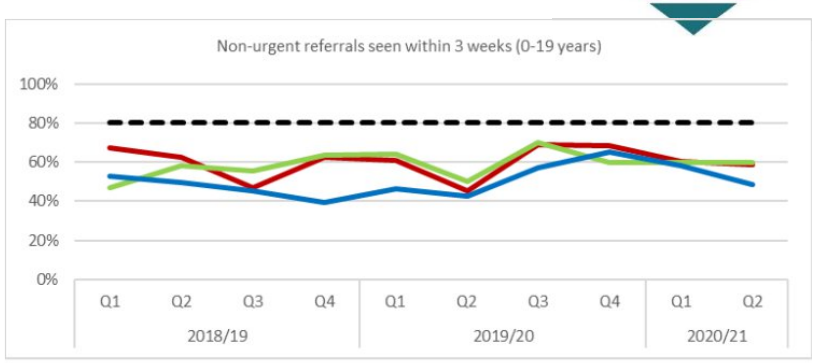
What is this measure?
- ≥80% of non-urgent referrals seen within 3 weeks
- Number of patients admitted for more than 14 days
- Number of people aged 0-19 years referred to AOD services

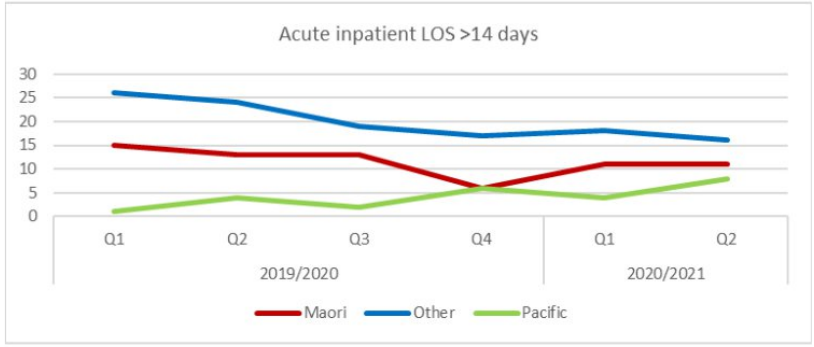
Why is this important?
- The time between a referral being created and first activity is critical to reducing patient distress and managing caseloads. Further, timely care can improve outcomes through early intervention.
- The demand for acute inpatient services is growing along with waitlist sizes.
- With no AOD service designed for those aged 0-19, we are seeing a large proportion of youth presenting at EDs for AOD-related reasons, highlighting unmet need.

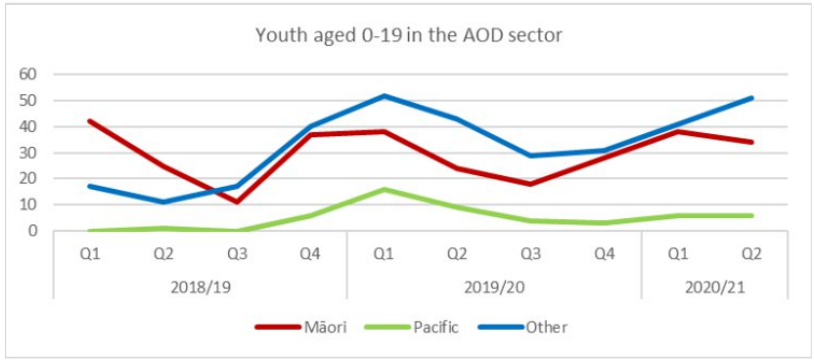
How are we performing?
- The proportion of non-urgent referrals seen within 3 weeks for 0-19 year olds has been consistently below target for all groups. The Q2 result for 59% for Māori and 60% for Pacific.
- The number of people staying over 14 days as an acute mental health inpatient has decreased slightly for all groups. However, the overall volume change is small.
- Youth are currently under-represented in the AOD sector but there are a higher number of Māori youth using AOD services.

What is driving performance?
- An aim of the **3DHB Acute Care Continuum** project is to increase access to Crisis Respite services as an alternative to acute inpatient care or earlier discharge pathways.
- We are developing a **3DHB Model of Care for Addictions** to support improved health outcomes in our priority populations. Establishment of a new investment in primary and community mental health service will also provide greater access for youth and adult clients.

Management Comment
- We are developing smart systems as a key enabler of effective service delivery (e.g. the Te Haika system upgrade).
- We actively look at flow through our CAMHS services, and have been provided with some specific training from Werry Workforce on this to assist us in managing flow within our teams as effectively as possible.
- CAMHS teams undertake work with families prior to meeting the youth client which is counted as the first face-to-face activity.







2DHB COVID-19 Response

What is this measure?
- Vaccination roll-out

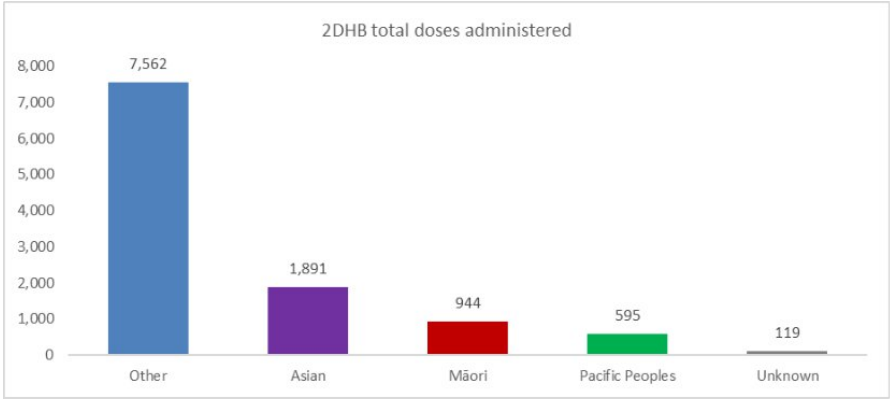
Why is this important?
- The COVID-19 vaccine rollout aims to protect Aotearoa by ensuring that everyone over 16 years old receives the two doses. Ensuring equal access to free COVID-19 vaccines is a priority for New Zealand.
- First we are protecting those most at risk of catching COVID-19 in their workplace to reduce the risk of future outbreaks and lockdowns.

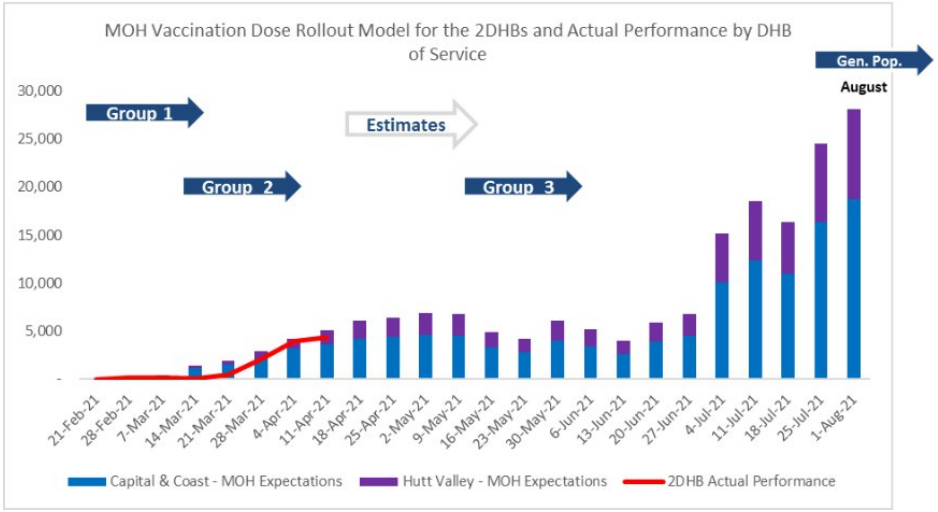
How are we performing?
- **Group 1:** Border, MIFQ workers and people they live with: **1,416 vaccinations**
- **Group 2:** Frontline health workforce interacting with patients, frontline health workforce supporting in high-risk places, at-risk people living in high-risk settings: **8,126 vaccinations**
- **Group 3:** people who are 65 years or older, people with underlying conditions, disabled people, people in custodial settings

2DHB group		Dose 1	Dose 2	% complete*
Group 1	Border Worker	1,088	328	60%
	Household	1,030	71	7%
Group 2a	DHB workforce	5,152	17	0.2%
	Community workforce	2,923	1	0.02%
Group 2b	Elevated Risk	33	0	0%
Group 3	Planned start date May 2021			

*Coverage rates are dependent on the 3-week cycle

Data Sources: COVID-19 Vaccination Events (MOH Qlik)
Date Range: 22/02/2021 to 10/04/2021
Data current at: 11/04/2021 @1:16PM





Commissioning: Hospital & Speciality Services

What is this measure?

- Triage priority of ED presentations
- Presentations to ED for children & youth and older people
- General adult surgical admissions from Hutt ED

Why is this important?

- One of our strategic priorities is to ensure our people presenting acutely to hospital receive timely access to assessment, treatment and discharge/admission to wards (*Acute inpatient hospital flow*).

How are we performing?

- In February 2021, Hutt ED treated 197 more triage 1&2 patients, 129 more triage 3 patients, and 97 *fewer* triage 4&5 patients compared to 2019.
- Presentations by children and medical patients are below expected for this time of year, and older people are presenting at the same rate.
- In contrast, surgical admissions from ED are increasing in both volume and proportion of patients seen.

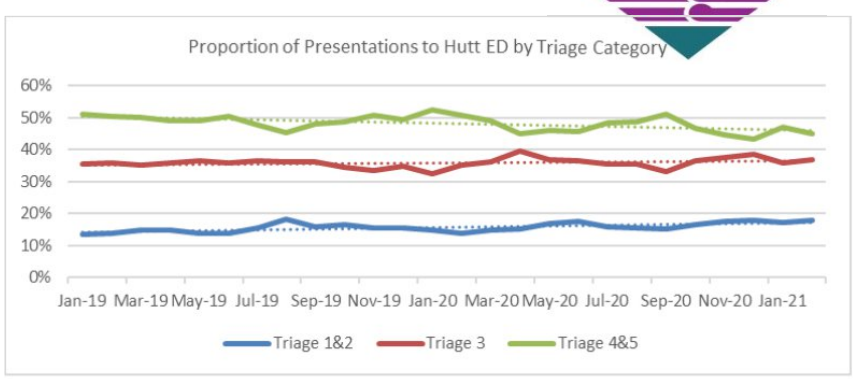
What is driving performance?

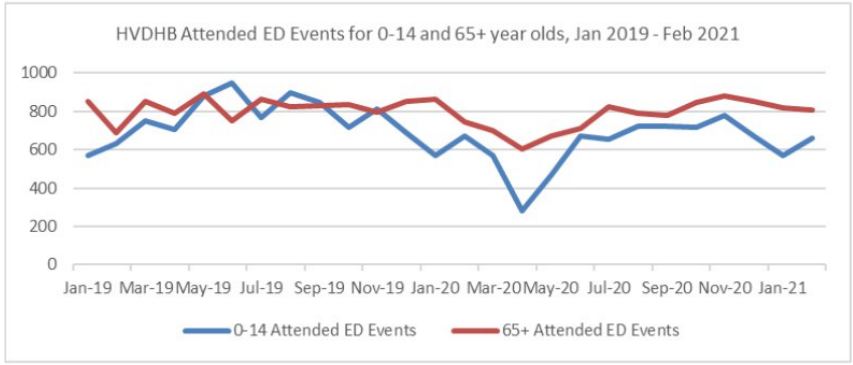
- People presenting to our Emergency Departments presenting at a higher acuity compared to the same time in recent years.
- Increasing surgical presentations is causing increased displacement of elective surgeries as acute cases require urgent treatment. This acute displacement is impacting the ability to deliver planned care surgeries.

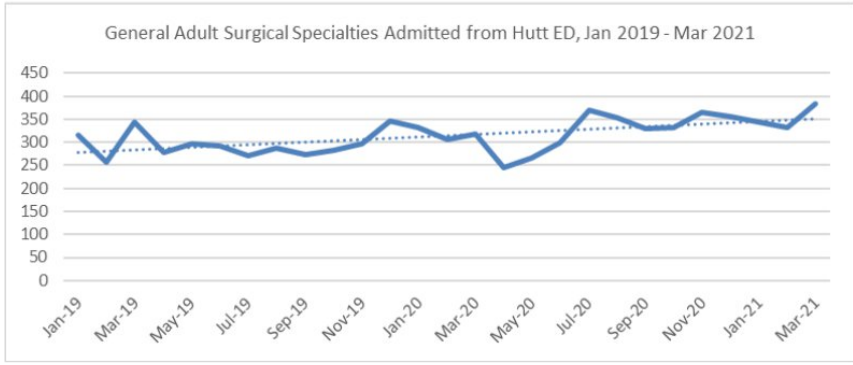
Management comment:

A range of strategies are in place to mitigate acute demand in both community and hospital settings:

- **Community initiatives to manage in-flow:** we are developing our community responses to population drivers alongside approaches to maximise the productivity and efficiency of our hospital system, for example early supported discharge.
- **Hospital initiatives to improve in-hospital flow:** we are exploring our short and medium term options for expansion of bed and theatre capacity this will increase the timeliness of flow through our emergency department. The options are being developed within the context of the Hospital Network programme.







Section 3

Hospital Performance

Executive Summary – Hospital Performance

- In March, activity was high over a number of services - ED attendances and both discharges and caseweights for all services. As we head towards winter this peaks – our winter bed plan to increase capacity by using every available space over the winter months is in development with the first draft due late April.
- The ability to discharge patients within 6 hours remained a challenge with 83% able to move through the ED within 6 hours. The expectation to improve long waits in ED for patients to see speciality services is supported by our work in the Assessment Planning Unit (APU) which continues to provide assessment space for patients requiring review from Medical, General Surgery and Gynaecology specialities. Despite hospital occupancy pressures in March 21, the team assessed 36% more patients compared to March 20 with an average length of stay of 26 hours.
- Hospital occupancy challenges provided an opportunity to trial an overnight 'flex-unit' for patients highlighted as a likely discharge the following day. The aim of this 'flex-unit' is to ensure inpatient beds for ED patients can be facilitated. Work is underway to formally establish the plan for future implementation when demand exceeds our capacity.
- Planned care – the delivery of Specialist assessments or Treatment within 120 days continues to be a major challenge. While the total March planned care target at 98.6 % was met we are behind target for the additional elective volumes. This is due in part to the impact of acute demand but also limited capacity in the private sector. A revised plan is in development that includes use of Saturday morning lists. We are liaising weekly with the Ministry planned care team seeking support and advice as we lead out our system improvement project aimed at making progress around all aspects of managing elective flow.
- We continue with the 2D Bed & Theatre Capacity project to identify and deliver solutions for short to medium term improvement in OT capacity across 3 Hospitals (Kenepuru, Wellington & Hutt).
- Our Maternity Units across the region continue struggling with midwifery vacancies - we are continually refining and reviewing processes to manage demand during busy periods and continue to work closely with our staff and union partners on workforce planning across the region noting this issue as requiring national solutions.
- Activity was high over a number of services with revenue correspondingly higher however Medical and Nursing service costs remain unfavourable to budget driving the overall provider result. The impact of more complex patients/increasing one to one care, treatment related costs particularly treatment disposables and implants are high again this month taking us well ahead of plan in line with the increased acute demand for surgery. Nursing Mitigations in place include active recruitment for the required FTE to reduce overtime, casual/allocation use, completion of the CCDM roll out and continual review use of minders/cohort watches to keep the level to a reasonable safe level. Leave planning is in place for the holiday period.

Hospital Throughput

Month					Hutt Valley DHB Hospital Throughput YTD Mar-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							
1,279	1,148	(131)	1,072	(207)	Surgical	10,280	9,677	(603)	9,413	(867)	12,950	12,797
1,891	1,680	(211)	1,688	(203)	Medical	16,872	14,710	(2,162)	16,379	(493)	19,737	19,506
525	425	(100)	443	(82)	Other	4,387	4,075	(312)	4,132	(255)	5,374	5,474
3,695	**3,253**	**(442)**	**3,203**	**(492)**	**Total**	**31,539**	**28,461**	**(3,078)**	**29,924**	**(1,615)**	**38,061**	**37,777**
					CWD							
1,361	1,266	(94)	1,116	(244)	Surgical	10,924	10,455	(469)	10,416	(508)	13,889	12,852
984	898	(86)	966	(18)	Medical	8,839	8,103	(735)	8,795	(44)	10,719	11,991
587	473	(114)	727	140	Other	5,051	4,423	(629)	5,034	(18)	5,811	4,698
2,932	**2,637**	**(295)**	**2,809**	**(123)**	**Total**	**24,814**	**22,981**	**(1,833)**	**24,245**	**(570)**	**30,419**	**29,540**
					Other							
4,315	4,235	(80)	3,558	(757)	Total ED Attendances	37,576	36,460	(1,116)	36,829	(747)	48,696	47,491
1,053	954	(99)	867	(186)	ED Admissions	9,146	8,510	(636)	8,785	(361)	11,386	11,847
892	823	(69)	704	(188)	Theatre Visits	7,076	7,042	(34)	6,719	(357)	9,370	9,271
145	125	(20)	123	(22)	Non- theatre Proc	1,249	1,108	(141)	1,136	(113)	1,500	1,891
7,841	7,094	(747)	6,925	(917)	Bed Days	66,723	61,198	(5,525)	66,152	(571)	82,873	85,515
4.87	4.50	(0.37)	5.28	0.41	ALOS Inpatient	4.54	4.50	(0.04)	4.52	(0.02)	4.50	4.29
2.22	2.18	(0.04)	2.55	0.34	ALOS Total	2.07	2.18	0.10	2.21	0.14	2.18	2.20
7.66%	8.02%	0.36%	8.03%	0.38%	Acute Readmission	8.10%	8.02%	-0.09%	7.94%	-0.16%	7.31%	7.36%

In March, both discharges and caseweights for all services were over budget. Year to date, caseweights for Surgical services are over budget mainly due to General Surgery, Orthopaedics and Gynaecology. Medical year to date, discharges and caseweights are higher than budget, due to an increase in Gastroenterology and Rheumatology compared to last year offset by lower volumes for Paediatrics. Other services are higher than budget due to more discharges under Maternity.

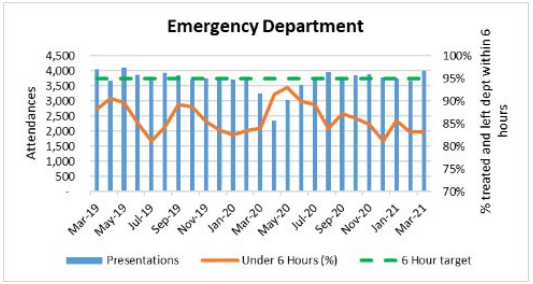
In March, ED visits were over budget. The number of patients who were admitted from ED were higher than budget. Theatre visits were over budget for the month, but close to budget year to date. Non-theatre procedures are higher than budget. Bed days were 11% higher than budget for the month. Inpatient ALOS in March was over budget but shorter than last year. The acute readmission rate was lower than budget for the month and the same time last year.

Operational Performance Scorecard – 13 mths

			13 Months Performance Trend												
Domain	Indicator (MoH KPIs highlighted yellow)	2019/20 Target	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Safe	Serious Safety Events[1]	Zero SSEs	1	2	2	2	3	3	1	2	3	0	1	3	3
	SABSI Cases [2]	Zero	1	0	0	0	1	0	1	2	1	1	1	0	1
	C. difficile infected diarrhoea cases	Zero	4	0	2	0	3	4	1	1	4	0	1	0	1
	Hand Hygiene compliance (quarterly)	≥ 80%	83%	87%			82%			79%			79%		
	Seclusion Hours- average per event (MH Inpatient ward TWA)[3]		31.1	39.1	16.3	13.8	27.7	36.7	11.4	13.3	1.4	43.6	7.6	22.4	39.8
Patient and Family Centred	Complaints Resolved within 35 calendar days[4]	≥90%													
	Patient reported experience measure[5] (quarterly)	≥80%	N/a	N/a			N/a			N/a			N/a		
Timely	Emergency Presentations	49,056	3,558	2,405	3,104	3,721	4,039	4,281	3,997	4,273	4,328	4,259	4,059	4,026	4,315
	Shorter Stays in ED (SSiED) % within 6hrs	≥95%	83.9%	91.4%	93.0%	89.9%	89.2%	84.0%	87.2%	86.3%	84.8%	81.3%	85.8%	83.1%	83.1%
	SSiED % within 6hrs - non admitted	≥95%	90.1%	95.7%	97.0%	94.7%	93.3%	90.7%	91.5%	91.0%	89.8%	86.9%	90.7%	89.9%	89.5%
	SSiED % within 6hrs - admitted	≥95%	66.6%	81.1%	82.4%	76.1%	78.6%	64.5%	75.1%	73.2%	71.8%	66.3%	72.0%	62.8%	65.3%
	Total Elective Surgery Long Waits -ESPI 5	Zero Long Waits	821	1,012	1,077	1,130	1,082	913	915	992	1,002	1,115	1,251	1,328	1,619
	No. Theater surgeries cancelled (OP 1-8)		194	50	72	98	140	148	154	142	128	138	87	139	197
	Total Elective & Acute Operations in MainTheatres 1-8[6]		704	389	673	733	868	792	805	824	775	744	664	712	892
	Specialist Outpatient Long Waits- ESPI 2	Zero Long Waits	1,265	1,396	1,384	1,240	1,096	798	674	723	704	758	1,016	1,124	1,093
	Outpatient Failure to Attend %	≤6.3%	6.9%	6.1%	7.4%	8.3%	6.8%	6.3%	5.4%	5.6%	6.0%	6.2%	7.7%	5.6%	5.6%
	Full Year Forecast surplus / (deficit) $m - Provider (1) (2)	($2.03)	($10.37)	($13.04)	($13.59)	($14.20)	($10.61)	($10.61)	($15.38)	($12.54)	($14.33)	($14.64)	($14.29)	($16.06)	TBC
	Full Year Forecast surplus / (deficit) $m - DHB (1) (2)	($8.14)	($13.04)	($14.64)	($15.64)	($21.45)	($10.65)	($10.65)	($13.37)	($12.31)	($12.87)	($14.54)	($14.33)	($14.24)	TBC
	% Theatre utilisation (Elective Sessions only)[7]	≤90%	86.4%	74.5%	85.2%	87.6%	85.7%	87.9%	90.4%	86.2%	88.1%	87.2%	86.4%	87.2%	87.5%
	Overnight Patients - Average Length of Stay (days)	≤4.3	5.31	4.90	4.26	4.44	4.39	4.76	4.52	4.26	4.72	4.79	4.50	4.37	4.91
	Long Stay Patients Not Yet Discharged (>14 days)	≤5	7	12	15	14	16	21	17	15	21	24	21	34	20
	Overnight Beds (General Occupancy) - Average Occupied	≤130	129	105	118	136	141	151	144	130	138	144	130	149	162
	Overnight Beds (General Occupancy) - % Funded Beds Occupied	≤85%	79.5%	65.1%	73.1%	84.2%	86.8%	93.1%	88.8%	80.4%	85.1%	93.4%	84.7%	96.5%	94.8%
	All Beds - ave. beds occupied[8]	≤250	223	179	207	241	244	254	249	231	240	240	229	253	280
	% sick Leave v standard	≤3.5%	3.6%	7.5%	6.9%	3.1%	4.3%	4.2%	4.0%	3.4%	3.4%	3.1%	2.0%	2.5%	3.5%
	% Nursing agency v employee (10)	≤1.49%	2.6%	2.3%	3.3%	2.0%	1.6%	1.2%	2.2%	26.2%	12.7%	12.7%	12.8%	12.4%	TBC
	% overtime v standard (medical) (10)	≤9.22%	7.6%	9.2%	9.7%	9.2%	6.7%	7.8%	8.1%	9.2%	10.7%	6.9%	11.9%	9.6%	TBC
	% overtime v standard (nursing)	≤5.47%	10.6%	13.2%	12.6%	12.3%	10.8%	13.6%	12.3%	12.3%	14.4%	11.6%	23.7%	14.2%	TBC

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

Shorter Stays in Emergency Department (ED)



Category	Volume	% Seen in time
1	33 (230)	100% (100%)
2	736 (6127)	36% (42%)
3	1607 (13695)	28% (27%)
4	1481 (13126)	39% (38%)
5	458 (4400)	71% (73%)
	Mth (YTD)	Mth (YTD)

Arrivals -
Month - 4,315 (3,558)
YTD - 37,578 (36,829)

Self Referred
Month - 2,825 (2,289)
YTD - 24,955 (24,171)

GP Referred
Month - 455 (365)
YTD - 3,652 (3,654)

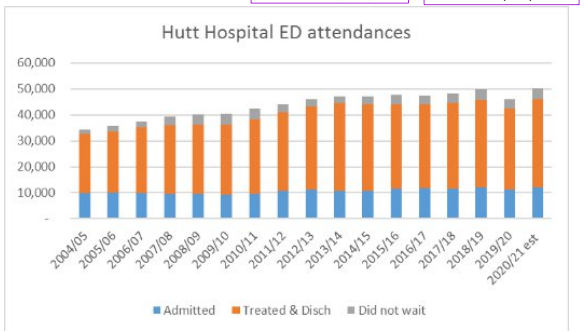
Other
Month - 1,035 (904)
YTD - 8,971 (9,004)
Current (Last Year)

Seen in Time
Triage
Diagnosis &/or Treatment

Did Not Wait
Month - 304 (312) 7%
YTD - 3174 (3454) 8%

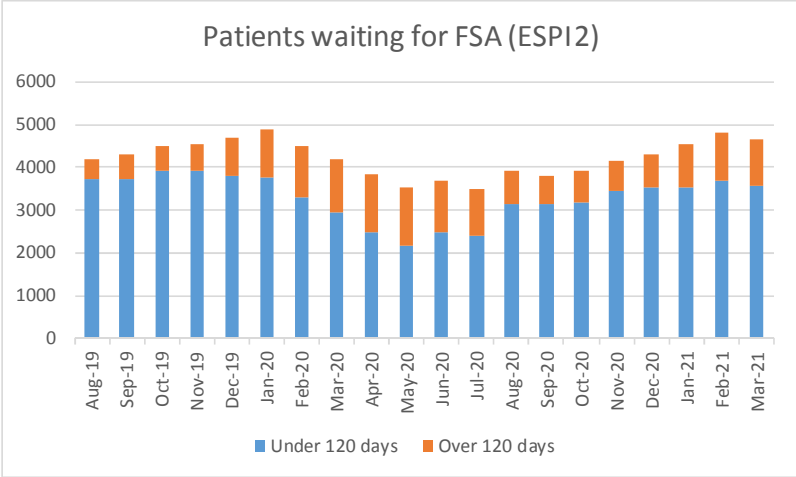
Treated & Disch
Month - 2958 (867) 89% <6hr
YTD - 25258 (24590) 90%

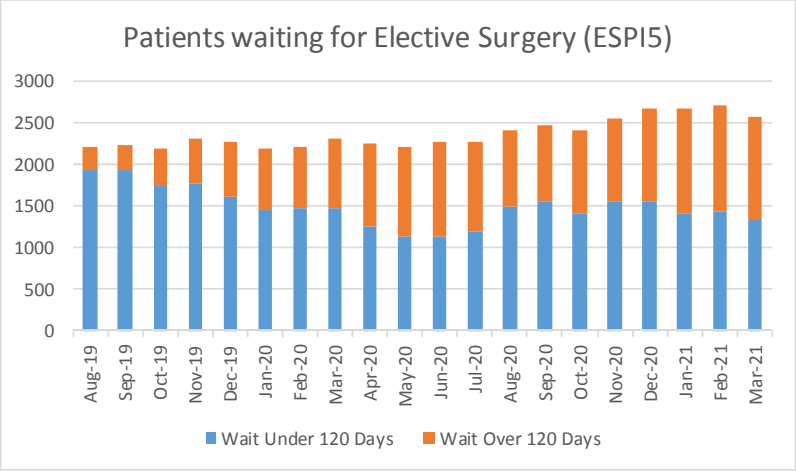
Admitted
Month - 1053 (867) 65% <6hr
YTD - 9146 (8785) 70%



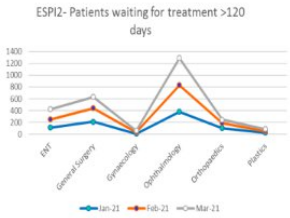
- **What is this Measure**
  - The percentage of patients admitted, discharged and transferred from an Emergency Department within 6 hours.
- **Why is it important**
  - This indicator measures flow through the whole system it is impacted by the number planned of people arriving at ED, how fast ED treats them, availability of beds in the hospital and community service availability.
- **How are we performing**
  - Hutt hospital had more attendances than budget in march however due to the acuity of presentations, delay in specialty assessment and difficulty in timely disposition, the ability to discharge patients within 6 hours remained a challenge with 83% able to move through the ED within 6 hours.
  - The total ED attendances in March was similar to Mar 19 (mar 20 was impacted by Covid) however the acuity mix was different with an increase in triage 1, 2 and 3 and decreases in triage 4 and 5 patients.
- **What is driving Performance**
  - March saw more presentations to the Emergency Department compared with February 21 with a notable increase in triage 3 and 4 patients. Although triage 1 presentations remained unchanged a 10% reduction in admission is seen for these patients.
  - The Assessment Planning Unit (APU) continues to provide assessment space for patients requiring review from Medical, General Surgery and Gynaecology specialities. Despite hospital occupancy pressures in March 21, the team assessed 36% more patients compared to March 20 with an average length of stay of 26 hours.
- **Management Comment**
  - Hospital occupancy challenges provided an opportunity to trial an overnight ‘flex-unit’ for patients highlighted as a likely discharge the following day. The aim of this ‘flex-unit’ is to ensure inpatient beds for ED patients can be facilitated. Work is underway to formally establish the plan for future implementation when demand exceeds our capacity.

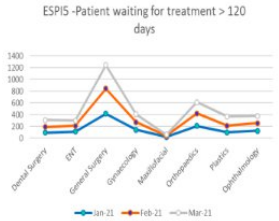
Planned Care – waiting times

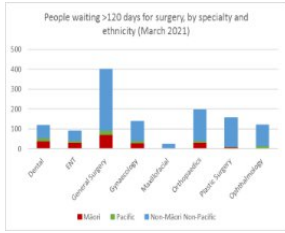




- **What is this measure?**
  - The delivery of Specialist assessments or Treatment within 120 days
- **Why is it important?**
  - It is important to ensure patients receive care at the most appropriate time to support improved health.
- **How are we performing?**
  - The total waiting for an FSA decreased by 3% this month and the number waiting over 120 days by 3% (31)
  - The number waiting for elective surgery fell by 26 to 2,577 and the number waiting over 120 days by 26 to 1,239
  - However the numbers of patients waiting longer then120 days for both assessment and treatment is high.







- **What is driving performance?**
  - Principally managing inflows to our waiting list and balancing against outflows is not yet robust,
  - Registered Nursing staffing in the value chain for OR production does not meet patient demand.
  - Cancellations due to acute demand.
  - Wait list trajectories are behind due to acute demand and historic backlog.

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Planned Care Funding & Service delivery

Figure one: Planned care funding sources

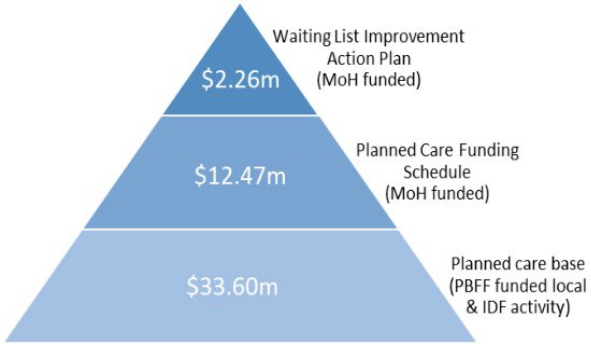
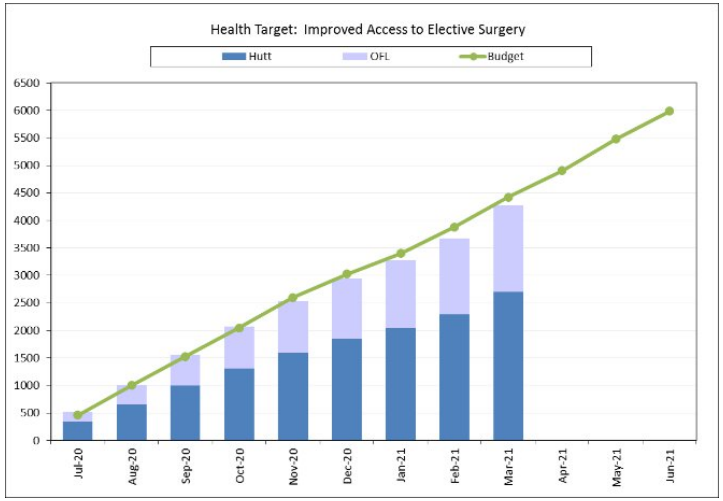
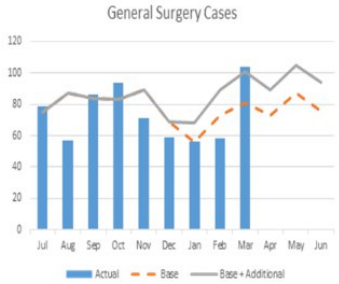


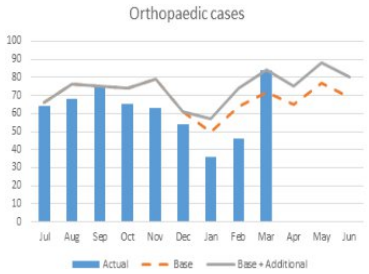
Figure two: Discharge trajectory for Planned care base and Planned care funding schedule - 98.6%

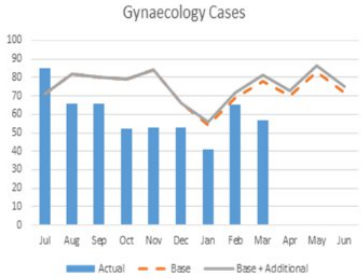


- **What is this measure?**
  - The delivery of an agreed number of inpatient surgical discharges and minor procedures to the Hutt Valley Population
  - The are three funding sources as per figure one – this is important as each has measures and deliverables required to access the funding which is paid after delivery .
- **How are we performing?**
  - Discharges are 149 behind budget for the Planned care base and Planned Care Funding Schedule (figure one) – this equates to 98.6 % as per figure 2. However YTD were have not been able to deliver any of the funding tagged for Waiting List Improvement Action Plan discharges ($2.26M)
- **What is driving performance?**
  - Two acute theatres are now permanently in place. This supports acute flow but the loss of elective theatre capacity due to acute demand is having an impact on theatre production.
  - The three services that were allocated Waiting List Improvement Action Plan funding have not been able to met targeted delivery month on month until March (figure three) . If this March trend continues then the Planned care base and Planned Care Funding Schedule would be met allowing us to access funding from the Waiting List Improvement Action Plan.

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







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Planned Care Funding & Service delivery

- **Management actions**

Supporting improved delivery

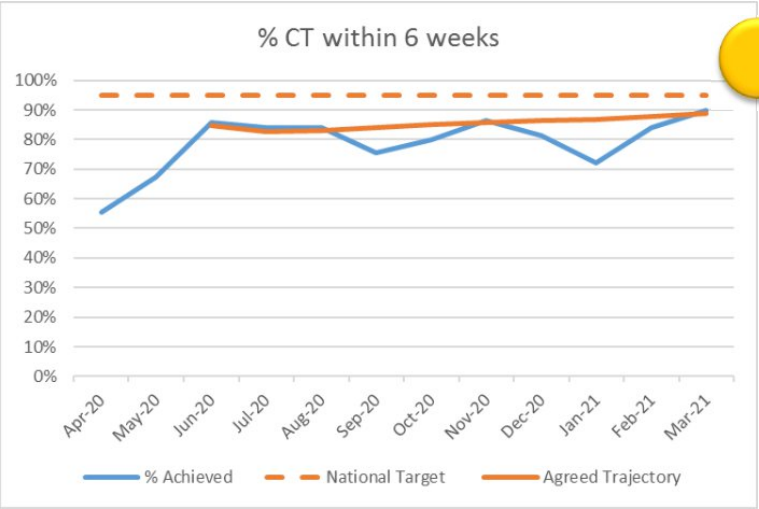
- Delivery of our current outsourcing contract of 65 cases to support planned care recovery (40 General Surgery and 25 orthopaedic) is at completion now
- Progressing increased appointment of Operating Room Recovery Nursing staff (PACU) so the establishment fits roster and this will reduce operating theatre delay times.
- We have sourced an ENT locum and backfill surgeon to cover leave for General Surgery to maintain production through operating theatre.
- General surgery will deliver additional all day elective Saturday lists on Alternate weekends
- Orthopaedics will commence regular additional local lists to operate on targeted day cases

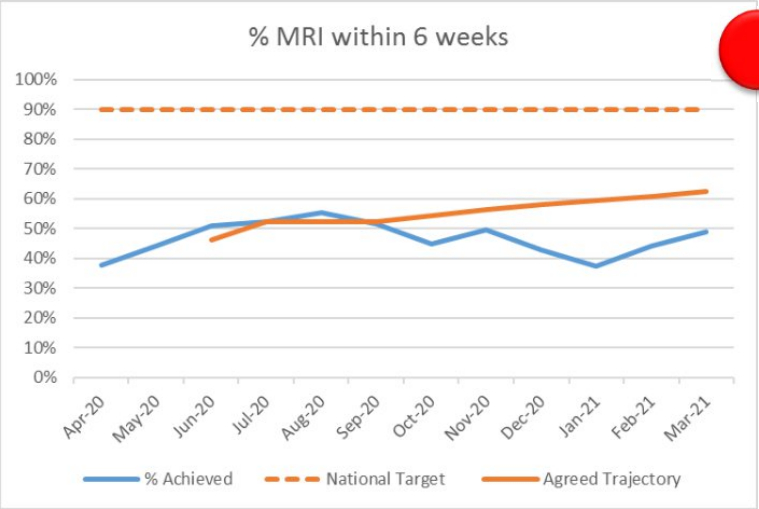
Supporting access to the waiting list improvement action plan

- We plan to outsource 70 surgeries to private hospital(s) across general surgery and orthopaedics . These are funded by the Waiting List Improvement Action Plan IF our services continue to deliver as in March. That is, Planned care base and Planned Care Funding Schedule volumes are met for both General Surgery and Orthopaedics.
- If these volumes are not achieved, we cannot access the Waiting List Improvement Action Plan funding. The DHB then bears the cost for these surgeries i.e. a funding risk exists. To mitigate this risk a robust plan supported by clinicians underpins the improved delivery above and expectation this continues.
- Our waiting lists for both general surgery and orthopaedic specialties are in the hundreds with 400 people waiting greater than 120 days for general surgery and 194 for orthopaedic surgery – this plan supports care for some of these patients.

50A

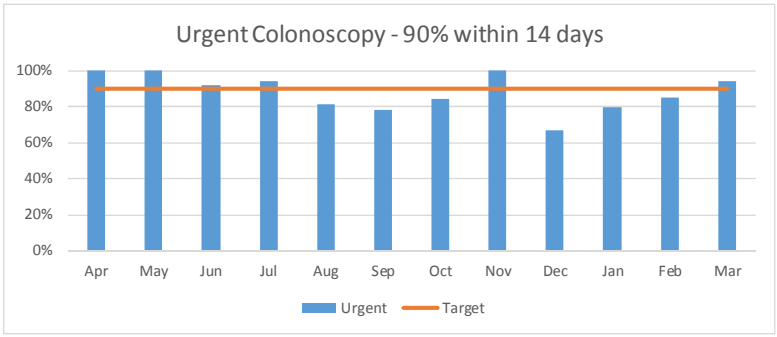
CT & MRI wait times



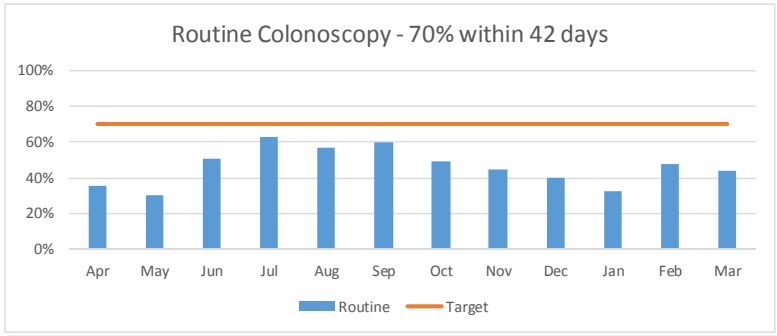


- **What is this measure?**
  - The delivery of computerised tomography (CT) scans and Magnetic Resonance Imaging (MRI) scans in a timely fashion to non-acute patients (within 42 days of referral).
- **Why is it important?**
  - Delayed diagnostic results can negatively affect health outcomes.
- **How 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?**
  - It is pleasing to see a lift in performance for CT and MRI however MRI continues to remain a challenge.
  - MRI staff are doing some voluntary overtime weekend days shifts, however this is still not enough to reset the trajectory to an acceptable level and outsourcing will need to continue.
- **Management comment**
  - Actions currently underway:
    - Managed daily outsourcing of reporting to Pacific Radiology to support in-house Radiologists.
    - All outpatient CT guided Steroid injections are no longer being provided in house which is creating more capacity for other core business
    - Reviewing what capacity is available to report for Wairarapa reporting
    - Weekend MRI lists have commenced
    - Weekend CT list to manage waitlist
    - MOH Planned Care funding being used to outsource 30 MRIs per month (scan and reports) the reporting of 100 CTs per month .

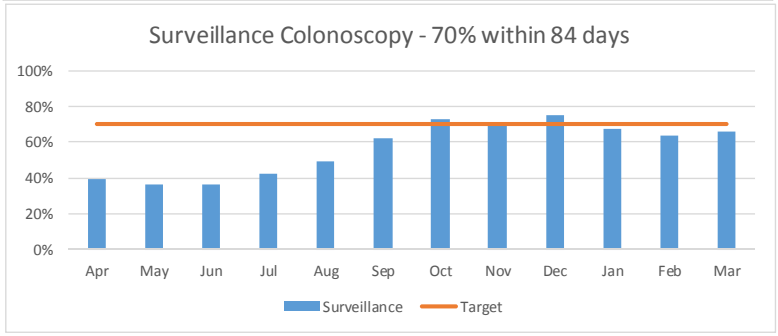
Colonoscopy Wait Times



Urgent
85% YTD



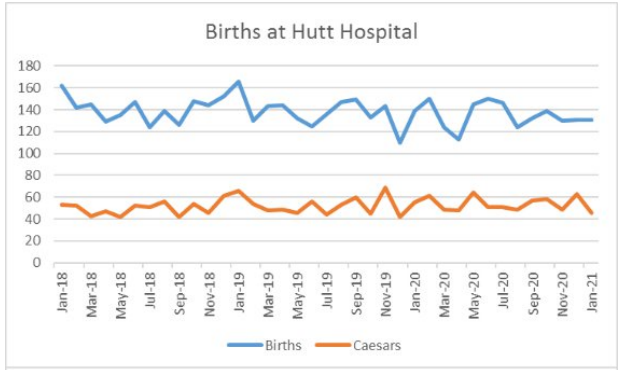
Routine
49% YTD

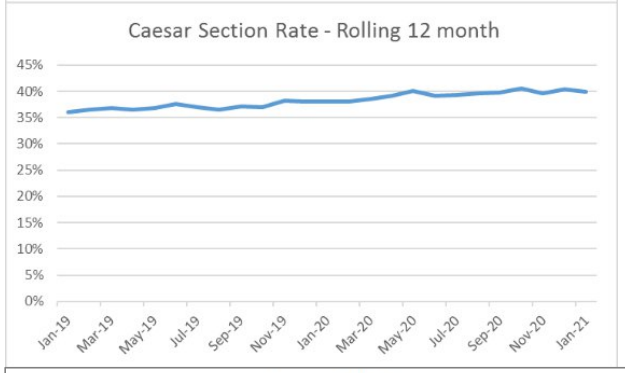


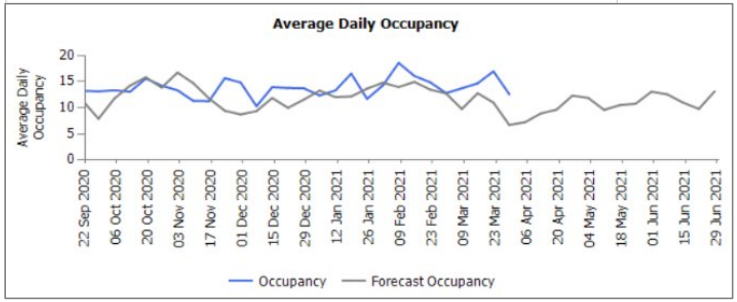
Surveil
61% YTD

- **What is this measure?**
  - The delivery of Colonoscopy, urgent within 14 days, routine 42 days and surveillance within 84 days of being due.
- **Why is it important?**
  - Delayed diagnostic results can negatively affect health outcomes.
- **How are we performing?**
  - We have met the target for Surveillance and are close to target for Urgent colonoscopies. However we continue to struggle with routine
- **What is driving performance?**
  - A growing surveillance waitlist with patients continuing to move onto this from the Bowel Screening Programme.
  - There is also an overall increase in referrals, with the past 6 months being higher numbers referred compared to the past 4 years.
- **Management comment**
  - A Nurse Endoscopist has commenced and is orientating and being credentialed by the SMOs – this will maintain current list numbers
  - Our Fellow will stay on at reduced FTE to continue providing lists, an SMO will pick up 0.1 FTE for six months from April will help to reduce waiting times.

Maternity

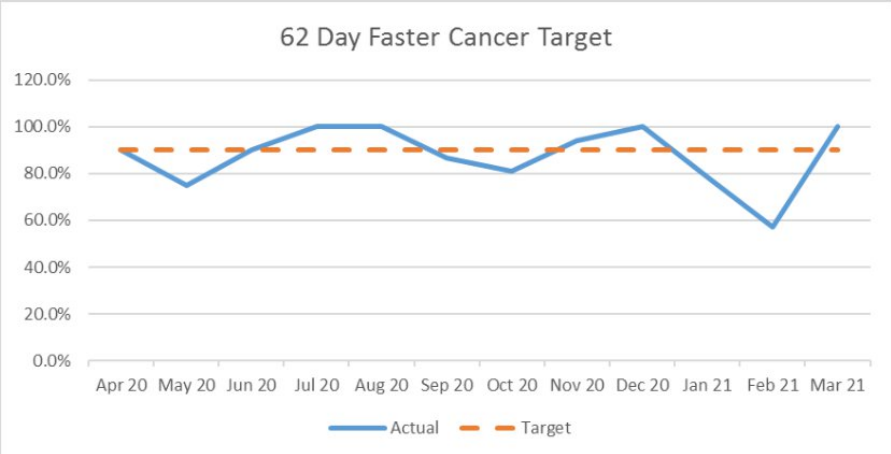


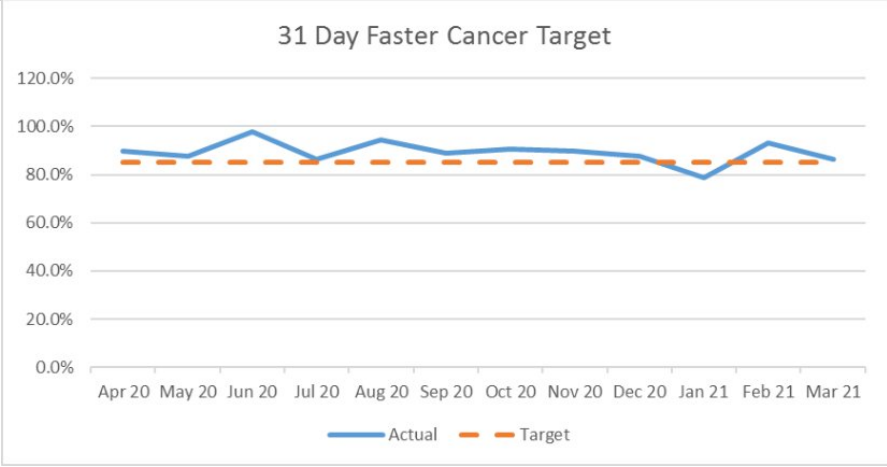




- **What is the issue?**
  - In 2019 a number of clinical and community concerns around Hutt hospital's maternity services were identified.
- **Why is it important?**
  - An external review of the service and HDC investigations showed a number of areas where improvements needed to be made.
- **How are we performing?**
  - A presentation to the CCDHB & HVDHB Boards in March focused on the maternity quality safety programme national clinical indicators – areas HVDHB is performing well in and those where improvement is being directed. We will seek to reduce Caesarean Sections through a birthing optimisation project and prospective case audit over a 3 month period will commence in April 2021
- **Management comment**
  - The Minister of Health confirmed in January 2021 approval to invest $9.47 million capital funding to upgrade the Maternity Assessment Unit, Maternity Ward and Special Care Baby Unit (SCBU).
  - The Governance Group for the facility in place and Phase One of building work (CMT space) commenced in March and is expected to complete by May.
  - Midwifery staffing was a key recognised risk in the external review; currently Hutt Valley's inpatient antenatal and post natal ward and Delivery Suite have a combined total workforce of 35.23 FTE. There is a RM vacancy of around 18 FTE at the end of March and an active recruitment campaign is in place.
  - We have processes to manage demand during busy periods. We continue to work closely with our staff and union partners on workforce planning across the region noting this issue as requiring national solutions.
  - We are also developing a more regional approach as both Hutt and WRH units are similarly challenged with workforce shortages.

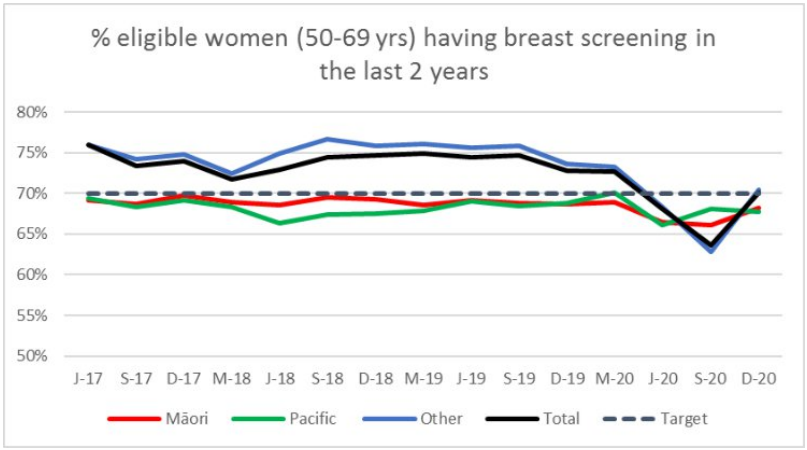
Faster Cancer Treatment

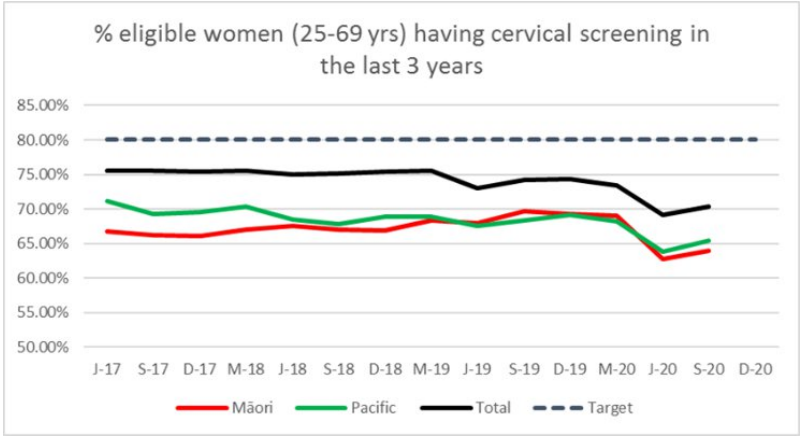




- **What is the issue?**
  - 62 day target: 90% of patients should receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.
  - 31 day indicator: The maximum length of time a patient should have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

Screening





- **What is the issue?**
  - 80% of Women aged 25-69 have completed cervical screening in the previous three years
  - 70% of Women aged 50-69 have completed breast screening in the previous two years
- **Why is it important?**
  - By improving breast and cervical screening coverage DHBs will assist in delivery of the Government's priority to support healthier, safer and more connected communities and our health system outcome that we live longer in good health
- **How are we performing?**
  - COVID lockdowns have resulted in a backlog of 6000 women that are overdue for BreastScreening in the 20/21 year. There has been longstanding recruitment issues for both Medical Imaging Technologists (MIT) and Radiologists.
- **What is driving performance?**
  - Due to COVID an increased volume of 36,000 screens due in the 20/21 year.
  - In March we provided Saturday sessions for the full month and screening capacity has increased. This continued on a volunteer basis while Medical Imaging Technologist (MIT) recruitment is underway.
  - Maori, Pacific and Asian (cervical) women are prioritised in both Cervical and Breast
  - 5 Cervical Clinics with Primary Health in March with 84 priority women screened
- **Management Comment**
  - MIT Recruitment has been successful and as of April 2021 only 1 MIT vacancy remains. Rostered Saturday screening will be in place from April.
  - The Breast Service now has 2 Radiologists training as Breast Specialists.
  - A Saturday Cervical 'Free' Screening clinic for priority women was run at Wairarapa DHB on 27 March. This clinic was organised collaboratively with Tu Ora Compass Health. 35 priority women attended this clinic for screening, and 19 of these women had previous high grade results.

Section 4

Financial Performance & Sustainability

Summary of Financial Performance for March 2021

Hutt Valley DHB

Operating Report for the month of March 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										
41,315	40,313	1,003	37,878	3,437	Devolved MoH Revenue	366,128	362,813	3,315	337,501	28,627	487,030	483,750	3,280	454,822	32,208
1,612	1,778	(166)	1,919	(306)	Non Devolved MoH Revenue	16,177	14,944	1,234	14,397	1,780	21,232	20,049	1,183	19,272	1,960
693	521	172	382	310	ACC Revenue	5,261	5,506	(245)	4,860	401	6,974	7,219	(245)	6,457	517
644	522	122	512	132	Other Revenue	5,805	4,740	1,065	4,821	983	7,074	6,309	765	6,074	1,000
9,697	9,229	468	8,315	1,382	IDF Inflow	84,411	83,057	1,355	77,564	6,847	112,366	110,742	1,624	102,288	10,078
852	303	549	282	570	Inter DHB Provider Revenue	9,206	2,727	6,478	3,058	6,148	11,786	3,637	8,149	4,507	7,280
54,814	**52,665**	**2,149**	**49,288**	**5,526**	**Total Revenue**	**486,988**	**473,786**	**13,202**	**442,200**	**44,787**	**646,462**	**631,707**	**14,756**	**593,420**	**53,042**
					Expenditure										
					Employee Expenses										
5,366	5,605	239	5,192	(174)	Medical Employees	46,729	47,463	734	44,708	(2,022)	62,349	63,310	961	60,010	(2,339)
6,203	6,754	551	6,206	3	Nursing Employees	54,494	57,678	3,184	55,454	960	72,461	76,767	4,306	75,339	2,878
2,718	3,083	365	2,879	161	Allied Health Employees	21,517	25,856	4,339	23,543	2,026	29,128	34,575	5,447	32,175	3,047
816	757	(59)	706	(110)	Support Employees	7,038	6,253	(785)	6,361	(678)	9,410	8,394	(1,015)	8,676	(733)
2,660	2,719	59	2,187	(473)	Management and Admin Employees	20,060	23,155	3,096	20,795	736	27,158	30,842	3,683	28,166	1,008
17,763	**18,919**	**1,156**	**17,171**	**(592)**	**Total Employee Expenses**	**149,838**	**160,405**	**10,567**	**150,860**	**1,022**	**200,506**	**213,888**	**13,382**	**204,366**	**3,861**
					Outsourced Personnel Expenses										
694	247	(447)	308	(386)	Medical Personnel	5,458	2,224	(3,233)	2,685	(2,772)	7,404	2,965	(4,439)	3,763	(3,642)
731	91	(640)	163	(568)	Nursing Personnel	4,992	819	(4,173)	1,503	(3,489)	6,875	1,093	(5,783)	2,002	(4,873)
506	87	(418)	(19)	(525)	Allied Health Personnel	3,558	787	(2,771)	339	(3,219)	5,137	1,049	(4,088)	583	(4,554)
43	20	(23)	72	29	Support Personnel	370	183	(187)	388	18	431	244	(187)	522	91
806	159	(647)	255	(551)	Management and Admin Personnel	4,721	1,282	(3,439)	1,126	(3,595)	6,376	1,765	(4,611)	1,671	(4,705)
2,780	**605**	**(2,175)**	**780**	**(2,000)**	**Total Outsourced Personnel Expenses**	**19,099**	**5,296**	**(13,803)**	**6,041**	**(13,058)**	**26,224**	**7,116**	**(19,108)**	**8,541**	**(17,683)**
1,141	697	(444)	790	(351)	Outsourced Other Expenses	7,590	6,272	(1,318)	6,737	(853)	9,991	8,363	(1,628)	9,845	(147)
3,009	2,418	(591)	2,713	(296)	Treatment Related Costs	23,570	21,390	(2,179)	22,412	(1,158)	31,596	28,666	(2,931)	27,169	(4,427)
2,553	1,532	(1,021)	1,606	(948)	Non Treatment Related Costs	20,445	13,773	(6,671)	14,524	(5,921)	27,686	18,465	(9,221)	37,215	9,530
9,293	9,151	(143)	8,594	(699)	IDF Outflow	82,817	82,355	(462)	74,444	(8,373)	110,284	109,807	(477)	101,298	(8,985)
17,823	18,814	991	17,926	102	Other External Provider Costs	170,442	169,892	(549)	158,593	(11,849)	227,565	227,534	(31)	218,583	(8,982)
2,414	2,376	(38)	2,071	(343)	Interest, Depreciation & Capital Charge	18,769	21,390	2,621	18,845	76	26,856	28,517	1,660	25,186	(1,671)
56,778	**54,512**	**(2,265)**	**51,651**	**(5,127)**	**Total Expenditure**	**492,569**	**480,773**	**(11,796)**	**452,456**	**(40,113)**	**660,708**	**642,354**	**(18,353)**	**632,203**	**(28,504)**
(1,964)	**(1,847)**	**(117)**	**(2,362)**	**398**	**Net Result**	**(5,581)**	**(6,987)**	**1,406**	**(10,256)**	**4,675**	**(14,245)**	**(10,647)**	**(3,598)**	**(38,784)**	**24,538**
					Result by Output Class										
1,563	162	1,401	(359)	1,923	Funder	4,694	913	3,781	(1,676)	6,370	4,734	(9)	4,743	(7,889)	12,623
102	8	94	67	35	Governance	760	233	527	385	375	742	310	432	634	108
(3,629)	(2,017)	(1,612)	(2,072)	(1,558)	Provider	(11,036)	(8,133)	(2,903)	(8,966)	(2,069)	(19,721)	(10,948)	(8,773)	(31,528)	11,807
(1,964)	**(1,847)**	**(117)**	**(2,364)**	**400**	**Net Result**	**(5,581)**	**(6,987)**	**1,406**	**(10,257)**	**4,676**	**(14,245)**	**(10,647)**	**(3,598)**	**(38,784)**	**24,538**

Executive Summary – Financial Position

Financial performance year to date

- Total Revenue favourable $13,202k
- Personnel and outsourced Personnel unfavourable ($3,236k)
  - Medical unfavourable ($2,500k); Nursing unfavourable ($989k); Allied Health favourable $1,568k, Support Staff unfavourable ($972k); Management and Admin unfavourable ($343k); Annual leave Liability cost has increased by $1,467k since March 2020
- Outsourced other expenses unfavourable ($1,318k), includes Outsourced radiology and inpatient services
- Treatment related Costs unfavourable ($2,179k)
- Non Treatment Related Costs unfavourable ($6,671k), includes Holiday Act provision.
- IDF Outflow unfavourable ($462k)
- Other External Provider Costs unfavourable ($549k)
- Interest depreciation and capital charge favourable $2,621k

Analysis of Operating Position – Revenue

- **Revenue:** Total revenue favourable $2,149k for the month
  - Devolved MOH revenue $1,003k favourable, driven by a reduction in funding for capital charge offset by PHO and COVID-19 funding.
  - Non Devolved revenue ($166k) unfavourable driven largely by the Regional Breast Screening accounting for revenue in advance year to date.
  - ACC Revenue $172k favourable.
  - Other revenue $122k favourable for the month driven in CTA funding and innovation funding for bowel screening.
  - IDF inflows favourable $468k for the month, reflecting higher than expected volumes, and wash-up adjustments for 2019/20.
  - Inter DHB Revenue favourable $549k, reflecting the use of shared 2 & 3DHB services, including recoveries from CCDHB for Mental Health. There is a corresponding increase in expenditure.

COVID–19 Revenue and Costs

YTD Result -March 2021	Funder (1) (4)	Provider (excl. Regional Public Health)	Provider - Regional Public Health (RPH) (1)(3)	Total
$000s	Actual	Actual	Actual	Actual
Revenue				
MoH Revenue Recognised - COVID19 (2)	4,260	157	1,146	5,563
Expenditure				
Employee Expenses				
Medical Employees		12	89	101
Nursing Employees		38	203	241
Allied Health Employees		19	236	255
Support Employees		50	0	50
Management and Admin Employees		22	57	79
Total Employee Expenses	**0**	**141**	**585**	**726**
Expenses				
Outsourced - Provider	0	0	0	0
External Providers - Funder	5,242			5,242
Clinical Expenses - Provider	0	2	6	8
Non-clinical Expenses- Provider	0	218	78	296
Total Non Employee Expenses	**5,242**	**220**	**83**	**5,546**
Total Expenditure	**5,242**	**361**	**668**	**6,271**
Net Impact	**(982)**	**(204)**	**477**	**(709)**

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

(2) Includes funding via Whanganui DHB

(3) Excludes overhead charges

(4) Includes technology grant

- The March year to date financial position includes $6.3m additional costs in relation to COVID-19.
- Revenue of $5.6m has been received to fund additional costs for community providers and Regional Public Health.
- The net impact year to date is $0.7m additional costs currently unfunded.

Analysis of Operating Position – Personnel

- **Total Personne**l including outsourced unfavourable ($1,019k) for the month
  - Medical personnel incl. unfavourable ($208k). Outsourced costs are ($447k) unfavourable, Medical Staff Internal are $239k favourable, the MHAIDS restructure $297k.
  - Nursing incl. outsourced ($89k) unfavourable. Employee costs are $551k favourable, driven by the 3DHB MHAIDS Restructure $607k. Adverse outsourced position ($640k) is driven 3DHB MHAIDS Restructure ($617k).
  - Allied Health incl. outsourced ($53k) unfavourable, with outsourced unfavourable ($418k) and internal employees favourable $365k. Employee costs are driven by the 3DHB MHAIDS Restructure $468k, the balance is mostly due to phased recruitment of dental trainees.
  - Support incl. outsourced unfavourable ($82k), with Outsourced ($23k) unfavourable, and employee costs ($59k) unfavourable, driven by Security ($13k), Cleaners ($23k), Sterile Supply Assistants ($23k) and Tradesmen & Maintenance supervisors ($33k).
  - Management & Admin incl. outsourced unfavourable ($588k); internal staff favourable $59k, Outsourced unfavourable ($647k). This reflects the transition to 2DHB services for ITS and MHAIDS.
  - Sick leave for March was 3.5%, which is the same as this time last year.

FTE Analysis

Month					FTE Report	Year To Date					Annual	
Actual	Budget	Variance	Last Year	Variance	Mar-21	Actual	Budget	Variance	Last Year	Variance	Budget	Last Year
					FTE							
279	287	8	295	15	Medical	280	287	8	290	10	287	294
758	828	70	814	56	Nursing	766	830	64	806	40	829	818
346	418	72	415	69	Allied Health	353	417	64	391	38	417	402
148	137	(11)	144	(4)	Support	146	137	(9)	141	(5)	137	143
323	388	65	368	45	Management & Administration	323	388	65	359	35	388	365
1,854	**2,058**	**204**	**2,036**	**182**	**Total FTE**	**1,868**	**2,058**	**191**	**1,986**	**119**	**2,058**	**2,023**
					$ per FTE							
19,220	19,513	292	17,628	(1,592)	Medical	167,145	165,286	(1,859)	154,188	(12,957)	217,098	215,094
8,184	8,158	(27)	7,625	(559)	Nursing	71,146	69,531	(1,615)	68,806	(2,340)	87,395	93,878
7,854	7,375	(479)	6,942	(912)	Allied Health	61,016	62,049	1,034	60,204	(811)	69,843	85,962
5,517	5,520	3	4,897	(620)	Support	48,133	45,580	(2,553)	45,142	(2,991)	68,590	58,552
8,235	7,011	(1,223)	5,937	(2,298)	Management & Administration	62,050	59,705	(2,344)	57,993	(4,057)	70,026	84,428
9,580	**9,192**	**(389)**	**8,434**	**(1,146)**	**Average Cost per FTE all Staff**	**80,227**	**77,927**	**(2,300)**	**75,945**	**(4,282)**	**97,410**	**105,731**

Medical under budget for the month by 8 FTE, driven by the MHAIDS restructure 13FTE:
Excluding MHAIDS the contribution to movements were; SMOs under budget by 3FTE, offset by RMO's & House Officers combined.

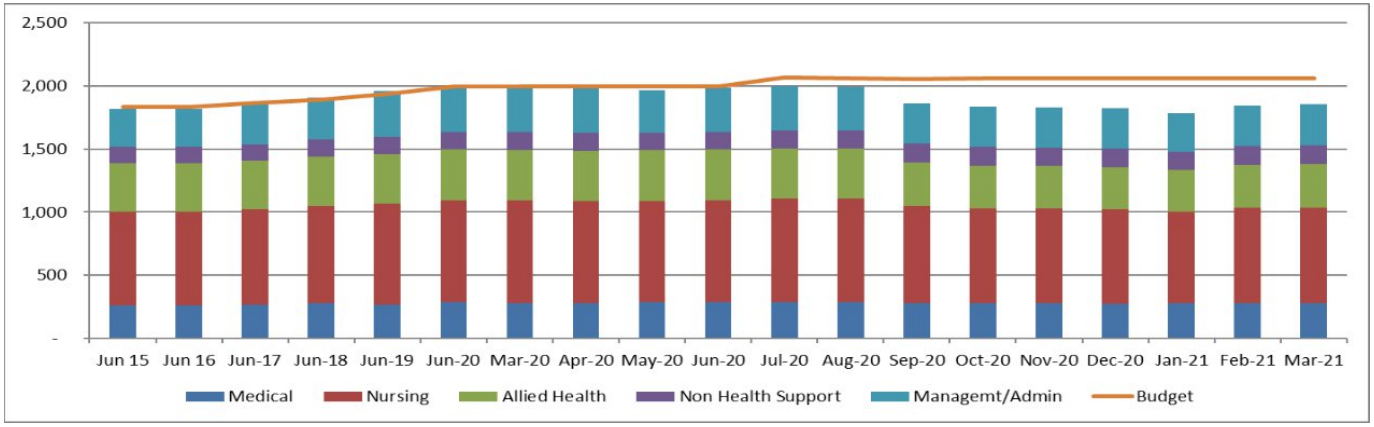
Nursing under by 70 FTE for the month, driven by MHAIDS restructure 75 FTE:
Excluding MHAIDS the movements were; Internal Bureau Nurses and HCA's over budget (24) FTE mostly driven by General Medical (7) FTE, Children's (7FTE), ED (5FTE) and other variances. This is offset by Midwives 21 FTE. This reflects the transition to changes made under both CCDM recommendations and the Maternity Review.

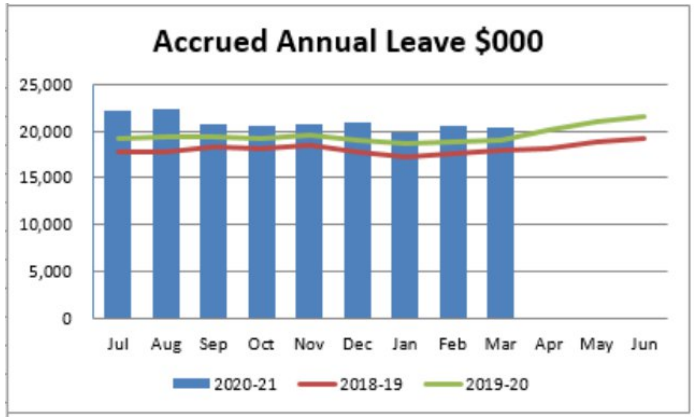
Allied FTEs are under by 72 FTEs for the month, driven by the MAHIDS restructure 62:
Excluding MHAIDS the contribution to movements were; Favourable variances in community support workers 3 FTE, Health promotion 4 FTE, Other Allied Health 10 FTE.

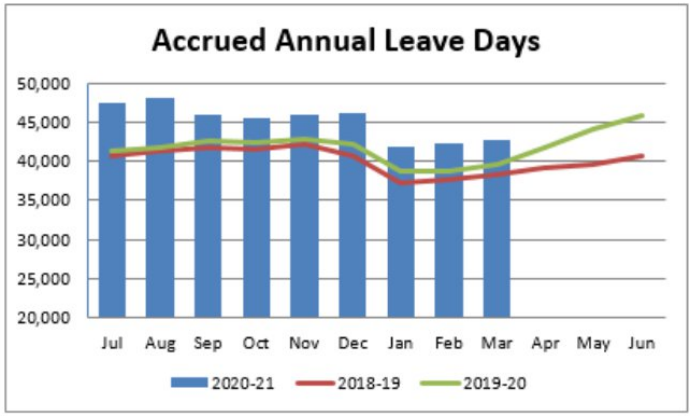
Support FTEs are (11) FTEs over budget driven by CSSD (2) FTE, Cleaning (2) FTE, Property Services (2) FTE and Orderlies (5) FTE, offset by other variances.

Management & Admin are under budget by 65 FTEs driven by the MHAIDS & ITS Restructures 40 FTE.
Excluding MHAIDS and ITS changes favourable variance of 25FTE, other variances include; Executive Office 5 FTE, Project Management 2FTE, SPP 7FTE, Quality 3 FTE, Chief operating officer 2 FTE, essential support Services 2 FTE, Surgical Women's & Children's 5 FTE, Regional Public Health 2 FTE and Regional Screening 5 FTE.

FTE Analysis







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

Analysis of Operating Position – Other Expenses

- **Other Operating Costs**
  - Outsourced other unfavourable ($447k) for the month, due to increase surgical costs at Boulcott.
  - Treatment related costs ($591k) unfavourable for March in line with the increased volumes.
  - Non Treatment Related costs unfavourable ($1,021k) including the provision for Holidays Act Settlement provision ($227k) which is not budgeted as advised by MoH, Hotel costs ($106k), Security ($78k) related mainly to COVID-19, Facilities ($82k), IT (including software) ($140k), MHAIDS ($316k), and other minor variances.
  - IDF Outflows ($143k) unfavourable for the month, driven by higher than expected volumes.
  - Other External Provider costs favourable $991k, driven largely by underspend for residential and community providers, partially offset by COVID-19 expenditure.
  - Interest, Depreciation & Capital Charge unfavourable ($38k), driven by a increase in Capital Charge for the month.

Section 5

Additional Financial Information & Updates

Financial Position as at 31 March 2021

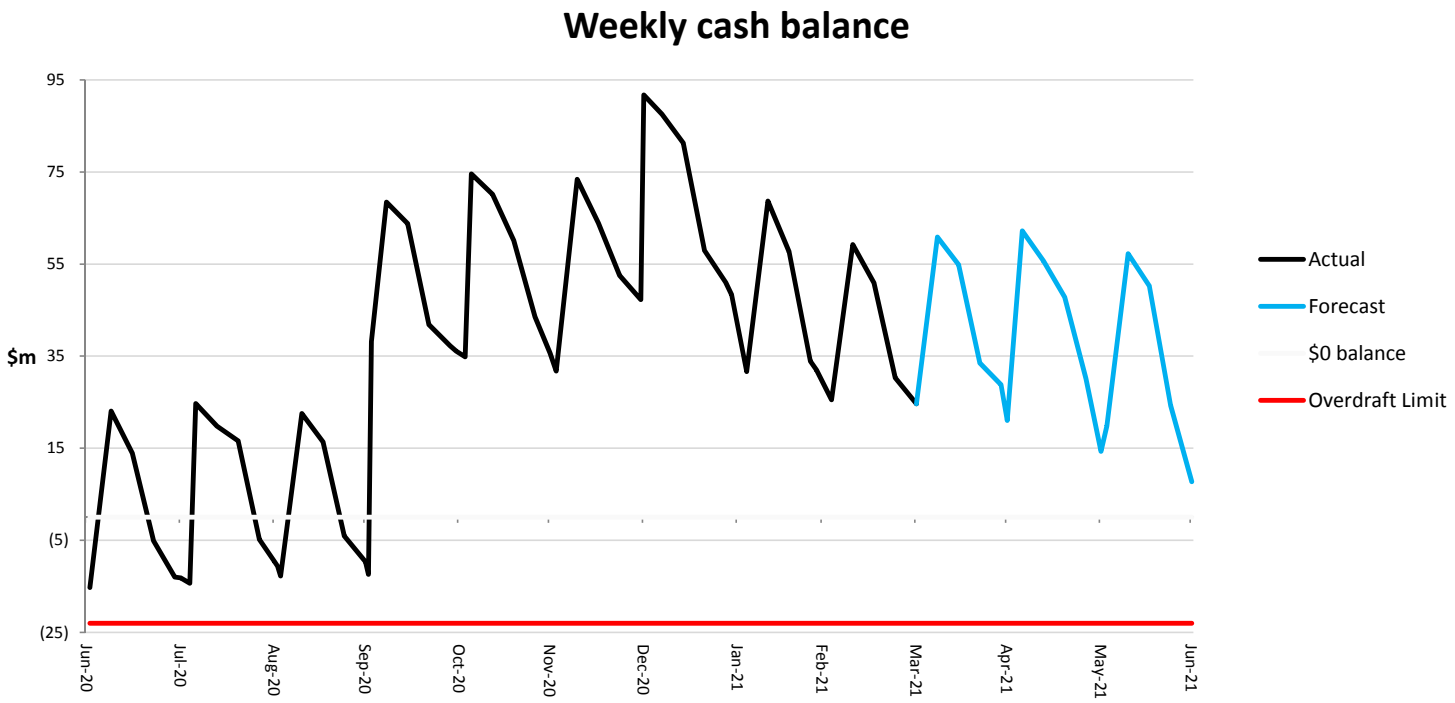
$000s	Actual	Budget	Variance	Jun 20	Variance	Explanation of Variances Between Actual and Budget
Assets						
Current Assets						
Bank	24,644	(1,248)	25,891	(10,986)	35,630	Average bank balance in Mar-21 was $44.7m ($35m equity injection received Oct-20)
Bank - Non DHB Funds *	5,352	4,927	425	4,927	425	
Accounts Receivable & Accrued Revenue	28,822	27,577	1,245	27,577	1,245	
Stock	2,095	2,200	(105)	2,199	(104)	
Prepayments	1,371	815	556	815	556	
Total Current Assets	**62,284**	**34,271**	**28,012**	**24,532**	**37,752**	
Fixed Assets						
Fixed Assets	224,791	249,722	(24,931)	229,790	(5,000)	
Work in Progress	14,338	11,001	3,337	14,001	337	
Total Fixed Assets	**239,129**	**260,723**	**(21,594)**	**243,791**	**(4,663)**	
Investments						
Investments in Associates	1,150	1,150	0	1,150	0	
Trust Funds Invested	1,301	1,347	(45)	1,347	(45)	
Total Investments	**2,451**	**2,497**	**(45)**	**2,497**	**(45)**	
Total Assets	**303,864**	**297,491**	**6,373**	**270,820**	**33,044**	
Liabilities						
Current Liabilities						
Accounts Payable and Accruals	73,468	63,564	(9,904)	73,615	147	Includes Holidays Act Provision of $29.5m
Crown Loans and Other Loans	10	42	31	42	31	
Capital Charge Payable	2,401	0	(2,401)	0	(2,401)	
Current Employee Provisions	27,590	26,018	(1,572)	26,518	(1,072)	
Total Current Liabilities	**103,469**	**89,624**	**(13,845)**	**100,175**	**(3,294)**	
Non Current Liabilities						
Other Loans	178	180	2	178	0	
Long Term Employee Provisions	8,972	8,972	0	8,972	0	
Non DHB Liabilities	5,352	4,927	(425)	4,927	(425)	
Trust Funds	1,252	1,347	94	1,347	94	
Total Non Current Liabilities	**15,755**	**15,426**	**(329)**	**15,424**	**(331)**	
Total Liabilities	**119,223**	**105,049**	**(14,174)**	**115,598**	**(3,625)**	
Net Assets	**184,641**	**192,442**	**(7,801)**	**155,222**	**29,419**	
Equity						
Crown Equity	158,916	168,123	(9,207)	123,916	35,000	Equity Deficit Support injection received $35m
Revaluation Reserve	146,289	146,289	0	146,289	0	
Opening Retained Earnings	(114,982)	(114,982)	(0)	(76,199)	(38,784)	
Net Surplus / (Deficit)	(5,581)	(6,987)	1,406	(38,784)	33,202	
Total Equity	**184,641**	**192,442**	**(7,801)**	**155,222**	**29,419**	

* NHMG - National Haemophilia Management Group

Statement of Cash Flows to 31 March 2021

$000s	Jul Actual	Aug Actual	Sep Actual	Oct Actual	Nov Actual	Dec Actual	Jan Actual	Feb Actual	Mar Actual	Apr Forecast	May Forecast	Jun Forecast
Operating Activities												
Government & Crown Agency Revenue	41,434	42,012	44,384	42,820	40,032	89,077	(1,303)	40,009	43,917	41,986	41,957	42,013
Receipts from Other DHBs (Including IDF)	9,112	10,490	8,932	18,597	8,010	13,752	6,345	9,493	10,593	10,375	10,080	10,080
Receipts from Other Government Sources	721	778	753	770	863	669	501	579	880	677	638	750
Other Revenue	1,833	1,581	(2,392)	1,408	(60)	(202)	3,478	63	(4,494)	283	280	280
Total Receipts	**53,100**	**54,861**	**51,678**	**63,595**	**48,845**	**103,296**	**9,021**	**50,144**	**50,897**	**53,322**	**52,955**	**53,123**
Payments for Personnel	(21,092)	(16,745)	(18,276)	(19,398)	(17,779)	(20,161)	(18,805)	(18,034)	(20,320)	(20,344)	(18,340)	(19,108)
Payments for Supplies (Excluding Capital Expenditure)	(4,686)	(5,368)	(4,330)	(4,464)	(3,394)	1,140	(6,009)	(12,721)	(10,312)	(5,907)	(5,816)	(5,946)
Capital Charge Paid	0	0	0	0	0	0	0	(3,868)	0	0	0	(3,868)
GST Movement	(710)	75	230	1,030	(1,535)	1,310	2,098	(4,899)	1,241	(1,000)	(2,500)	3,350
Payment to Own DHB Provider	0	(0)	(0)	(0)	120	30	30	(180)	(0)	0	0	(0)
Payment to Own DHB Governance & Funding Admin	0	0	0	0	(120)	(30)	(30)	180	0	(0)	(0)	0
Payments to Other DHBs (Including IDF)	(9,106)	(8,637)	(8,548)	(10,119)	(9,151)	(9,151)	(9,222)	(9,137)	(9,151)	(9,156)	(9,156)	(9,156)
Payments to Providers	(18,833)	(19,317)	(19,860)	(19,353)	(16,794)	(19,316)	(19,336)	(17,311)	(19,101)	(19,038)	(19,182)	(18,904)
Total Payments	**(54,427)**	**(49,991)**	**(50,784)**	**(52,305)**	**(48,652)**	**(46,177)**	**(51,274)**	**(65,970)**	**(57,642)**	**(55,444)**	**(54,994)**	**(53,631)**
Net Cashflow from Operating Activities	**(1,327)**	**4,871**	**894**	**11,290**	**193**	**57,119**	**(42,253)**	**(15,826)**	**(6,745)**	**(2,122)**	**(2,039)**	**(508)**
Investing Activities												
Interest Receipts	0	0	0	28	35	39	44	27	26	21	21	21
Dividends	0	0	0	0	0	0	0	0	0	4	4	4
Total Receipts	**0**	**0**	**0**	**28**	**35**	**39**	**44**	**27**	**26**	**25**	**25**	**25**
Capital Expenditure	(913)	(1,399)	(964)	(512)	(595)	(1,028)	(1,226)	(567)	(604)	(14,772)	(4,972)	(5,773)
Increase in Investments and Restricted & Trust Funds Assets	99	57	13	(58)	(15)	(48)	17	(8)	(11)	0	0	0
Total Payments	**(814)**	**(1,343)**	**(951)**	**(571)**	**(610)**	**(1,076)**	**(1,208)**	**(575)**	**(616)**	**(14,772)**	**(4,972)**	**(5,773)**
Net Cashflow from Investing Activities	**(814)**	**(1,343)**	**(951)**	**(542)**	**(575)**	**(1,038)**	**(1,164)**	**(548)**	**(590)**	**(14,747)**	**(4,947)**	**(5,748)**
Financing Activities												
Equity Injections - Capital	0	0	0	0	0	0	0	0	0	13,000	0	0
Equity Injections - Deficit Support	0	0	0	35,000	0	0	0	0	0	0	0	0
Total Receipts	**0**	**0**	**0**	**35,000**	**0**	**0**	**0**	**0**	**0**	**13,000**	**0**	**0**
Interest Paid on Finance Leases	(9)	(5)	(3)	(3)	(0)	(3)	(0)	0	(0)	(5)	(5)	(5)
Total Payments	**(9)**	**(5)**	**(3)**	**(3)**	**(0)**	**(3)**	**(0)**	**0**	**(0)**	**(5)**	**(5)**	**(5)**
Net Cashflow from Financing Activities	**(9)**	**(5)**	**(3)**	**34,997**	**(0)**	**(3)**	**(0)**	**0**	**(0)**	**12,995**	**(5)**	**(5)**
Total Cash In	53,100	54,861	51,678	98,624	48,880	103,335	9,065	50,171	50,923	66,347	52,980	53,148
Total Cash Out	(55,250)	(51,338)	(51,738)	(52,878)	(49,262)	(47,256)	(52,482)	(66,544)	(58,258)	(70,222)	(59,971)	(59,409)
Net Cashflow												
Opening Cash	(10,986)	(13,136)	(9,613)	(9,673)	36,073	35,691	91,770	48,352	31,979	24,644	20,769	13,778
Net Cash Movements	(2,150)	3,523	(60)	45,746	(382)	56,079	(43,417)	(16,374)	(7,335)	(3,874)	(6,992)	(6,262)
Closing Cash	**(13,136)**	**(9,613)**	**(9,673)**	**36,073**	**35,691**	**91,770**	**48,352**	**31,979**	**24,644**	**20,769**	**13,778**	**7,516**

Weekly Cash Flow – Actual to 31 March 2021



Note

- the overdraft facility shown in red is set at $23 million as at January 2021
- the lowest bank balance for the month of March was $24.6m

Summary of Leases – as at 31 March 2021

		Original Cost	Monthly Amount	Annual Amount	Total Lease Cost	Start Date	End Date	Lease type
Rental Property Leases	**Occupants**							
Wainuiomata Health Centre	District Nurses (*Lease renewal currently in negotiation)		1,149	13,787		1/11/2017	31/10/2020*	Operating
Public Trust House Lower Hutt	Community Mental Health		23,915	286,976		1/09/2017	1/09/2023	Operating
CREDS - Johnsonville	Eating Disorders		5,370	64,435		1/01/2015	Rolling lease	Operating
RPH - Porirua Public Health	RPH School Health - Promotional Health		9,088	109,055		15/03/2015	14/03/2021	Operating
Criterion Lane, Lagan Building, Upper Hutt	Physiotherapy & Counselling		2,573	30,879		5/01/2021	31/12/2023	Operating
Criterion Lane, Lagan Building, Upper Hutt	Midwives		575	6,897		16/06/2020	16/05/2023	Operating
CBD Towers Upper Hutt	Community Mental Health		9,854	118,247		8/06/2015	7/06/2021	Operating
Upper Hutt Health Centre	District Nurses		974	11,688		24/01/2015	1/02/2022	Operating
			53,498	**641,964**				
Car Park Leases								
CBD Towers Upper Hutt			542	6,500		8/06/2015	7/06/2021	Operating
			542	**6,500**				
Motor Vehicle Leases								
Motor Vehicle Lease plus Management Fees (121 Vehicles)			40,105	481,263		Ongoing	Ongoing	Operating
Custom Fleet (Nissan Leaf electrical vehicle)			556	6,671		1/10/2020	1/06/2024	Operating
			40,661	**487,934**				
Equipment Leases	**Supplier**							
MRI Ingenia 1.5T	De Lage Landen (paid monthly in arrears)		22,498	269,981	1,349,905	19/09/2019	19/08/2024	Operating
Fluoroscopy Combi Diagnost	De Lage Landen (paid monthly in arrears)		9,753	117,037	585,185	1/08/2019	31/07/2024	Operating
Plastics Micro Power Tools	Stryker New Zealand Ltd	293,188	3,490	41,884	125,652	1/10/2018	30/09/2025	Finance
Orthopaedic Tools	Stryker New Zealand Ltd		9,024	108,292	758,044	1/09/2016	31/08/2023	Operating
3 x Ultrasounds (Equigroup)	GE Healthcare Ltd		7,315	87,782	153,618	28/09/2020	28/06/2022	Operating
1 x Ultrasound Epiq (Equigroup)	Philips NZ Commercial Ltd		1,761	21,129	40,498	28/09/2020	28/08/2022	Operating
CT Scanner 128 Slice (Equigroup)	Toshiba Medical Systems		24,976	299,711	499,518	28/09/2020	28/05/2022	Operating
Philips Digital Diagnost C90	De Lage Landen (paid monthly in arrears)		7,265	87,186	435,930	31/01/2020	31/01/2025	Operating
Philips Digital Diagnost C90	De Lage Landen (paid monthly in arrears)		6,184	74,214	371,070	31/01/2020	31/01/2025	Operating
Philips Diagnost R2	De Lage Landen (paid monthly in arrears)		3,932	47,186	235,930	1/06/2020	1/06/2025	Operating
Philips Digital Diagnost C90 (ED)	De Lage Landen (paid monthly in arrears)		6,177	74,118	370,592	30/09/2020	30/09/2025	Operating
Philips Digital Diagnost C90 (Resus)	De Lage Landen (paid monthly in arrears)		3,877	46,520	232,601	31/08/2020	31/08/2025	Operating
Logiq E10 4D Ultrasound (Equigroup)	GE Healthcare Ltd		3,649	43,794	218,969	28/01/2021	28/01/2026	Operating
		293,188	**109,901**	**1,318,834**	**5,377,512**			
Total Leases			**204,602**	**2,455,232**				

Treasury as at 31 March 2021

1) Short term funds / investment ($000)

NZHP banking activities for the month	Current month ($000)	Last month ($000)
Average balance for the month	$44,684	$53,567
Lowest balance for the month	$24,634	$31,663
Average interest rate	0.68%	0.64%
Net interest earned/(charged) for the month	$26	$27

2) Hedges

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

3) Foreign exchange transactions for the month ($)

No. of transactions involving foreign currency	4
Total value of transactions	$21,284 NZD
Largest transaction	$10,737 NZD

	No. of transactions	Equivalent NZD
AUD	2	$489
GBP		
SGD		
USD	2	$20,795
Total	**4**	$21,284

4) Debtors ($000)

Top 10 Debtors	Outstanding	Current	1-30 Days	31-60 Days	61-90 Days	91-120 Days	121-180 Days	181+ Days
Capital & Coast District Health Board	$8,569	$3,777	$1,530	$283	$272	$11	$228	$2,468
Ministry of Health	$1,653	$1,489	$8	$133	$27	$18	$0	($22)
Accident Compensation Corporation	$929	$530	($25)	$4	$80	$14	$49	$278
Wairarapa District Health Board	$464	$75	$164	$1	$0	$0	($2)	$226
Health Workforce NZ Limited	$295	$295	$0	$0	$0	$0	$0	$0
ESR Limited	$112	$100	$12	$0	$0	$0	$0	$0
Southern Cochlear Implant Programme	$90	$90	$0	$0	$0	$0	$0	$0
Wellington Southern Community Laboratories	$64	$2	$0	$0	$0	($0)	($0)	$62
Estate of Crispin Gondra	$54	$0	$0	$0	$0	$0	$0	$54
Pemerika Tosoliga	$49	$0	$49	$0	$0	$0	$0	$0
Total Top 10 Debtors	**$12,280**	**$6,358**	**$1,739**	**$421**	**$380**	**$42**	**$275**	**$3,066**

Concurrent Board Information

2 June 2021

Capital & Coast DHB March 2021 Financial and Operational Performance Report

Action Required

The Capital & Coast DHB Board note:

(a) The DHB had a ($8.1m) deficit for the month of March 2021, being ($2.6m) unfavourable to budget before excluding COVID-19 and Holidays Act [2003]

(b) The DHB year to date had a deficit of ($35.1m), being ($11.4m) unfavourable to budget before excluding COVID-19 and Holidays Act [2003]

(c) In the nine months we have incurred $10.3m additional net expenditure for COVID-19 and $6m against provision for Holidays Act [2003]

(d) This means that the DHB has an overall YTD deficit of ($18.8m) from normal operations (excluding COVID-19 and Holidays Act) being $5m favourable to our underlying budget.

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

Executive Summary

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

Excluding the COVID-19 net expenses and Holidays Act [2003] provision the DHB's result for the nine months to 31 March 2021 is $18.8m deficit, versus a budget deficit of $23.8m.

Additional net COVID related expenditure above funding, year to date is $10.3m.

The monthly provision for increasing Holidays Act liability is $705k and year to date the impact on the result is $6m

For the nine months to 31 March 2021 the overall DHB year to date result, including COVID and Holidays Act costs is $35.1m deficit.

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

Capital Expenditure was $45 million year to date.

We had a negative cash Balance at month-end of $26.6 million offset by positive "Special Funds" of $13.3 million, net $13.3 million. It should be noted that there is a significant amount of the COVID response that has not been funded by the crown at this time and this has a negative cash impact on the DHB.

We know that every year the pressure on our emergency department increases with the number of people presenting, their acuity and the delays to access for inpatient care. Over winter this peaks and so each year we create winter bed plans to increase capacity by using every available space over the winter months. We are now planning for this 365 days of the year. This plan is in development with the first draft due late April.

We continue with two projects to increase capacity in a more sustainable way. Front of Whare and 2D Bed & Theatre Capacity are projects to identify and deliver solutions for implementation over the coming two years. Importantly, changes that can be made now, will be. These projects aim to increase capacity in the short term, while we continue to work on our medium-long term plan and Hospital Network configuration.

Looking at our Activity Performance report the increase in acute discharges both IDF and non IDF and elective discharges is having some impact on planned care patient flow. Both in-house elective surgical discharges and outsourced delivery are adverse to plan, the latter due to private capacity. The number of patients waiting beyond 120 days for treatment remains static; total planned care results at March month end are unfavourable to the tune of 44 discharges of plan of 968, YTD unfavourable (711) to our planned target of 8,115. Our focus remains on scheduling our longest waiting patients in all specialities, and ensuring our theatre sessions are fully utilised.

Recruitment of anaesthetists to our current vacancies another key limiting factor, a key limit is making limited progress. We are projecting a 1.5 FTE vacancy for anaesthesia SMOs - workforce numbers vary month on month due to locum cover requirements for fixed term for parental leave cover and fellowships. In addition we are anticipating future retirements later this year and early 2022 that will require replacement with permanent appointments. We continue to recruit to cover both fixed term and permanent positions.

Our Maternity Units across the region continue to struggle with midwifery vacancies and high occupancies - 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 within the national frameworks.

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

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 156 FTE above our annual budget (however note lead DHB roles).
Financial	The YTD result for the DHB was ($18.8m) deficit from normal operations, against our DHB budget of ($23.8m). An additional ($10.3m) was spend on unfunded COVID-19 costs split between the provider and funder arm, and ($6m) was recognised for Holidays Act provisions.
Governance	The Board has a responsibility to scrutinise the financial reports alongside FRAC, and report back issues as identified.

Engagement/Consultation

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

Identified Risks

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

Attachment/s

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

Capital & Coast District Health Board

Monthly Financial and Operational Performance Report

For the period ending 31 March 2021

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

- Excluding the COVID-19 net expenses and Holidays Act [2003] provision the DHB's result for the nine months to 31 March 2021 is $18.8m deficit, versus a budget deficit of $23.8m.

- Additional net COVID related expenditure above funding, year to date is $10.3m.

- The monthly provision for increasing Holidays Act liability is $705k and year to date the impact on the result is $6.0m

- For the nine months to 31 March 2021 the overall DHB year to date result, including COVID and Holidays Act costs is $35.1m deficit.

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

- Capital Expenditure including equity funded capital projects was $45m year to date.

- We had a negative cash Balance at month-end of $28.6 million offset by positive "Special Funds" of $13.2 million (net $15.4 million). It should be noted that there is a significant amount of the COVID response that remains unfunded by the crown at this time and this has a cash impact on the DHB. Overall the DHB cash balance is better than was budgeted for this point in time however the equity injection of $39.8m signalled in the 2021/22 Annual Plan will be requested for the last quarter of the year.

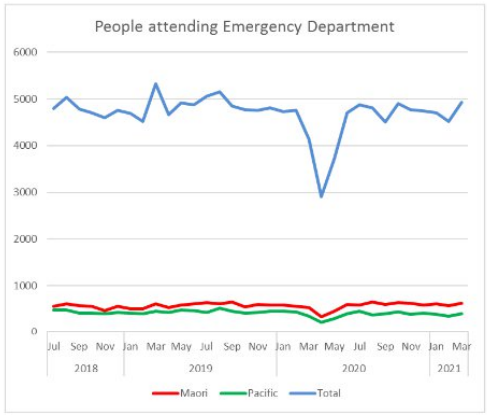
Executive Summary continued

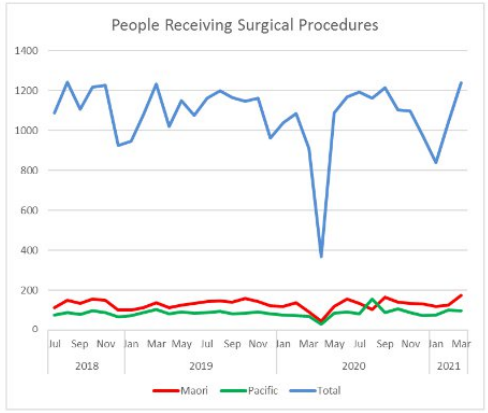
- We know that every year the pressure on our emergency department increases with the number of people presenting, their acuity and the delays to access for inpatient care. Over winter this peaks and so each year we create winter bed plans to increase capacity by using every available space over the winter months. We are now planning for this 365 days of the year. This plan is in development with the first draft due late April.
- We continue with two projects to increase capacity in a more sustainable way. Front of Whare and 2D Bed & Theatre Capacity are projects to identify and deliver solutions for implementation over the coming two years. Importantly, changes that can be made now, will be. These projects aim to increase capacity in the short term, while we continue to work on our medium-long term plan and Hospital Network configuration.
- The increase in acute discharges both IDF and non IDF and elective discharges is having some impact on planned care patient flow. Both in-house elective surgical discharges and outsourced delivery are adverse to plan, the latter due to private capacity. The number of patients waiting beyond 120 days for treatment remains static; total planned care results at March month end are unfavourable to the tune of 44 discharges cf plan of 968, YTD unfavourable (711) to our planned target of 8,115.. Our focus remains on scheduling our longest waiting patients in all specialities, and ensuring our theatre sessions are fully utilised.
- Our Maternity Units across the region continue to struggle with midwifery vacancies and high occupancies - 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 within the national frameworks.
- The provider arm remains within budget YTD outside two extraordinary items (additional costs during COVID-19 and Holidays Act Provisions) not included within the budget. Targeted efficiency measures are in place however the pressure of clinical service demands and FTE management especially around annual leave continues to be a major challenge. Leave hours taken as a percentage of FTE was less than the same time last year but annual leave balances are increasing –leave management plans are in place with a proactive approach being taken by managers and leaders.

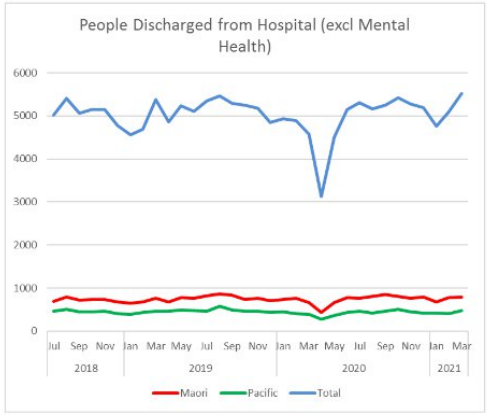
Performance Overview: Activity Context (People Served)

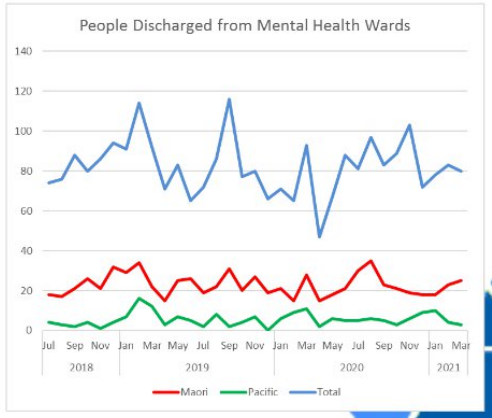
CCDHB funds services that touch thousands of people in our community every month. Unless otherwise indicated, the numbers below count individuals once and are based on CCDHB being the DHB of Service. Our services have returned to delivering services to our population without the restrictions due to COVID-19.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

People attending ED	**4,928**	627 Maori, 404 Pacific
People receiving Surgical Procedures (in main theatres)	**1,239**	175 Maori, 97 Pacific
People discharged from Kenepuru Community Hospital or Wellington Regional Hospital (excl Mental Health)	**5,525**	794 Maori, 482 Pacific
People discharged from Mental Health Wards	**80**	25 Maori, 3 Pacific



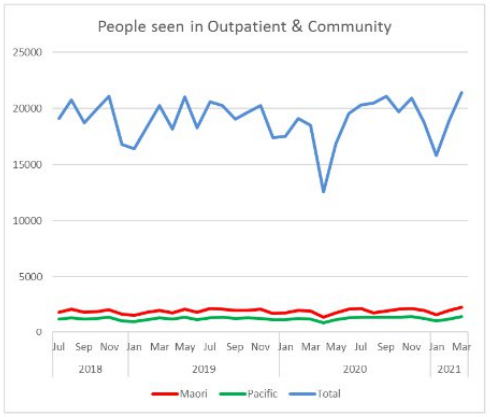


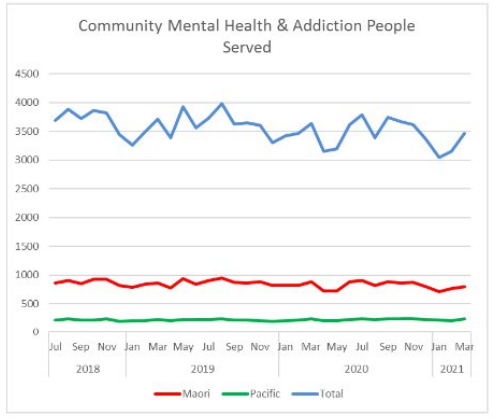


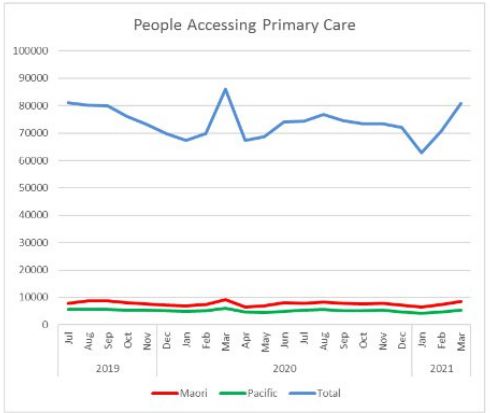


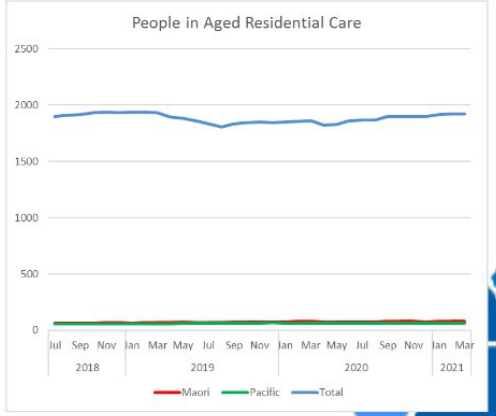
Performance Overview: Activity Context (People Served)

People seen in Outpatient & Community	**21,399**	2,251 Maori, 1,478 Pacific
Community Mental Health & Addiction People Served	**3,467**	801 Maori, 242 Pacific
People accessing primary care	**80,834**	8,423 Maori, 5,411 Pacific
People in Aged Residential Care	**1,921**	77 Maori, 62 Pacific









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Financial Overview – March 2021

YTD Operating Position	YTD Provider Position	YTD Funder Position	YTD Capital Exp
$35.1m deficit Incl. $10.3m COVID-19 costs Incl. $6.0m Holidays Act	$40m deficit Incl. $11.3m COVID-19 costs Incl. $6.0m Holidays Act	$4.2m Surplus Incl. $15m COVID-19 costs	$45m spend Incl. $24.2m strategic capex
Against a budgeted YTD deficit of $23.8m. BAU Month result was $3.0 Unfavourable. YTD $5m Favourable BAU variance.	Against a budgeted deficit of $29.6m. BAU Month result was $3.7m unfavourable. BAU YTD $5.9m favourable variance.	Against a budgeted deficit of $1.8m. BAU Month result was $1.3m Favourable result. YTD $1.6m unfavourable BAU variance.	Against a KPI of a budgeted baseline (non-strategic) spend of $49.6m. Strategic incorporates funded project such as Children's Hospital

YTD Activity vs Plan (CWDs)	YTD Paid FTE	Annual Leave Taken
0.78% ahead[1]	5,605[3]	($10.3m) annualised[4]
418 CWDs ahead PVS plan (-74 IDF CWDs , but 187 Hutt ahead). Month result +214 CWDs excluding work in progress.	YTD 156 above annual budget of 5,449 FTE (budget excludes lead DHB). There is 611 FTE vacancies at end March inclusive of lead DHB transfers.	Underlying YTD annual leave taken is under by 3.8 days per FTE and Lieu leave taken for public holidays is short by 3.2 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 1925 cwd outsourced (1055 events) ~$10.7m 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 $6.3m 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 – March 2021

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

ED (SSIED) 6 Hour rule	ESPI 5 Long Waits	Specialist Outpatient Long Waits	Serious Safety Events[2]
66.3%	530	264**	2
28.7% below the ED target of 95% Monthly +3.8%	Against a target of zero long waits a monthly movement of -13	Against a target of zero long waits, a monthly movement of -89 .**internal figures	An expectation is for nil SSEs at any point.

YTD Activity vs Plan (CWDs)	YTD Paid FTE	YTD Cost per WEIS
0.78% ahead[1]	3,668[3]	$5,821*
418 CWDs ahead PVS plan (-74 IDF CWDs , but 187 Hutt ahead). Month result +1 CWDs excluding work in progress.	YTD 8 below annual budget of 3,675 FTE. 274 FTE vacancies at month end.	Against a national case-weight price per WEIS of $5,545 (5% above).*to Dec 2020

[1] Note that the PVS (Price volume schedule for HHS/MHAIDS) is not total Surgical/Medical case-weight throughput largely due to Non-Residents & ACC. Also Outsourced PVS cases within this result cannot yet be compared to target, however a total of 1925 cwd outsourced (1055 events) ~$10.7m 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 $1.1m adverse

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

Section 2.1

Funder Performance

Executive Summary – Funder Performance

- Overall the funder has a unfavourable variance of ($1.6m). Revenue is $15m ahead of budget most of which is mainly due to CCDHB having additional COVID accrued revenue of $16.4m. This includes additional revenue for Pharmaceuticals to offset the effect of COVID in the unstable international market. Offsetting COVID costs are ($14m). Recovery of all costs remains the subject of negotiations with MoH seeking a full cost recovery. The ongoing demand for managed isolation facilities, and community surveillance will continue. Vaccination rollout started in March 2021. A funding recovery model has been received from MoH.
- An amount of ($2.2m), was not paid to the Provider Arm due to under achievement of the IDF targets at YTD Mar 2021. Reduced revenue of ($2.9m) from the Ministry for capital charge costs offsets a reduced cost in the Provider Arm.
- Funding for community services are ($7.6m) unfavourable with Pharmaceuticals being ($7.1m) over budget. Of this overspend $4m is an unplanned budget saving that will not be achieved. The year end position will reflect the impact of COVID related costs. Age residential care reflects the impact of stronger homecare support services and models of care for older people. Primary care demand driven services such as vaccination, urgent dental and other services are also underspent reflecting the impact of COVID.
- There remains risk in the loss of inter-district flow revenue, planned care for the provider arm and pharmaceutical costs in a post-covid environment. All of these elements are being closely managed.
- The COVID Vaccine programme is progressing well and in line with MoH targets. There is a strong focus on equity for Māori and for our Pacific and Disability communities.
- 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 are strengthening referral pathways to smoking cessation services through the Maternal Quality and Safety Programme, instituting 6-monthly smoking cessation training for LMCs, and increasing the visibility of Hapū Ora service on the maternity wards. From April 2021 our Hapū Ora service will be able to offer nicotine replacement therapy directly to their clients as an additional support tool.
  - The total 12-month immunisation coverage was at or above 95% for all ethnicities, meaning that while some children were delayed, they did ‘catch up.’
  - The WCTO Quality Improvement Network meets regularly to discuss opportunities to increase engagement with children in the first year of life. We are investing in wrap around services for Māori and Pacific families.
  - We are working on ED waiting times through community responses to population drivers alongside approaches to redesign the Front of Whāre (ED and acute assessment units) to facilitate delivery of contemporary models of care and ensure facilities are appropriately sized to meet demand.
  - Our ED attendances are becoming more complex. In February 2021, Wellington ED treated 99 more triage 1 & 2 patients, 160 more triage 3 patients, and 237 fewer triage 4 & 5 patients compared to 2019. Presentations by children and medical patients are below expected for this time of year, and older people are presenting at the same rate. Surgical patients are increasing in both volume and proportion of patients seen.

Funder Financial Statement of Performance

Month					Capital & Coast DHB	Year to Date				
			Variance		**Funder Result - $000**				Variance	
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	**Mar 2021**	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year
72,885	72,885	68,138	0	4,747	Base Funding	655,965	655,965	613,243	0	42,722
4,880	4,665	6,199	215	(1,319)	Other MOH Revenue - Funder	41,483	41,984	47,047	(501)	(5,564)
2,173	0	0	2,173	2,173	COVID Revenue from MOH	16,345	0	0	16,345	16,345
106	45	72	61	35	Other Revenue	1,217	408	854	809	363
2,937	2,936	2,743	1	194	IDF Inflows PHOs	27,073	26,423	25,105	650	1,968
18,407	18,517	16,489	(109)	1,919	IDF Inflows 20/21 Wash-up Prov	164,256	166,649	151,260	(2,393)	12,996
101,389	**99,048**	**93,640**	**2,341**	**7,749**	**Total Revenue**	**906,339**	**891,429**	**837,509**	**14,910**	**68,830**
					Internal Provider Payments					
824	824	958	0	134	DHB Governance & Administration	7,413	7,413	8,623	0	1,210
54,836	54,815	47,553	(21)	(7,284)	DHB Provider Arm Internal Costs - HHS	474,962	476,880	428,453	1,918	(46,509)
7,767	7,752	8,836	(16)	1,069	DHB Provider Arm Internal Costs - MH	69,907	69,764	78,872	(143)	8,965
1,311	1,942	2,118	631	807	DHB Provider Arm Internal costs - Corp	10,921	13,688	17,928	2,767	7,007
547	0	0	(547)	(547)	DHB Provider Arm Internal costs - COVID	2,090	0	0	(2,090)	(2,090)
65,285	**65,332**	**59,465**	**47**	**(5,821)**	**Total Internal Provider**	**565,293**	**567,745**	**533,876**	**2,452**	**(31,417)**
					External Provider Payments:					
5,284	5,703	5,698	418	414	- Pharmaceuticals	58,393	51,325	52,672	(7,068)	(5,721)
6,693	6,645	6,451	(48)	(242)	- Capitation	60,298	59,807	57,523	(491)	(2,774)
7,240	7,354	7,077	114	(164)	- Aged Care and Health of Older Persons	64,782	66,190	63,025	1,408	(1,757)
3,122	2,862	2,566	(260)	(556)	- Mental Health	26,728	25,758	22,287	(970)	(4,441)
1,166	807	710	(359)	(456)	- Child, Youth, Families	7,637	7,264	6,217	(373)	(1,420)
431	851	713	420	282	- Demand driven Primary Services	4,934	5,608	5,008	675	74
2,661	2,356	2,089	(305)	(572)	- Other services	21,592	21,207	20,418	(385)	(1,174)
3,727	3,725	3,456	(1)	(271)	- IDF Outflows Patients to other DHBs	33,540	33,528	29,836	(12)	(3,704)
5,253	5,240	4,944	(13)	(309)	- IDF Outflows Other	47,600	47,160	44,649	(440)	(2,951)
35,578	**35,545**	**33,704**	**(33)**	**(1,873)**	**Total External Providers**	**325,504**	**317,848**	**301,635**	**(7,656)**	**(23,869)**
1,075	0	914	(1,075)	(161)	- COVID in Community PHO, Pharms, ARC	11,328	0	914	(11,328)	(10,414)
101,939	**100,877**	**94,083**	**(1,061)**	**(7,694)**	**Total Expenditure**	**902,125**	**885,593**	**836,425**	**(16,532)**	**(65,700)**
(550)	**(1,829)**	**(443)**	**1,280**	**(107)**	**Net Result**	**4,213**	**5,836**	**1,084**	**(1,622)**	**3,130**

Funder Financials – Variance Explanations

Revenue

SPP Funder Revenue Variances	Mth $000's	YTD $000's
COVID-19 Community funding	1,658	11,136
COVID-19 Pharmaceuticals	347	3,119
COVID-19 Managed in Quarantine	169	2,091
PHOs volume change funding	86	1,360
Mental Health, Aged Care, Family CFAs	310	2,310
CWD IDF 2020/21 below target	99	(2,162)
Capital Charge reduced funding	(327)	(2,943)
Year to Date Revenue Variances	**2,341**	**14,910**

External Revenue Variances

- COVID-19 actual funding and accrued provision of $16.3m YTD is in support of GP assessment testing, pharmaceutical costs, quarantine hotel staffing plus response funding for Maori and Pacific groups. Cost offsets currently exceed paid funding. Ongoing discussions with the Ministry indicate that the DHB will be fully funded for all COVID community costs.

- PHO funding wash-ups and volume funding of $1.4m. There are increased costs of ($1.1m) offsetting this revenue. New funding for Mental Health and Child & Youth services of $2.3m has been contracted to NGO Providers.

Internal Revenue Variances

- Provision for 20/21 IDF wash up revenue is down by ($2.2m) due to Provider Arm not achieving the targets set. The ministry reduced the capital charge funding due to a reduction in the interest rate charged. YTD reduction is ($2.9m).

Payments to Internal and External Providers

SPP Funder Payment Variances	Mth $000's	YTD $000's
COVID-19 Community funding	(1,075)	(11,240)
Pharms increased volumes incl COVID	865	(3,046)
Pharms savings not achieved	(447)	(4,022)
COVID-19 MIQ HHS	(169)	(2,091)
PHOs volume variances offset	(132)	(1,073)
Other Community NGOs	(529)	(167)
CWD PVS below target	99	2,162
Capital Charge reduced funding	327	2,943
Year to Date Payment Variances	**(1,061)**	**(16,532)**

External Provider Payments:

- Community COVID-19 costs paid ($11.3m) mainly due to ongoing GP test assessment claims in support of the COVID-19 response as directed by the Ministry.
- Pharmaceuticals costs have been impacted by COVID-19 with increasing costs unfavourable to budget by ($3m). The DHB has received additional COVID funding which offsets this cost pressure. The DHB had budgeted for pharmaceutical savings in 2020/21 pre COVID. Budgeted YTD savings of ($4m) have not been achieved.
- PHO Capitation expenses are ($1.1m) unfavourable. Additional costs due to volume changes are offset by additional revenue. Effect is expected to be neutral at year end.
- Other Community NGO contracts have a net YTD variance of ($167k). New funded NGO contracts offset lower volume trends due to COVID in NGO contracted services such as immunisations and aged care costs.

Internal Provider Payments:

- An amount of $2.2m, was not paid to the Provider Arm due to under achievement of targets at YTD Mar 2021. Reduced capital charge funding of $2.9m as per the Ministry has been passed through to Provider. Provider has been paid for MIQ provisional costs of ($2.1m).

Inter District Flows (IDF)

IDF Inflow Categories Variance to Budget Target	YTD March 2021 $000's
Inpatient CWD	-408
Outpatient Non DRG	-465
PCT Pharms	-1,289
PHO Volume changes	558
Other IDF Inflows	-139
Total per Financials	**-1,743**

Inter District Revenue Inflows

We have recognised changes in IDF inflows which has resulted in an unfavourable variance of ($1.7m) YTD, a ($100k) increase to last month. Breakdown of the variance commented below:

- Inpatient Case weight IDF inflows are unfavourable by ($408k) which is driven by lower elective IDF flows.
- The majority of the lower IDF inflows (actuals) are caused by planed care inpatient lower volumes:
  - Acute: ($108k): Cardiology ($1.3m), followed by Gen Med ($660k) and Oncology ($650k). Offset by Cardiothoracic $940k (with significant outsource earlier in the year), NICU $1.6m, Neuro $895k
  - Planned Care: ($299); Vascular $920k, followed by Cardiology $603k & Paediatric $471k offset by Cardiothoracic ($1.4m), Orthopaedic ($366k) & General Surgery ($352k)
- Outpatient Non DRG inflow relates to all IDF patient visits that do not require a overnight stay
- PCT Pharms under target inflow is offset by a equivalent reduction in Pharmaceutical expenditure causing a nil impact on the bottom line
- PHO Volume change inflows relates to a increase in PHO enrolments through a quarterly wash-up by the Ministry

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

Commissioning: Families & Wellbeing

What is this measure?

- 90% of children living in smoke-free homes at 6 weeks
- 95% of children fully immunised at 8 months
- 90% of children receiving all WCTO contacts in the first year of life

Why is this important?

The early years of life set the foundation for lifelong health and wellbeing:

- Reducing infant exposure to smoking requires an integrated approach between maternity, community and primary care and a focus beyond maternal smoking to the home and whānau environment.
- Immunisation rates at age 8 months are a measure of timely protection against whooping cough and other vaccine-preventable diseases.
- The WCTO programme is a package of universal health services offered free to all New Zealand families/whānau for children from birth to 5 years.

How are we performing?

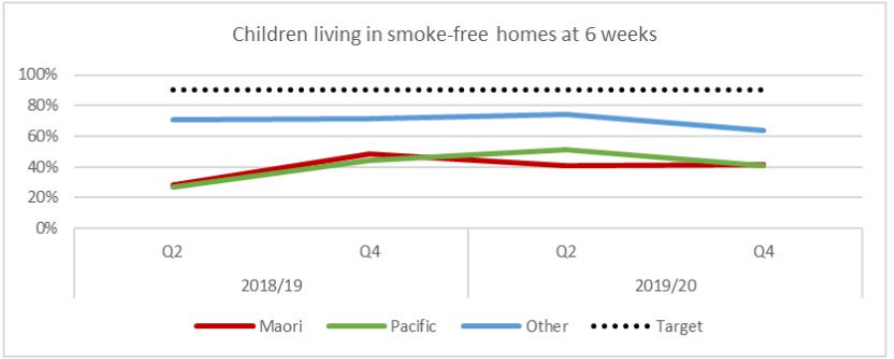
- The proportion of children living in smoke-free homes at 6 weeks is consistently below target for all groups, and is significantly lower for Māori (42%) and Pacific (41%). Rates have been decreasing overall.
- The 95% immunisation target was not met for Māori and Pacific. To meet the total 95% target , 11 children needed to be vaccinated. 15 children not vaccinated due to declines.
- The number of children receiving all of their core WCTO contacts in the first year of life is below target for all groups and significantly lower for Māori and Pacific children (68% and 64% respectively).

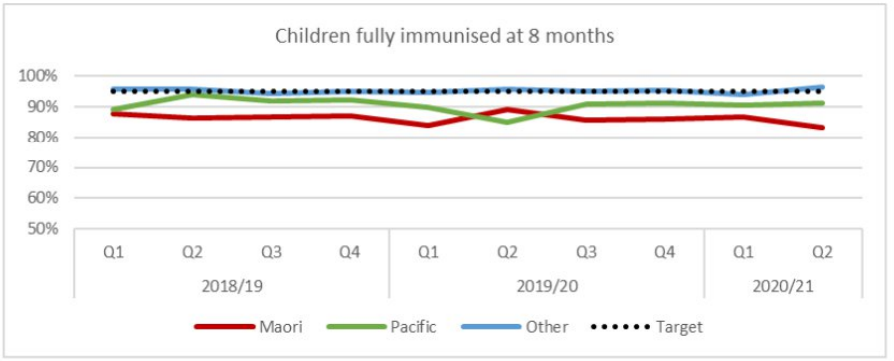
What is driving performance?

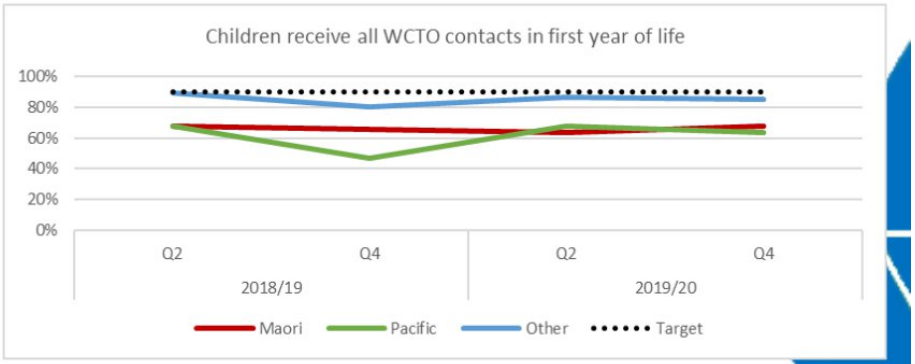
- Engagement with the full set of WCTO visit in the first year of life is challenging and CCDHB is one of the highest performing DHB for this metric across all ethnicities.

Management comment

- We are strengthening referral pathways to smoking cessation services through the Maternal Quality and Safety Programme, instituting 6-monthly smoking cessation training for LMCs, and increasing the visibility of Hapū Ora service on the maternity wards. From April 2021 our Hapū Ora service will be able to offer nicotine replacement therapy directly to their clients as an additional support tool.
- The total 12-month immunisation coverage was at or above 95% for all ethnicities, meaning that while some children were delayed, they did 'catch up.'
- The WCTO Quality Improvement Network meets regularly to discuss opportunities to increase engagement with children in the first year of life. We are investing in wrap around services for Māori and Pacific families.







Commissioning: Primary & Complex Care

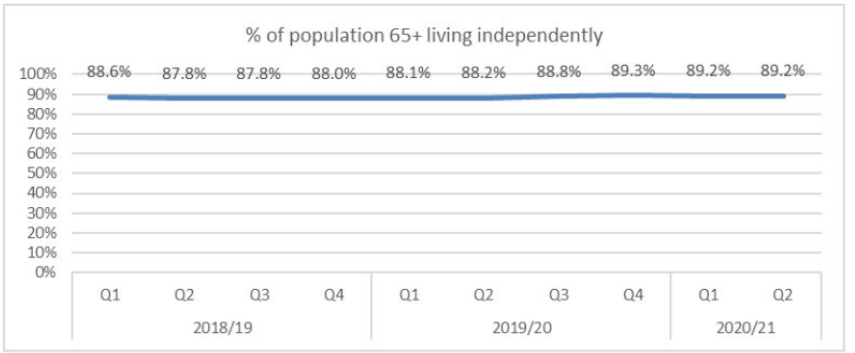
What is this measure?
Older people & frailty
- % of population living at home independently
- % supported to live at home
- Acute bed day rate per 1000 (65+)

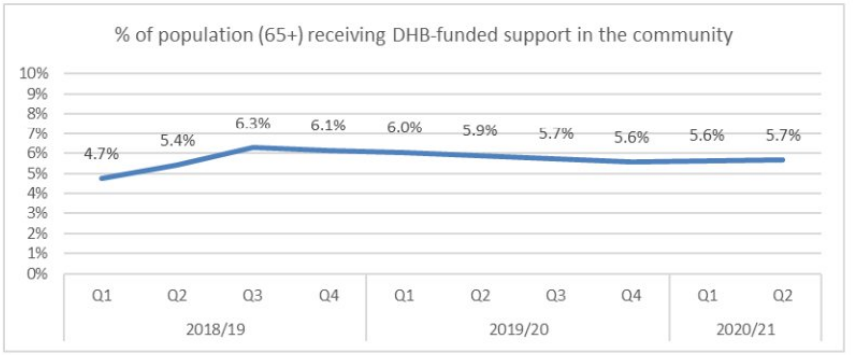
Why is this important?
- A significant pressure on CCDHB's health system over the next 15 years is its ageing population.
- We can support older people to maintain their independence through prevention and early intervention activities using a range of community-based supports. These investments can improve quality of life for individuals, and reduce demand on costly health services that have limited capacity.

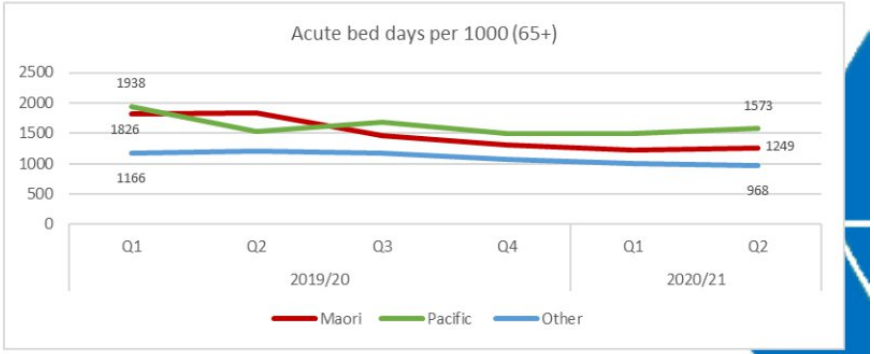
How are we performing?
- 89% of older people (65+ years) are living at home without support.
- 6% of older people (65+ years) receive DHB-funded support in the community to continue living at home.
- Acute bed days for 65+ year olds are decreasing but are higher for Māori and Pacific.

What is driving performance?
Initiatives CCDHB has invested in to support frailty across the whole of system include:
- **Community Health of Older People Initiative (CHOPI):** Geriatricians and Nurse Practitioners support primary care practitioners with advice and same day home visits to avoid hospital admission. Cost of $928 per person saving $5,500 for each admission averted.
- **Acute Health of Older People (AHOP):** Inpatient care model moving frail people through the system faster from ED (90 minutes quicker) and reduced LOS
- **Early Supported discharge (AWHI):** Patients are supported home sooner through a restorative model. In 2019/20 525 bed days were saved at a saving exceeding $1m.
- **Community Acute response Services (CARS):** Prototyped in Kāpiti to support primary care in avoiding ED presentations using ambulance diversion. This cost effective initiative for frailty management. Marginal cost savings are $60,000.

Management Comment
- Our main lever to reduce demand is to invest in community HCSS and community organisations to support frail elderly at home for longer. This funding has been stable for the last three years and allows for in-between travel and pay equity. Investment in HCSS is required in order to support people to remain at home for longer. ARC is the highest cost care option and ARC expenditure is going down against our population suggesting we are supporting more people to live at home for longer







Commissioning: Mental Health & Addictions

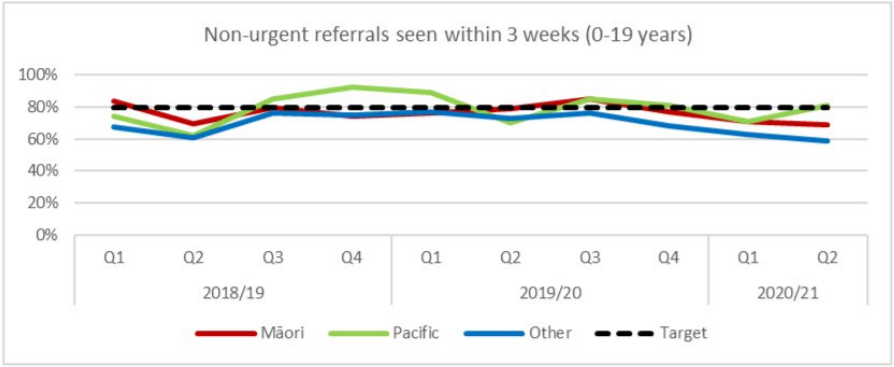
What is this measure?
- ≥80% of non-urgent referrals seen within 3 weeks
- Number of patients admitted for more than 14 days
- Number of people aged 0-19 years referred to AOD services

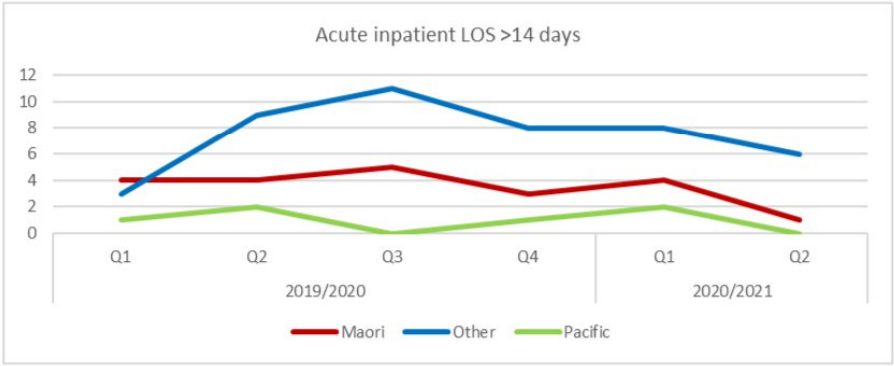
Why is this important?
- The time between a referral being created and first activity is critical to reducing patient distress and managing caseloads. Further, timely care can improve outcomes through early intervention.
- The demand for acute inpatient services is growing along with waitlist sizes.
- With no AOD service designed for those aged 0-19, we are seeing a large proportion of youth presenting at EDs for AOD-related reasons, highlighting unmet need.

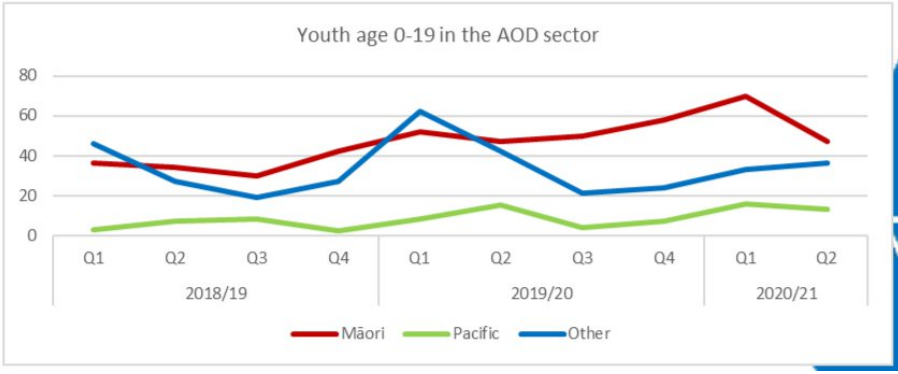
How are we performing?
- Non-urgent referrals seen within 3 weeks for 0-19 year olds have been below target and decreasing for all groups. Wait-times have been consistently below target for Māori; at 69% in Q2.
- The number of people staying over 14 days as an acute mental health inpatient has decreased slightly for all groups. However, the overall volume change is small.
- Youth are currently under-represented in the AOD sector but there are a higher number of Māori youth using AOD services.

What is driving performance?
- An aim of the **3DHB Acute Care Continuum project** is to increase access to Crisis Respite services as an alternative to acute inpatient care or earlier discharge pathways.
- We are developing a **3DHB Model of Care for Addictions** to support improved health outcomes in our priority populations. Establishment of a new investment in primary and community mental health service will also provide greater access for youth and adult clients.

Management comment
- We are developing smart systems as a key enabler of effective service delivery (e.g. the Te Haika system upgrade).
- We actively look at flow through our CAMHS services, and have been provided with some specific training from Werry Workforce on this to assist us in managing flow within our teams as effectively as possible.
- CAMHS teams undertake work with families prior to meeting the youth client which is counted as the first face-to-face activity.







2DHB COVID-19 Response

What is this measure?
- Vaccination roll-out

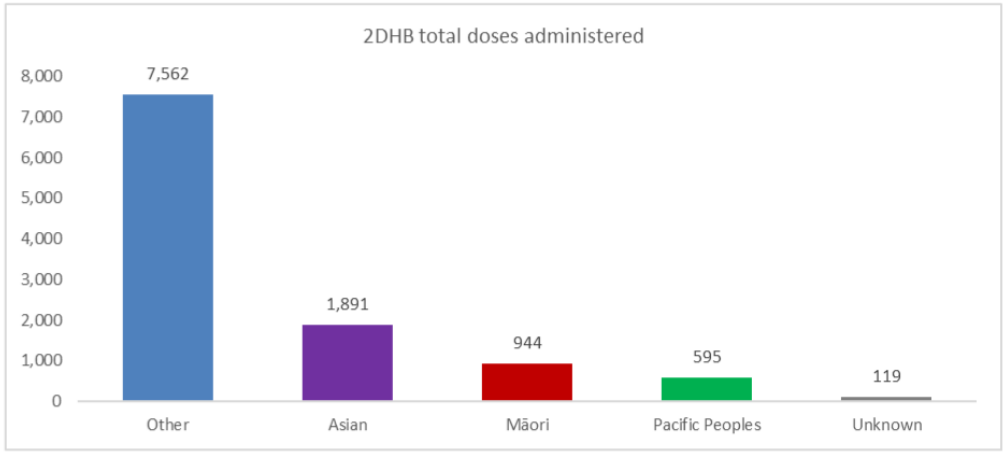
Why is this important?
- The COVID-19 vaccine rollout aims to protect Aotearoa by ensuring that everyone over 16 years old receives the two doses. Ensuring equal access to free COVID-19 vaccines is a priority for New Zealand.
- First we are protecting those most at risk of catching COVID-19 in their workplace to reduce the risk of future outbreaks and lockdowns.

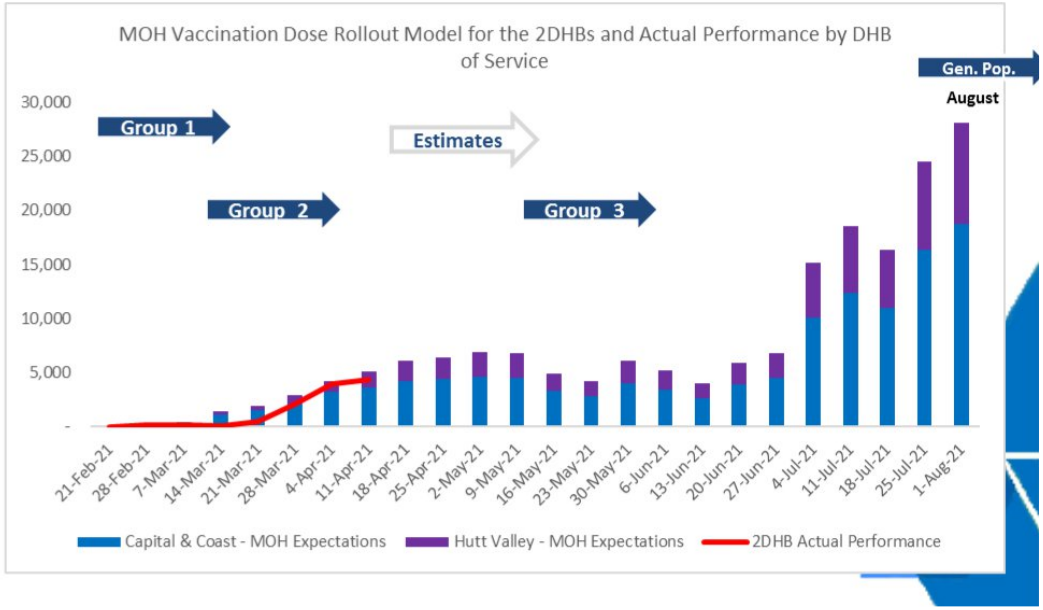
How are we performing?
- **Group 1:** Border, MIFQ workers and people they live with: **1,416 vaccinations**
- **Group 2:** Frontline health workforce interacting with patients, frontline health workforce supporting in high-risk places, at-risk people living in high-risk settings: **8,126 vaccinations**
- **Group 3:** people who are 65 years or older, people with underlying conditions, disabled people, people in custodial settings

2DHB group		Dose 1	Dose 2	% complete*
Group 1	Border Worker	1,088	328	60%
	Household	1,030	71	7%
Group 2a	DHB workforce	5,152	17	0.2%
	Community workforce	2,923	1	0.02%
Group 2b	Elevated Risk	33	0	0%
Group 3		Planned start date May 2021		

*Coverage rates are dependent on the 3-week cycle

Data Sources: COVID-19 Vaccination Events (MOH Qlik)
Date Range: 22/02/2021 to 10/04/2021
Data current at: 11/04/2021 @1:16PM





Commissioning: Hospital & Speciality Services

What is this measure?

- Triage priority of ED presentations
- Presentations to ED for children & youth and older people
- General adult surgical admissions from Wellington ED

Why is this important?

- One of our strategic priorities is to ensure our people presenting acutely to hospital receive timely access to assessment, treatment and discharge/admission to wards (*Acute inpatient hospital flow*).

How are we performing?

- In February 2021, Wellington ED treated 99 more triage 1 & 2 patients, 160 more triage 3 patients, and 237 fewer triage 4 & 5 patients compared to 2019.
- Presentations by children and medical patients are below expected for this time of year, and older people are presenting at the same rate.
- Surgical patients are increasing in both volume and proportion of patients seen.

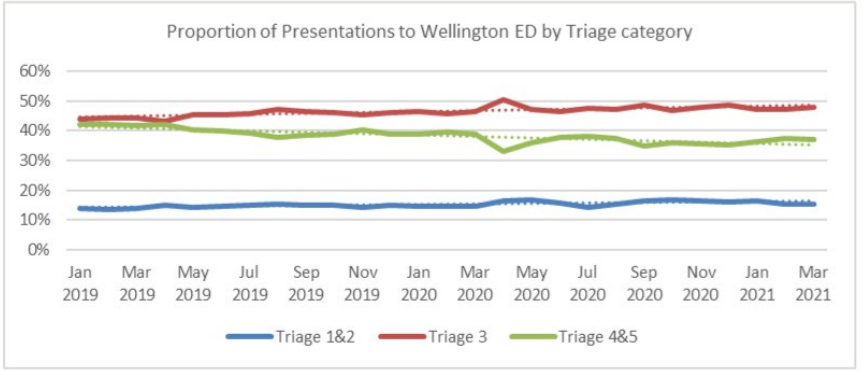
What is driving performance?

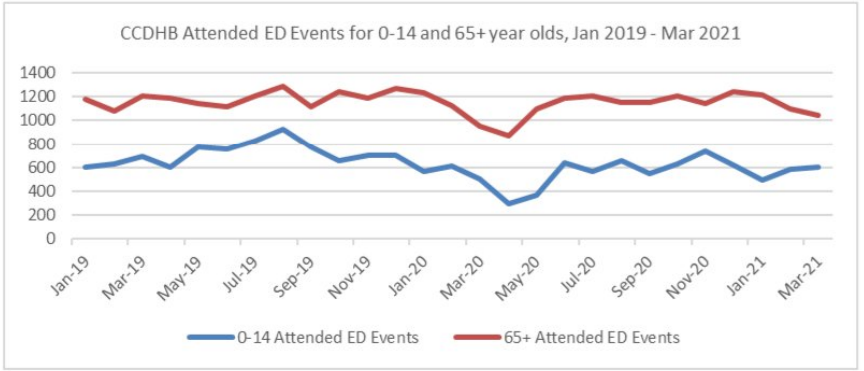
- People presenting to our Emergency Departments presenting at a higher acuity compared to the same time in recent years.
- Increasing surgical presentations is causing increased displacement of elective surgeries as acute cases require urgent treatment. This acute displacement is impacting the DHBs' ability to deliver planned care.

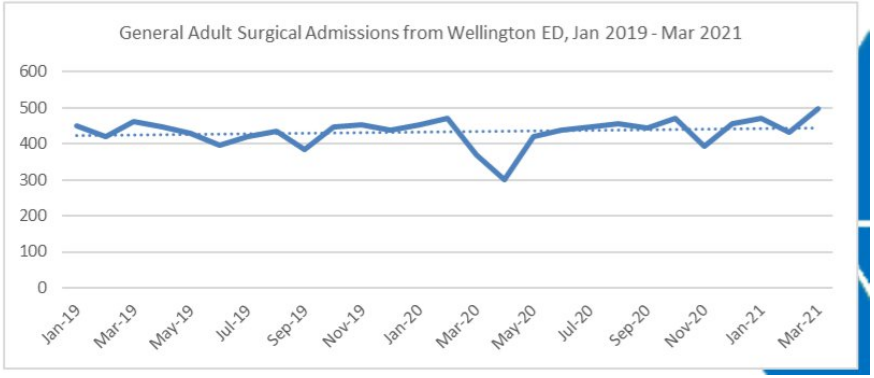
Management comment:

A range of strategies are in place to mitigate acute demand in both community and hospital settings:

- **Community initiatives to manage in-flow:** we are developing our community responses to population drivers alongside approaches to maximise the productivity and efficiency of our hospital system, including: ambulance diversion initiative (CARS), services that address demand for our ageing population (CHOPI, AHOP & AWHI).
- **Hospital initiatives to improve in-hospital flow:** our Front of Whāre (ED and acute assessment units) project is underway. This project in on track to identify how we can use contemporary models of care and appropriately configured facilities to meet demand. In parallel we are exploring our short and medium term options for expansion of bed and theatre capacity. These options are being developed within the context of the Hospital Network programme.







Section 2.2

Hospital Performance

Executive Summary – Hospital Performance

- We know that every year the pressure on our emergency department increases with the number of people presenting, their acuity and the delays to access for inpatient care. Over winter this peaks and so each year we create winter bed plans to increase capacity by using every available space over the winter months. We are now planning for this 365 days of the year. This plan is in development with the first draft due late April.
- We continue with two projects to increase capacity in a more sustainable way. Front of Whare and 2D Bed & Theatre Capacity are projects to identify and deliver solutions for implementation over the coming two years. Importantly, changes that can be made now, will be. These projects aim to increase capacity in the short term, while we continue to work on our medium-long term plan and Hospital Network configuration.
- Looking at our Activity Performance report the increase in acute discharges both IDF and non IDF and elective discharges is having some impact on planned care patient flow. Both in-house elective surgical discharges and outsourced delivery are adverse to plan, the latter due to private capacity. The number of patients waiting beyond 120 days for treatment remains static; total planned care results at March month end are unfavourable to the tune of 44 discharges cf plan of 968, YTD unfavourable (711) to our planned target of 8,115. Our focus remains on scheduling our longest waiting patients in all specialities, and ensuring our theatre sessions are fully utilised.
- Recruitment of anaesthetists to our current vacancies another key limiting factor, a key limit is making limited progress. We are projecting a 1.5 FTE vacancy for anaesthesia SMOs - workforce numbers vary month on month due to locum cover requirements for fixed term for parental leave cover and fellowships. In addition we are anticipating future retirements later this year and early 2022 that will require replacement with permanent appointments. We continue to recruit to cover both fixed term and permanent positions.
- Our Maternity Units across the region continue to struggle with midwifery vacancies and high occupancies - 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 within the national frameworks.
- The provider arm remains within budget YTD outside two extraordinary items (additional costs during COVID-19 and Holidays Act Provisions) not included within the budget. Targeted efficiency measures are in place however the pressure of clinical service demands and FTE management especially around annual leave continues to be a major challenge. Leave hours taken as a percentage of FTE was less than the same time last year but annual leave balances are increasing –leave management plans are in place with a proactive approach being taken by managers and leaders.

CCDHB Contract Activity Performance

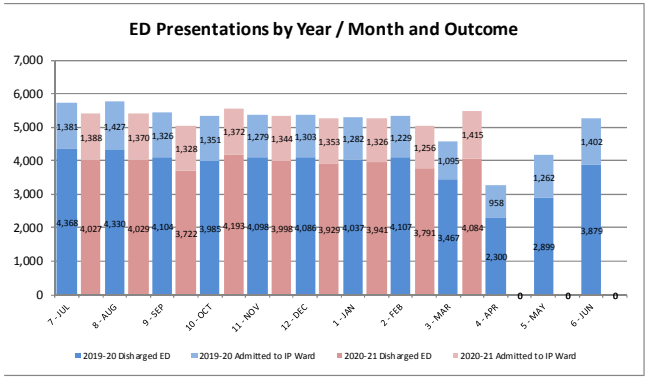
Capital and Coast DHB: March 2021

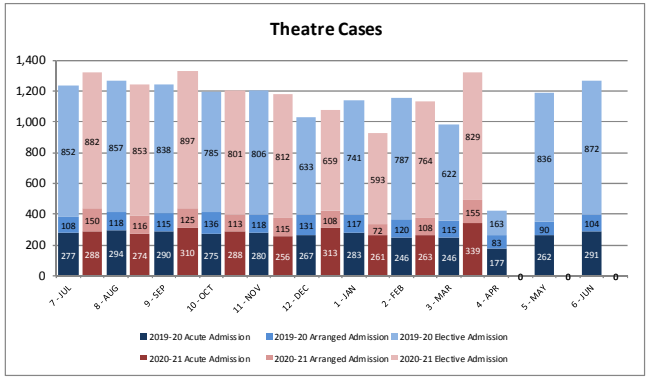
ED Presentations

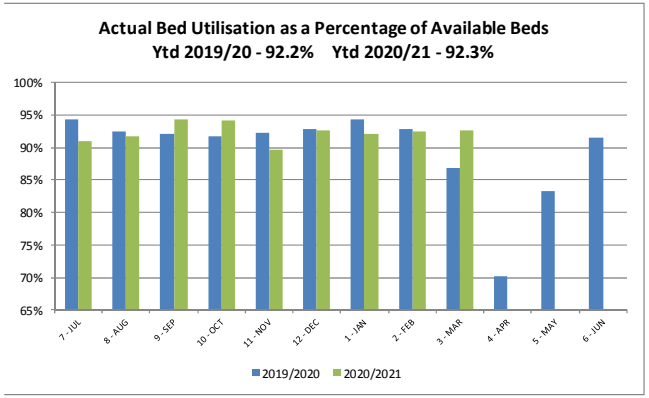
	2019/20	2020/21
YTD Totals	48,255	47,866
Change		-389
% Change		-1%

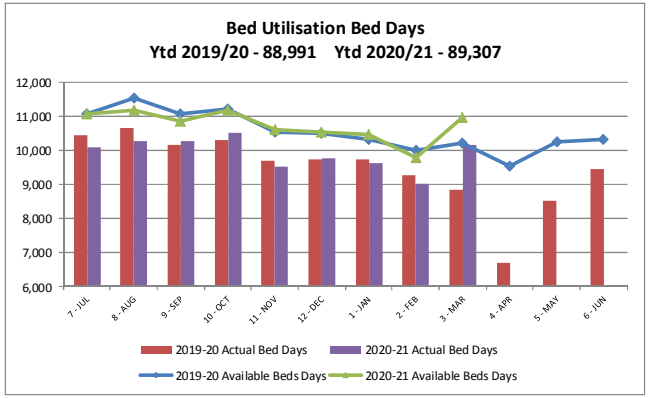
Theatre Cases

	2019/20	2020/21
YTD Totals	10,457	10,744
Change		287
% Change		3%









- The total number of presentations to ED in March 2019 was 5,456, March 2020 was 4,285 and ED in March 2021 was 5,010
- For context the average number of daily presentations in February 2021 was 180 per day compared to 178 in March 2021.
- In terms of March 2021 what was significant in respect of the complexity of the patient mix was that ED experienced the second highest number of triage 3 presentations (2,630) in a single month. Withstanding Triage 3 the average daily mix of Triage presentations was consistent with previous months.
- The utilisation of available of adult beds in core wards in March 2021 is 92.6% which is consistent with the rates recorded in December 2020 (92.7%), January 2021 (92.0%) and February 2021 (92.4%).
- The number of Elective theatre cases has decreased for the month of March 2021 by 7.2% (69 cases) when compared to March 2019. The decreases are spread across a number of specialties in particular Gynaecology (27), Orthopaedics (20) and General Surgery (14) but countered by increases in Dental (11) and ENT (10).
- This has had a significant impact on our planned care programme – refer planned care

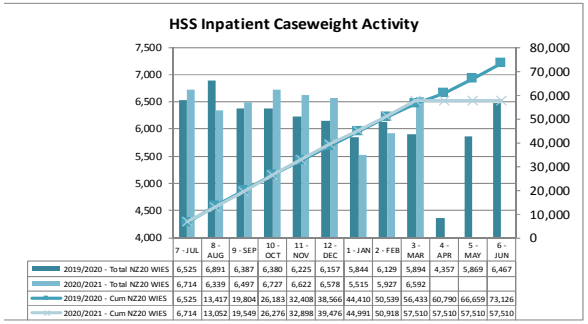
CCDHB Activity Performance

Capital and Coast DHB: March 2021

HSS Inpatient Caseweight Activity

	2019/20	2020/21
YTD Totals	56,433	57,510
Change		1,077
% Change		1.9%

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

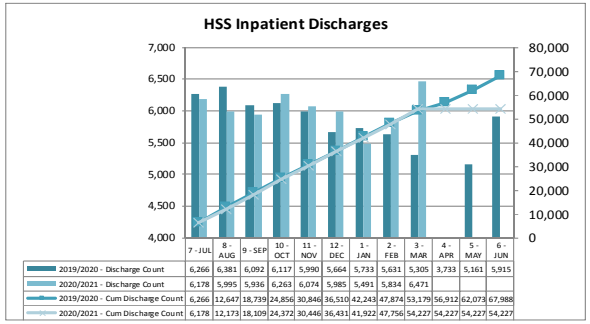


	7 - JUL	8 - AUG	9 - SEP	10 - OCT	11 - NOV	12 - DEC	1 - JAN	2 - FEB	3 - MAR	4 - APR	5 - MAY	6 - JUN
2019/2020 - Total NZ20 WIES	6,525	6,891	6,387	6,380	6,225	6,157	5,844	6,129	5,894	4,357	5,869	6,467
2020/2021 - Total NZ20 WIES	6,714	6,339	6,497	6,727	6,622	6,578	5,515	5,927	6,592			
2019/2020 - Cum NZ20 WIES	6,525	13,417	19,804	26,183	32,408	38,566	44,410	50,539	56,433	60,790	66,659	73,126
2020/2021 - Cum NZ20 WIES	6,714	13,052	19,549	26,276	32,898	39,476	44,991	50,918	57,510	57,510	57,510	57,510

HSS Inpatient Discharges

	2019/20	2020/21
YTD Totals	53,179	54,227
Change		1,048
% Change		2.0%

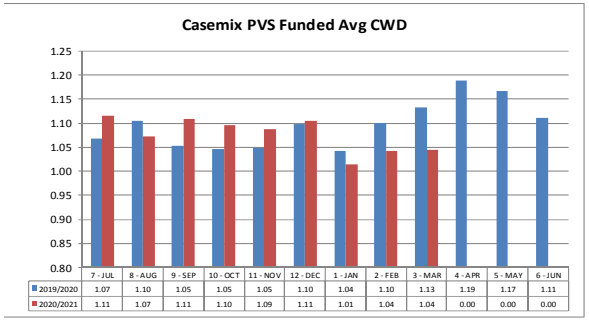
** This includes all Hospital Acitivty including ACC, Non Resident, Non-Casemix but excludes Mental Health*



	7 - JUL	8 - AUG	9 - SEP	10 - OCT	11 - NOV	12 - DEC	1 - JAN	2 - FEB	3 - MAR	4 - APR	5 - MAY	6 - JUN
2019/2020 - Discharge Count	6,266	6,381	6,092	6,117	5,990	5,664	5,733	5,631	5,305	3,733	5,161	5,915
2020/2021 - Discharge Count	6,178	5,995	5,936	6,263	6,074	5,985	5,491	5,834	6,471			
2019/2020 - Cum Discharge Count	6,266	12,647	18,739	24,856	30,846	36,510	42,243	47,874	53,179	56,912	62,073	67,988
2020/2021 - Cum Discharge Count	6,178	12,173	18,109	24,372	30,446	36,431	41,922	47,756	54,227	54,227	54,227	54,227

Casemix PVS Funded Avg CWD

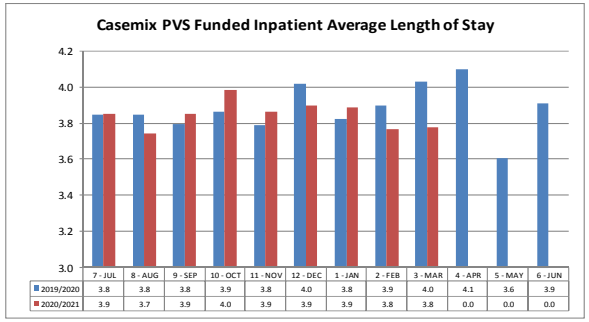
	2019/20	2020/21
YTD Totals	1.09	1.08
Change		-0.02
% Change		-1%



	7 - JUL	8 - AUG	9 - SEP	10 - OCT	11 - NOV	12 - DEC	1 - JAN	2 - FEB	3 - MAR	4 - APR	5 - MAY	6 - JUN
2019/2020	1.07	1.10	1.05	1.05	1.05	1.10	1.04	1.10	1.13	1.19	1.17	1.11
2020/2021	1.11	1.07	1.11	1.10	1.09	1.11	1.01	1.04	1.04	0.00	0.00	0.00

Casemix PVS Funded Inpatient Average Length of Stay

	2019/20	2020/21
YTD Totals	3.87	3.85
Change		-0.02
% Change		-0.6%



	7 - JUL	8 - AUG	9 - SEP	10 - OCT	11 - NOV	12 - DEC	1 - JAN	2 - FEB	3 - MAR	4 - APR	5 - MAY	6 - JUN
2019/2020	3.8	3.8	3.8	3.9	3.8	4.0	3.8	3.9	4.0	4.1	3.6	3.9
2020/2021	3.9	3.7	3.9	4.0	3.9	3.9	3.9	3.8	3.8	0.0	0.0	0.0

Comparisons with same period last year:

- Local acute CWDs despite lockdown remain lower than previous financial year (-294 CWDs) however with an increase in discharges; a lower ALOS and a similar average CWD. The discharge increase is driven primarily by Emergency Medicine and Orthopaedics. The CWD decrease is driven primarily by Neonatal, General Medicine Paediatric Medicine, Respiratory and ENT.
- Local Elective CWDs are higher than the previous financial year (341 CWDs) however again with an increase in discharges; a similar ALOS and average CWD. The discharge increase is driven primarily by General Surgery, Cardiology and Vascular Surgery. The CWD increase is driven primarily by Cardiology, General Surgery and Neurosurgery.
- IDF acute CWDs are higher (194 CWDs) than the previous financial year also with an increase in discharges; a lower ALOS and average CWD. The discharge increase is driven primarily by Emergency Medicine, Haematology and Neurology. The CWD increase is driven primarily by Neonatal, Haematology and Neurology.
- IDF Elective CWDs are higher than the previous financial year (698 CWDs) with more discharges; a lower ALOS and a higher average CWD. The discharge increase is driven primarily by Ophthalmology, Vascular Surgery and Neurosurgery. The CWD increase is driven primarily by Cardiothoracic, Cardiology and Neurosurgery.
- In combination these four admission groups equate to an increase of 938 CWDs compared to the previous year. The services that most significantly impact this shift are Emergency Medicine (418), Cardiothoracic (374) and Neurology (219) but countered by deceases in General Medicine (-267), Paediatric Medicine (-245), and Respiratory Medicine (-162).
- The reduction in General Medicine (-267 CWDs) will have been impacted in the WRH AHOP counting change (357 CWDs not counted as bed days) and Paediatric Medicine (-253 CWDs) who will be heavily impacted by the reduction in the number of presentations to the Emergency department (926 Ytd).

Discharges:

- The impact of lockdown can be seen in the number of publicly funded casemix discharges for the month of March 2021 have increased by 1,122 (23.2%) in comparison to the number of discharges recorded in March 2020.
- The number of outsourced discharges recorded in March 2021 (158) is the highest number recorded in a single month since March 2019 (excluding COVID lockdown months) with CCDHB now utilising Boulcott Hospital, Bowen Hospital, Southern Cross Hospital and Wakefield Hospital.

HHS Operational Performance Scorecard – period Mar 20 to Mar 21

Domain	Indicator	2020/21 Target	Performance Trend											
			2020-Mar	2020-Apr	2020-May	2020-Jun	2020-Jul	2020-Aug	2020-Sep	2020-Oct	2020-Nov	2020-Dec	2021-Jan	2021-Feb	2021-Mar
Care	Serious Safety Events	Zero SSEs	7	7	10	5	16	9	11	5	22	7	10	11	2
	Total Reportable Events	TBD	1,207	725	906	1,086	1,167	1,269	1,370	1,359	1,416	1,511	1,420	1,475	1,418
Patient and Family Centred	Complaints Resolved within 35 calendar days	TBD	92.4%	100.0%	93.5%	91.8%	86.4%	94.3%	93.9%	94.9%	92.0%	81.8%	93.1%	95.5%	100.0%
	% Discharges with an Electronic Discharge summary	TBD													
Access	Emergency Presentations		4,562	3,258	4,161	5,281	5,415	5,399	5,050	5,565	5,342	5,282	5,267	5,047	5,499
	Emergency Presentations Per Day		147	109	134	176	175	174	168	180	178	170	170	180	177
	Emergency Length of Stay (ELOS) % within 6hrs	≥95%	78.7%	84.7%	82.8%	74.6%	72.6%	68.5%	65.6%	65.1%	67.6%	65.9%	68.6%	62.5%	66.3%
	ELOS % within 6hrs - non admitted	TBD	84.6%	90.7%	90.4%	82.6%	79.8%	76.8%	75.2%	73.6%	73.7%	73.7%	75.8%	70.3%	75.6%
	ELOS % within 6hrs - admitted	TBD	61.8%	70.5%	66.3%	54.6%	53.5%	46.8%	41.3%	42.3%	51.3%	46.0%	49.6%	42.4%	42.6%
	Total Elective Surgery Long Waits	Zero Long Waits	177	400	433	350	247	107	99	184	208	308	493	543	530
	Additions to Elective Surgery Wait List		1,271	553	1,091	1,505	1,520	1,376	1,542	1,397	1,389	1,284	917	1,222	1,202
	% Elective Surgery treated in time	TBD	89.0%	92.7%	76.3%	71.3%	73.0%	84.2%	90.3%	89.0%	86.3%	88.5%	75.4%	75.6%	71.9%
	No. surgeries rescheduled due to specialty bed availability	TBD	1	1	1	12	5	9	13	14	1	6	2	6	11
	Total Elective and Emergency Operations in Main Theatres	TBD	927	378	1,103	1,202	1,237	1,192	1,254	1,130	1,118	1,002	878	1,076	1,270
	Faster Cancer Treatment 31 Day - Decision to Treat to Treat	85%	89.0%	91.0%	92.0%	91.0%	93.0%	85.0%	87.0%	82.0%	85.0%	86.0%	81.0%	89.0%	87.0%
	Faster Cancer Treatment 62 Day - Referral to Treatment	90%	97.0%	92.0%	77.0%	85.0%	94.0%	83.0%	88.0%	88.0%	83.0%	89.0%	91.0%	82.0%	94.0%
	Specialist Outpatient Long Waits	Zero Long Waits	488	1,079	1,286	1,450	1,076	571	314	185	225	314	353	355	Tbc
	% Specialist Outpatients seen in time	Zero Long Waits	81.9%	87.1%	81.1%	74.3%	74.3%	85.0%	90.1%	88.8%	92.2%	92.9%	89.0%	88.1%	85.8%
	Outpatient Failure to Attend %	TBD	7.7%	4.4%	7.1%	6.6%	7.1%	6.7%	7.0%	7.6%	7.6%	7.8%	7.3%	7.3%	6.7%
	Maori Outpatient Failure to Attend %	TBD	15.2%	8.1%	13.9%	13.7%	14.8%	13.9%	15.2%	15.4%	16.0%	16.6%	16.2%	15.7%	14.9%
	Pacific Outpatient Failure to Attend %	TBD	16.5%	7.8%	16.5%	16.1%	16.9%	14.4%	14.6%	16.3%	16.3%	18.7%	19.6%	17.6%	15.5%
Financial Efficiency	Forecast full year surplus (deficit) ($million)		($29.5m)	($47.5m)	($47.5m)	($44.2m)	($39.8m)	($39.8m)	($62.0m)	($62.0m)	($62.0m)	($62.0m)	($62.4m)	($62.4m)	($62.4m)
	Contracted FTE (Internal labour)		4,847	4,893	4,930	4,976	4,976	5,035	5,237	5,267	5,265	5,261	5,256	5,354	5,342
	Paid FTE (Internal labour)		5,198	5,188	5,199	5,317	5,317	5,368	5,607	5,606	5,649	5,692	5,694	5,808	5,706
	% Main Theatre utilisation (Elective Sessions only)	85.0%	80.0%	78.1%	82.0%	81.0%	83.0%	82.0%	82.0%	82.0%	80.0%	78.2%	81.0%	80.0%	83.0%
Discharge and Occupancy	% Patients Discharged Before 11AM	TBD	22.7%	19.3%	20.4%	21.9%	24.4%	23.1%	25.4%	22.2%	25.3%	22.7%	22.8%	22.3%	23.2%
	Adult Long Stay Patients Not Yet Discharged (>14 days) WLG	TBD	29	19	24	29	30	35	51	33	34	37	37	38	41
	Adult Overnight Beds - Average Occupied WLG	TBD	331	273	323	357	362	363	382	378	363	360	356	373	381
	Adult Long Stay Patients Not Yet Discharged (>14 days) KEN	TBD	10	17	16	17	19	19	18	23	18	17	16	14	19
	Adult Overnight Beds - Average Occupied KEN	TBD	62	46	55	63	71	72	74	76	67	64	67	71	69
	Child Overnight Beds - Average Occupied	TBD	18	15	18	23	24	23	22	23	24	22	17	19	22
	NICU Beds - ave. beds occupied	36	34	38	30	29	28	31	38	36	33	35	38	39	44
ALOS	Overnight Patients - Average Length of Stay (days)	TBD	4.03	4.10	3.61	3.91	3.85	3.74	3.85	3.98	3.86	3.90	3.89	3.76	3.75
Care	Rate of Presentations to ED within 48 hours of discharge	TBD	3.7%	4.1%	3.3%	3.8%	3.7%	3.7%	4.3%	4.6%	3.2%	3.2%	4.1%	4.0%	3.5%
	Presentations to ED within 48 hours of discharge	TBD	168	133	139	203	199	201	215	254	171	170	218	202	194
Staff Experience	Staff Reportable Events	TBD	137	91	109	161	140	155	138	180	173	176	147	179	146
	% sick Leave v standard	TBD	3.5%	2.2%	2.5%	3.5%	4.0%	4.0%	3.6%	3.4%	3.4%	3.1%	2.0%	2.7%	3.4%
	Nursing vacancy	TBD	206.6	193.0	171.0	157.6	248.1	265.3	251.1	247.4	267.5	268.5	267.8	223.4	234.4
	% overtime v standard (medical)	TBD	1.9%	1.4%	1.4%	1.6%	1.7%	1.9%	2.1%	1.9%	2.0%	1.8%	1.8%	2.0%	1.9%

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

Shorter Stays in ED (SSIED)

What is this measure?

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

Why is this important?

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

How are we performing?

- CCDHB SSIED performance for March 2021 was 66.3%. This result is an increase on the 62.6% recorded last month in February 2021 and a decrease on the 79% recorded in March 2020. The performance of patients who were seen, treated and discharged by ED for March 2021 was 77%. The performance of patients who were seen and admitted to hospital for March 2021 was 47%.
- A factor that affects our SSiED performance is the occupancy/bed utilisation in our wards. The average occupancy for March 2021 was 93%. The occupancy rate is based on core Adult Wards (Wellington and Kenepuru) excluding Ward 4 North and ICU. The number of available adult beds in March 2021 was 354.

What is driving performance?

- Our performance being less than target continues to be due to the increase of elective and acute surgical work. There has also been the seasonal increase in admissions. We also have in place ongoing processes related to COVID-19 screening and precautions.
- We continue to operate parallel processes in our in-patient wards to manage COVID case definition vs. non-COVID patients. Our acute flow programme of work is focusing on medical teams identifying and discharging patients earlier in the day. This then frees beds for those being admitted from ED to move to the ward in a timelier manner and thus improves our SSiED performance.

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

Performance	JAN	FEB	MAR
2019-20	80%	76%	79%
2020-21	69%	63%	66%

Breaches	JAN	FEB	MAR
2019-20	997	1,180	919
2020-21	1,507	1,678	1,686

ED Volumes	JAN	FEB	MAR
2019-20	4,998	4,822	4,285
2020-21	4,807	4,489	5,010

Management Comment

The following work streams continue to be progressed and implemented including:

- The Acute Frailty Unit will be available again from 1 May 2021, The transit lounge will reopen extended hours from 5 May
- The Advancing Wellness at Home Initiative (AWHI) project is an early supported discharge for people whose level of function has declined on admission and has involved making changes to the Patient Care Coordination service to identify potential patients needing intervention earlier in admission with the goal of reduction in the over 10 day stays for complex patients in general medicine and reducing need for in-hospital stay.
- Project group to review patients who have been in hospital more than 10 days, continues to identify barriers to discharge and address these with our teams.
- Activities continue across the organisation to improve discharge processes.
- Work group established to identify space to create additional acute assessment beds supporting winter planning .
- Work underway to relocate Kenepuru Day ward creating additional surgical and Rehabilitation beds on the Kenepuru Hospital site.
- Our Front of Whāre (ED and acute assessment units) project is underway. This project in on track to identify how we can use new of care and appropriately configured facilities to meet demand. In parallel we are exploring our short and medium term options for expansion of bed and theatre capacity. These options are being developed within the context of the Hospital Network programme.

Planned Care – Inpatient Surgical Discharges/Minor Procedures

What is this measure?

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

Why is this important?

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

How are we performing?

- Total planned care results year to date is unfavourable (711) to our planned target of 8,115.
- March month end result is unfavourable (44) to a plan of 968. The main driver of this result is our outsource delivery (48) being adverse to planned target. Although we continue to be affected by contractual constraints, we achieved our highest monthly volume in March for the past 12 months. Our in-house elective surgical discharge were adverse 27 to our planned 560. We are still experiencing high volumes of cancellations due to increased acute demand as highlighted under our activity section.
- Our IDF outflow position is positive for March (16) and minor procedures are 165 ahead of our month plan of 391.

What is driving performance?

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

Management Comment

- Our focus remains on scheduling our longest-waiting patients in all specialities, and ensuring our theatre sessions are fully utilised. At Kenepuru the installation of theatre lights is on track, but necessitates having one theatre closed for several months. Where possible we relocate theatre sessions from Kenepuru to Wellington, however we do not have sufficient spare capacity in Wellington to cover off all lost lists.
- Outsource contracts are still being negotiated, but are on track to be in place by the end of June. We have interim agreements on some procedures but will not manage the required volume to meet our planned care target this year.
- 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 inside of a 42 day period. The clock begins at the date Radiology receives the referral for imaging.

Why is this important?

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

How are we performing?

- Waiting times for CT and MRI remain high as a result of historical insufficient capacity to meet demand. Subsequently, the percentage measure is low and has been for a long time.
- Due to the planned care funding directly from the MOH confirmed December 2020, increased outsourcing and improved performance can be expected throughout the remainder of FY 20/21.

What is driving performance?

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

Figure Two: CT wait times

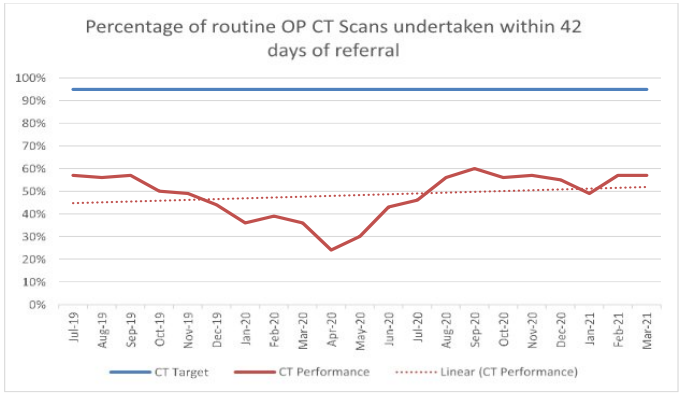
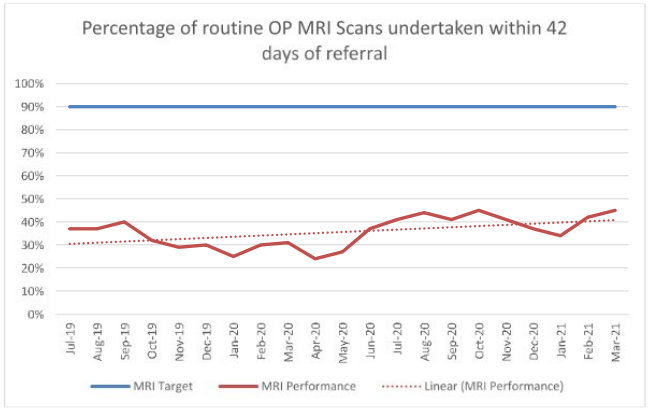


Figure Three: MRI wait times



Management Comment

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

- Despite an increase in output for the last 6 months in CT and MRI, increased referral demand continues to outstrip improvements in output.

	Referral demand average per month 2019/20	Referral demand average per month 2020/21	Demand Percentage Increase	Output average per month 2019/20	Output average per month 2020/21
CT	254	326	+28%	525	672
MRI	115	136	+18%	337	410

- Average increase in demand for the last 3 years has been 5% for CT and 2% for MRI. With recent demand figures, it has made recovery and progress into waiting lists extremely challenging. We continue to look at options for increasing capacity and ensuring our demand is clinically justified.

Coronary

Coronary Angiography Waiting Times

What is this measure?

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

Why is this important?

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

How are we performing?

- The proportion of patients waiting less than 90 days for angiography has decreased to 82.5% this month.

What is driving performance?

- Remaining just below target has been influenced by SMO leave (Annual and Parental)

Management Comment

- A total of 41 days SMO Leave was taken over March. We also currently have two consultants on parental leave, with gaps in interventional cover arrangements until staff are available. Patient cancellations or deferment related to social or medical issues are included in those breaching the target.

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 February results (Target is ≥70%):

National Performance	76.2%
Central Region	83.3% (115/138)
CCDHB	96.3% (26/27)
Hawkes Bay	63.3% (19/30)
Hutt Valley	78.9% (15/19)
Mid Central	88.9% (24/27)

- As a region we achieved the target. Hawkes Bay remains below target this month, although improved on last month result

What is driving performance?

- Achievement of the target differs for each centre. The referral to transfer is directly influenced by CCDHB, ultimately this relates to access to beds. Other factors include regional decision making timeframes, and timing of presentation. Regional COOs have been discussing how we can better managing acute patient flow across the region- the adoption of a repatriation policy has assisted with this but more visibility at the regional DHB level would be helpful – this is a work in progress.

Management Comment

- Increased lab capacity resulting from the new SMO roster and redistribution of interventional lab sessions, has allowed better lab utilisation, although staffing has been a challenge this month due to two SMO's on parental leave and a number of operators taking annual leave. The underlying issue remains access to beds, increased by Cardiology having access to short stay beds reduced. This has resulted in less flexibility and impacts on the service's ability to transfer regional patients in a timely manner when busy. Trans-oesophageal Echocardiograms and CTCA patients have been moved out of the IRW space, utilising the Transit Lounge and Clinical Management Unit for this work to free up bed space in IRW and Ward 6 South to help mitigate this issue. We are currently investigating other procedures that can be managed this way.

Faster Cancer Treatment

What is this measure?

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

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

Why is this important?

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

How are we performing?

- CCDHB is compliant with the 62 day target for March at 94% compared to the aim of 90% of patients receiving their first cancer treatment within 62 days of being referred with a high suspicion of cancer. This is only the third month CCDHB has been compliant YTD and has struggled since early 2020 to consistently achieve the target.
- CCDHB is compliant with the 31 day indicator for March at 88% vs the aim of 85% of patients commencing treatment within 31 days from decision to treat.
- Patient numbers for both measures have improved but remain 15% lower than expected. This likely indicates reduced services over December/January.

What is driving performance?

- There was one patient who breached the 62 day target for patient specific reasons.
- The average delay for all 31 day capacity related breach patients was 75 days (range 40-95 days) an increase over last month (45 days) but most patients were not prioritised as urgent.

Management Comment

- The reduction in services over the Christmas/New Year break did, as anticipated, result in some patients having experienced increased delays.
- Work is also ongoing on the Quality Performance Indicators for lung and prostate cancers which have been released for consultation. CCDHB's low pathological diagnosis rate (patients not proceeding to biopsy for lung cancer) will be monitored. Audit showed that the reasons for this were multifactorial - co morbidities, patient declining to have biopsy or further treatment. The rate for Maori is slightly higher than non Maori; this is a key focus of the new Maori cancer coordinator.

Figure Eight: FCT 62 day target

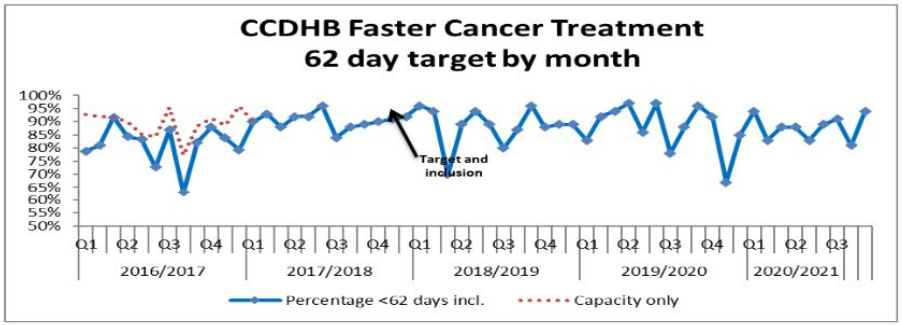
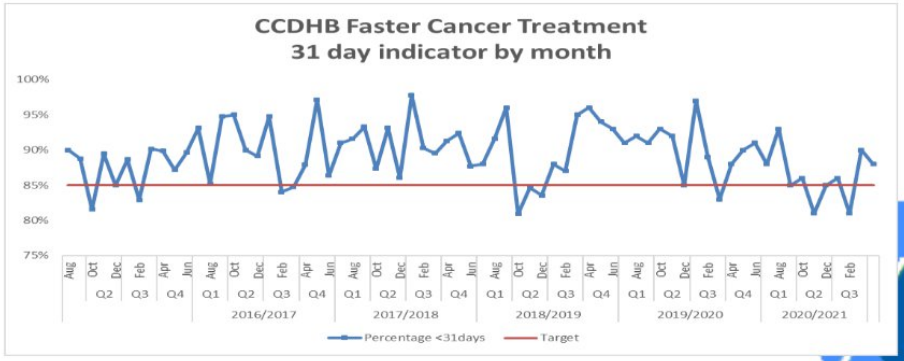


Figure Nine: FCT 31 day target



Colonoscopy

What is this measure?

Diagnostic colonoscopy

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

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

Surveillance colonoscopy

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

Why is this important?

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

How are we performing?

- CCDHB again exceeded the Ministry of Health target for urgent colonoscopies achieving 100% (target 90%) but did not meet the target for diagnostic, achieving 56.4% (target 70%). This is an improvement from the February return of 46%.
- We did not meet the Ministry of Health target for surveillance achieving 68%, (target 70%). This is an improvement on the February return of 66.5%.

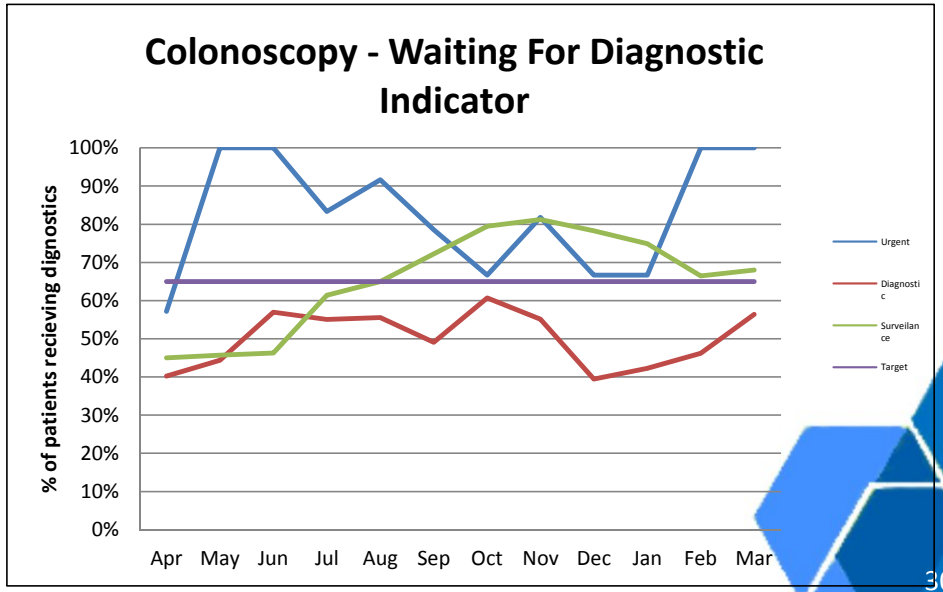
What is driving performance?

- At the end of March there were 432 patients waiting for either a diagnostic or surveillance colonoscopy compared to 481 the previous month. There were 62 waiting beyond recommended and 21 waiting beyond maximum at the end of March compared to 142 and 32 respectively at the end of February.

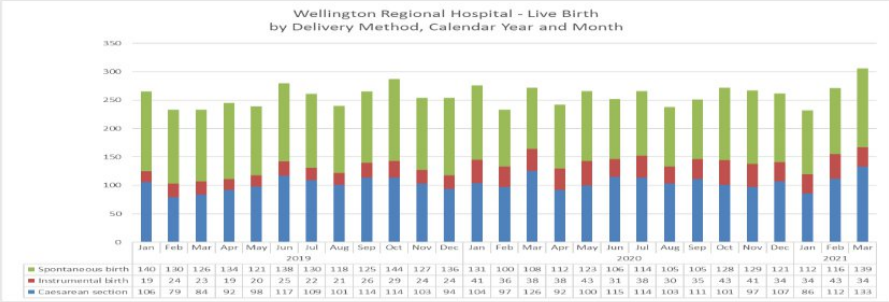
	Feb-21				Mar-21			
	Maori	Pacific	Other	Total Feb-21	Maori	Pacific	Other	Total Mar-21
Total Waiting	8.32%	4.78%	86.90%	100.00%	8.33%	4.63%	87.04%	100.00%
Waiting More than Recommended	10.73%	4.52%	84.75%	100.00%	6.38%	4.26%	89.36%	100.00%
Waiting More than Maximum	12.50%	0.00%	87.50%	100.00%	14.29%	0.00%	85.71%	100.00%

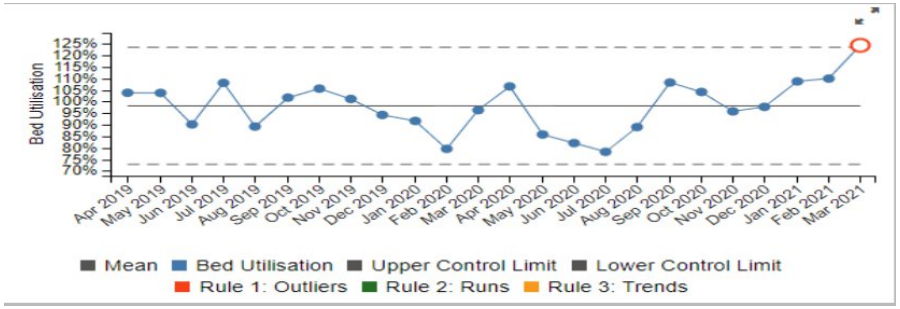
Management Comment

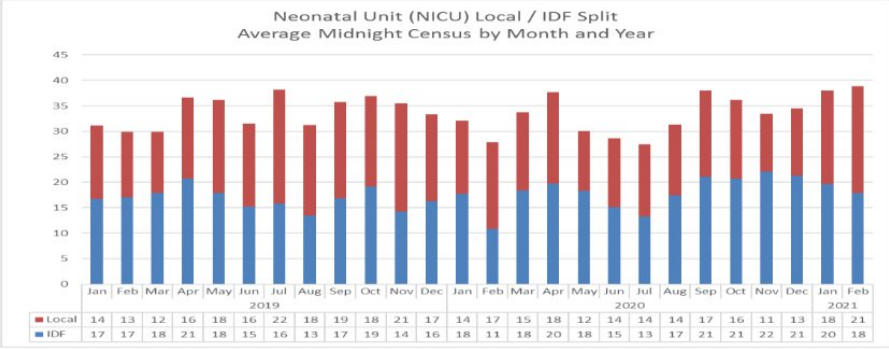
- There was an increase in the number of available lists in March which has contributed to the performance. There has also been work undertaken in the new Unit in Kenepuru which has also assisted with the reduction in numbers waiting. The total waiting is 432 at the end of March compared with 481 at the end of February 2021. Work is ongoing in-house to improve the number of patients per list and replacement endoscopes to ensure a fully operational fleet for the department are now available.
- The limitations to maximising the capacity at Wellington remain and are attributed to the layout of the department, which is inconsistent with contemporary standards for an endoscopy unit. Plans are being developed to scope out the work required.



Maternity and Neonatal Intensive Care services







What is the issue?

- The Wellington Regional Hospital Maternity and Delivery Suite continues to experience a high acuity and bed utilisation. Also impacted by this trend is our Neonatal Intensive Care service.
- As reported both Wellington Regional Hospital (WRH) and Kenepuru maternity unit, have significant Registered Midwifery vacancies (circa 33 %) this includes 11 FTE new roles that have been created by CCDM FTE calculations but not yet filled. The NICU had an increase of 27FTEs from CCDM calculation last year but continue to struggle with over occupancies – NB resourced beds are 36.
- We are currently recruiting additional RN's to fill RM vacancies however this provides skill mix challenges
- An international recruitment drive is being relaunched with a focus on Australia, and the UK.
- Escalation plans are in place and are followed but are being challenged with continued presentations, high acuity, and continued shortages.
- We continue to work closely with our staff and union partners on workforce planning across the region noting this issue as requiring national solutions.

Section 3

Financial Performance and Sustainability

Executive Summary Financial Performance and Position

- The DHB has budgeted a deficit of $39.8 million. The responsible deficit YTD was $5m favourable against budget.
- Two extraordinary items exist which are not included within the budget, which the ministry has advised are regarded as outside the DHBs performance assessment:
  - ($26.3m); COVID-19: additional costs during COVID-19
  - ($6m); Holidays Act Provisions
- The DHB had targeted a reasonable number of efficiency measures for the year ahead totalling $38m, which are required to meet our deficit position, $22.4 million relates to our YTD from both personnel vacancies, efficiency savings across all services and ICT gains through consolidation and rationalisation.
- The DHB also had a number of key safe care initiatives totalling $15.8m some of which are still due to start within the year.
- The DHB's cash is under pressure for 2020/21 due to level of deficit support lower than last years deficit and no cash funding provided for provider arm COVID-19 costs. This was mitigated at year end by a delay to payment of capital charge, increase in leave liabilities (as this is non cash) and significant delays to our capex spend (offset by non cash depreciation). The DHB by the start of March was already ($18.1m) in overdraft, offset by $13.2m in special fund balances. Moving to ten day payment of creditors as required has had an estimated impact of around $8m on the DHB cash balance.
- COVID-19 from the first outbreak continues to incur some additional costs and also disruption to normal BAU for some components of the hospital operation and management. We have put in place tracking and monitoring systems to enable all the costs to be captured and reported to the Ministry, the key items of which are shown on the next slide, this is in addition to the unfunded ($8m) from the prior financial year in which cash has not been provided.

COVID-19 Revenue and costs & Holidays Act

Last Year			Capital & Coast DHB Operating Results - $000s	This Year to Date			Total Provision/Expense	
COVID-19 change from Trend - Provider	COVID-19 change from Trend - Funder	Holidays Act [2003]	YTD March 2021	COVID-19 change from Trend - Provider	COVID-19 change from Trend - Funder	Holidays Act [2003]	COVID-19	Holidays Act [2003]
	(8,317)		Devolved MoH Revenue	(2,266)	(14,421)		(25,004)	0
			Non-Devolved MoH Revenue				0	0
2,037			Other Revenue	693			2,730	0
			IDF Inflow				0	0
			Inter DHB Provider Revenue			(44)	0	(44)
2,037	**(8,317)**	**0**	**Total Revenue**	**(1,573)**	**(14,421)**	**(44)**	**(22,274)**	**(44)**
			Personnel					
(1,610)		(2,049)	Medical	(4,508)		(1,784)	(6,118)	(25,922)
(1,620)		(9,145)	Nursing	(2,687)		(2,924)	(4,307)	(42,491)
		(1,370)	Allied Health			(487)	0	(7,073)
		32	Support			(131)	0	(1,898)
		168	Management & Administration			(558)	0	(8,026)
(3,230)	**0**	**(12,365)**	**Total Employee Cost**	**(7,195)**	**0**	**(5,883)**	**(10,425)**	**(85,408)**
			Outsourced Personnel					
(51)			Medical	(109)		(16)	(160)	(16)
			Nursing				0	0
			Allied Health				0	0
			Support				0	0
			Management & Administration				0	0
(51)	**0**	**0**	**Total Outsourced Personnel Cost**	**(109)**	**0**	**(16)**	**(160)**	**(16)**
2,834			Treatment related costs - Clinical Supp	(1,732)			1,102	0
(1,952)			Treatment related costs - Outsourced	(564)			(2,516)	0
(1,921)			Non Treatment Related Costs	(1,707)		(194)	(3,628)	(194)
			IDF Outflow				0	0
	(9,917)		Other External Provider Costs (SIP)		(14,963)		(24,880)	0
			Interest Depreciation & Capital Charge				0	0
(1,039)	**(9,917)**	**0**	**Total Other Expenditure**	**(4,002)**	**(14,963)**	**(194)**	**(29,921)**	**(194)**
(4,320)	**(9,917)**	**(12,365)**	**Total Expenditure**	**(11,306)**	**(14,963)**	**(6,093)**	**(40,506)**	**(85,618)**
6,357	**1,600**	**12,365**	**Net result**	**9,734**	**542**	**6,049**	**18,233**	**85,574**

- The year to date financial position includes $26.3m additional costs in relation to COVID-19.
- Revenue of $16m has been received to fund additional costs for community providers however this has not been sufficient for these costs
- Additional personnel costs of $6m have been accrued YTD for the Holidays Act
- COVID-19 costs are spread across personnel, clinical supplies, outsourced treatment and infrastructure and non-clinical costs.

CCDHB Operating Position – March 2021

Month - March 2021									Capital & Coast DHB Operating Results - $000s	Year to Date									
			Variance		Adjustments			Variance					Variance		Adjustments			Variance
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	COVID-19 change from Trend	Holidays Act [2003]	Actuals exc COVID/HA	Actuals exc COVID vs Budget	YTD March 2021	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	COVID-19 change from Trend	Holidays Act [2003]	Actuals exc COVID-19 / HA	Actuals exc COVID vs Budget
79,938	77,550	74,337	2,388	5,601	2,239		77,699	149	Devolved MoH Revenue	713,794	697,950	660,290	15,844	53,504	16,687		697,107	(843)
3,678	3,625	3,855	53	(177)			3,678	53	Non-Devolved MoH Revenue	32,888	32,029	31,820	859	1,069			32,888	859
4,349	2,913	2,927	1,436	1,422	(0)		4,349	1,436	Other Revenue	42,688	25,967	29,120	16,721	13,568	(693)		43,381	17,414
21,344	21,452	19,232	(108)	2,113			21,344	(108)	IDF Inflow	191,328	193,072	176,365	(1,743)	14,963			191,328	(1,743)
4,196	782	750	3,414	3,446		0	4,196	3,414	Inter DHB Provider Revenue	29,956	6,947	6,439	23,009	23,517		44	29,956	23,009
113,505	**106,321**	**101,101**	**7,184**	**12,404**	**2,239**	**0**	**111,267**	**4,945**	**Total Revenue**	**1,010,654**	**955,964**	**904,034**	**54,690**	**106,621**	**15,994**	**44**	**994,660**	**38,696**
									Personnel									
17,719	15,902	14,756	(1,817)	(2,963)	401	209	17,109	(1,207)	Medical	140,761	137,381	128,504	(3,380)	(12,256)	4,508	1,784	134,469	2,912
21,515	20,331	18,710	(1,184)	(2,805)	(738)	343	21,910	(1,579)	Nursing	189,883	173,842	165,544	(16,041)	(24,339)	2,687	2,924	184,272	(10,429)
6,716	6,025	5,599	(691)	(1,117)		57	6,659	(634)	Allied Health	55,898	51,312	46,173	(4,586)	(9,725)		487	55,411	(4,100)
948	964	857	16	(91)		15	933	32	Support	7,916	8,225	7,727	309	(189)		131	7,786	440
7,880	6,413	6,248	(1,467)	(1,632)		65	7,815	(1,402)	Management & Administration	61,568	58,534	54,706	(3,034)	(6,862)		558	61,010	(2,476)
54,778	**49,636**	**46,170**	**(5,142)**	**(8,608)**	**(337)**	**690**	**54,426**	**(4,790)**	**Total Employee Cost**	**456,026**	**429,294**	**402,654**	**(26,732)**	**(53,372)**	**7,195**	**5,883**	**442,948**	**(13,654)**
									Outsourced Personnel									
572	445	646	(126)	74	21	0	550	(105)	Medical	6,713	3,962	5,066	(2,751)	(1,647)	109	16	6,587	(2,626)
33	25	21	(8)	(12)			33	(8)	Nursing	425	224	199	(202)	(226)			425	(202)
192	114	141	(78)	(50)			192	(78)	Allied Health	1,187	1,023	1,171	(164)	(16)			1,187	(164)
46	22	12	(24)	(35)			46	(24)	Support	325	197	233	(129)	(92)			325	(129)
383	84	232	(299)	(151)			383	(299)	Management & Administration	3,163	728	1,692	(2,435)	(1,471)			3,163	(2,435)
1,226	**691**	**1,052**	**(535)**	**(174)**	**21**	**0**	**1,204**	**(513)**	**Total Outsourced Personnel Cost**	**11,813**	**6,133**	**8,361**	**(5,680)**	**(3,452)**	**109**	**16**	**11,688**	**(5,554)**
11,987	11,462	10,615	(524)	(1,371)	78		11,909	(447)	Treatment related costs - Clinical Supp	100,108	99,653	94,529	(454)	(5,578)	1,732		98,376	1,277
2,843	2,697	1,732	(147)	(1,112)	(0)		2,843	(147)	Treatment related costs - Outsourced	19,516	21,038	16,616	1,522	(2,900)	564		18,952	2,086
9,523	7,046	6,855	(2,477)	(2,668)	(263)	15	9,771	(2,725)	Non Treatment Related Costs	79,611	62,239	57,609	(17,372)	(22,002)	1,707	194	77,710	(15,472)
8,979	8,965	8,403	(14)	(576)			8,979	(14)	IDF Outflow	81,140	80,688	74,528	(452)	(6,613)			81,140	(452)
27,674	26,579	26,231	(1,094)	(1,443)	1,570		26,103	476	Other External Provider Costs (SIP)	255,692	237,160	228,114	(18,532)	(27,578)	14,963		240,729	(3,568)
4,644	4,818	4,969	174	326			4,644	174	Interest Depreciation & Capital Charge	41,898	43,550	44,426	1,652	2,528			41,898	1,652
65,650	**61,568**	**58,805**	**(4,082)**	**(6,845)**	**1,385**	**15**	**64,250**	**(2,681)**	**Total Other Expenditure**	**577,965**	**544,328**	**515,822**	**(33,637)**	**(62,143)**	**18,966**	**194**	**558,805**	**(14,477)**
121,653	**111,895**	**106,027**	**(9,759)**	**(15,627)**	**1,069**	**705**	**119,880**	**(7,985)**	**Total Expenditure**	**1,045,803**	**979,755**	**926,837**	**(66,048)**	**(118,966)**	**26,270**	**6,093**	**1,013,441**	**(33,686)**
(8,148)	**(5,573)**	**(4,926)**	**(2,575)**	**(3,222)**	**1,170**	**(705)**	**(8,613)**	**(3,040)**	**Net result**	**(35,149)**	**(23,791)**	**(22,804)**	**(11,358)**	**(12,345)**	**(10,276)**	**(6,049)**	**(18,780)**	**5,010**
(550)	(1,829)	(443)	1,280	(107)					Funder	4,213	5,836	1,084	(1,622)	3,129				
77	0	66	77	12					Governance	687	0	754	687	(67)				
(7,676)	(3,744)	(4,549)	(3,932)	(3,127)					Provider	(40,050)	(29,626)	(24,642)	(10,424)	(15,408)				
(8,148)	**(5,573)**	**(4,926)**	**(2,575)**	**(3,222)**					**Net result**	**(35,149)**	**(23,791)**	**(22,804)**	**(11,358)**	**(12,345)**				

Note two adjustments are made for

1. COVID-19 and
2. Holidays Act.

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

Executive Summary – Financial Variances

- The DHB deficit year to date is ($35.1m). The variance to the YTD Budget is ($11.4m)
- Included within this result is recognition of the adjustment to the holiday act provision ($6m) and an estimated impact of COVID-19 of ($10.3m).
- Excluding the two items above brings the deficit for the year into deficit of ($18.8m) being $5m favourable to budget.
- Revenue is favourable by $52.2m YTD, after excluding COVID-19, lead DHB changes this is on budget. The variances are due to mental health national contracts, special fund/ research revenue offset by donation and interest revenue. Inpatient IDF revenue was recognised behind target by ($1.7m), with planned care (electives) set to target whilst the year gets underway.
- Personnel costs including outsourced is ($32.4m) YTD, excluding the Holidays Act provision ($6.0m) and the COVID-19 related costs of ($7.2m) incurred the net unfavourable variance is ($19.2m). This ($19.2m) net unfavourable variance has been more than offset by the transfer of Mental Health and ICT services to CCDHB from other DHBs ($17.2m). CCDHB receives revenue to fully cover the costs of the transferred services and this is recognised in the ytd result.
- Treatment related clinical supplies $1.1m is unfavourable with increased costs associated with Bloods, prostheses and grafts offset by a favourable movement in drugs and outreach clinics.
- Outsourced clinical services is favourable YTD by $1.6m; favourable movement due to outsourced surgical service delayed compared to budget plan, however this is offset by the increase in MRI, CT Scans and other radiology services.
- Non treatment related costs ($15.2m) YTD unfavourable, however after excluding COVID-19, lead DHB changes and settlement this was a $3.6m favourable variance; which is due to lower spend on asset maintenance, and new investment initiatives not yet commenced.
- The funder arm is unfavourable YTD due to additional spend requirements for our community COVID-19 response which may not all be funded. Some new programmes in the NGO space have commenced alongside increased revenue from MoH to support these initiatives.

Analysis of the Operating Position – Revenue and Personnel

Revenue

- Revenue is ($1.6m) unfavourable YTD (after lead DHB and other items indicated on previous page) despite recognising IDFs being behind target by ($1.7m)
- The variance is due to revenue for special funds/research of $626k, Interest due to overdraft situations ($361k), Donations ($761k) MHAIDS non-lead DHB revenue of ($1.1m). The funder arm is also unfavourable by $1.8m revenue however with offsetting community cost.

Personnel (including outsourced)

- Medical Personnel is ($1.94m) unfavourable for the month, YTD unfavourable by ($6.1m). The unfavourable position for the month is due to the timing of the RMO rotation that was due to happen in December 20, and the transfer of costs to CCDHB for MHAIDs services (~$480k), Holidays Act provisions ($190k) and the year to date exc MHAIDS, Holidays Act was a favourable variance of $128k is driven by vacancies across other services, most notably surgery and Women's and Children's services offset by COVID expenditure.
- Nursing Personnel is ($1.18m) unfavourable to budget for the month, YTD ($16m) unfavourable. This is driven by overspend to budget for MHAIDs, partially driven by the transfer of staff from other DHBs to CCDHB.
- Allied Personnel labour is ($769k) unfavourable to budget for the month, YTD ($4.75m) unfavourable to budget. $3.6m of the YTD variance results from the transfer of staff from other DHBs to CCDHB.
- Support Personnel labour month position is favourable by $8k, YTD favourable by $180k.
- Management/Admin Personnel is unfavourable in the month by ($1.8m), YTD unfavourable by ($5.5m). $3.9m YTD of this variance has corresponding offsetting revenue within ICT, the remainder is spread across the organisation and driven largely by the use of outsourced contractors.

Section 4

Financial Position

Cash Management – March 2021

Month : Mar 2021					Capital & Coast DHB Statement of Cashflows	Year to Date				
			Variance						Variance	
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	YTD Mar 2021	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year
					Operating Activities					
124,936	**111,708**	**115,627**	**13,227**	**9,309**	**Receipts**	**1,048,329**	**1,005,374**	**967,181**	**42,955**	**81,147**
					Payments					
46,345	45,974	40,454	(371)	(5,891)	Payments to employees	443,438	413,766	406,527	(29,673)	(36,911)
63,406	66,956	62,552	3,550	(854)	Payments to suppliers	560,318	571,823	534,073	11,505	(26,245)
0	0	0	0	0	Capital Charge paid	21,845	23,465	12,297	1,619	(9,549)
6,445	(137)	(762)	(6,582)	(7,208)	GST (net)	(3,697)	1,231	718	4,927	4,415
116,197	**112,794**	**102,244**	**(3,403)**	**(13,953)**	**Payments - total**	**1,021,905**	**1,010,284**	**953,615**	**(11,621)**	**(68,290)**
8,739	**(1,085)**	**13,383**	**9,824**	**(4,644)**	**Net cash flow from operating Activities**	**26,424**	**(4,910)**	**13,566**	**31,334**	**12,858**
					Investing Activities					
9	**75**	**75**	**66**	**65**	**Receipts**	**164**	**675**	**1,336**	**511**	**1,173**
					Payments					
5,051	5,511	3,063	460	(1,987)	Purchase of fixed assets	45,005	49,598	27,286	4,593	(17,719)
5,051	**5,511**	**3,063**	**460**	**(1,987)**	**Payments - total**	**45,005**	**49,598**	**27,286**	**4,593**	**(17,719)**
(5,041)	**(5,436)**	**(2,989)**	**526**	**(1,922)**	**Net cash flow from investing Activities**	**(44,841)**	**(48,923)**	**(25,949)**	**5,104**	**(16,546)**
					Financing Activities					
16,323	**0**	**1,158**	**16,323**	**15,165**	**Receipts**	**23,705**	**0**	**11,752**	**23,705**	**11,953**
					Payments					
0	**0**	**0**	**0**	**0**	Interest payments	**8**	**0**	**0**	**(8)**	**(8)**
0	**0**	**0**	**0**	**0**	**Payments - total**	**8**	**0**	**0**	**(8)**	**(8)**
16,323	**0**	**1,158**	**16,323**	**15,165**	**Net cash flow from financing Activities**	**23,697**	**0**	**11,752**	**23,697**	**11,945**
20,021	**(6,521)**	**11,552**	**26,673**	**8,599**	**Net inflow/(outflow) of CCDHB funds**	**5,279**	**(53,833)**	**(631)**	**60,134**	**8,256**
3,495	(29,075)	(4,100)	(32,570)	(7,595)	**Opening cash**	18,236	18,236	8,083	0	(10,153)
141,268	111,783	116,859	29,616	24,539	Net inflow funds	1,072,197	1,006,048	980,270	67,171	94,273
121,247	118,305	105,307	(2,943)	(15,940)	Net (outflow) funds	1,066,918	1,059,881	980,901	(7,037)	(86,017)
20,021	**(6,521)**	**11,552**	**26,673**	**8,599**	**Net inflow/(outflow) of CCDHB funds**	**5,279**	**(53,833)**	**(631)**	**60,134**	**8,256**
23,515	**(35,597)**	**7,452**	**59,112**	**16,064**	**Closing cash**	**23,515**	**(35,597)**	**7,452**	**59,112**	**16,063**

RECONCILIATION OF CASH FLOW TO OPERATING BALANCE

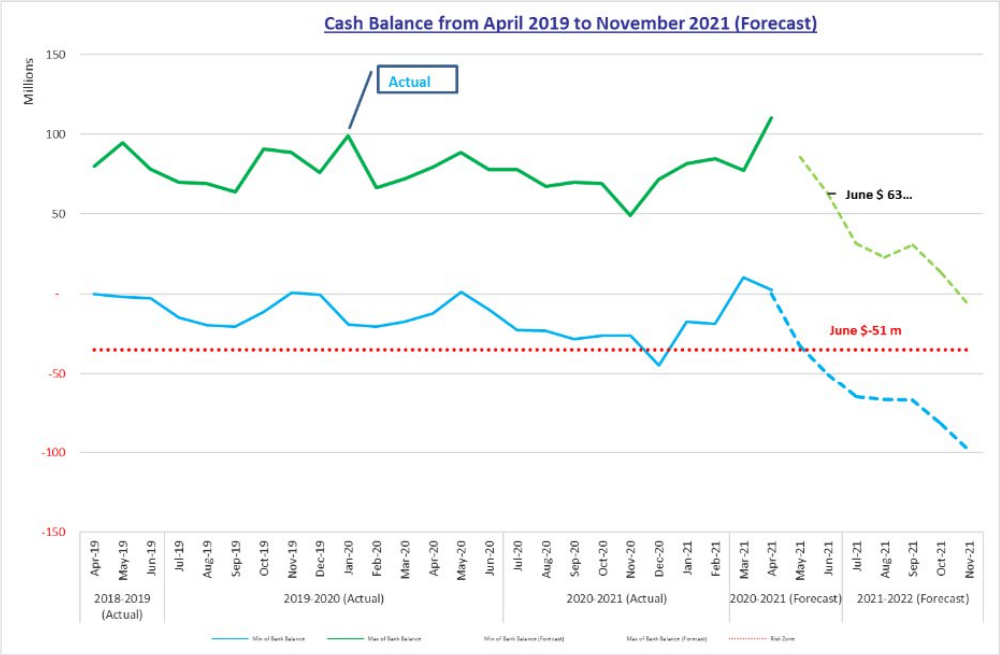
	YTD Mar 2021		
	Actual $000	**Budget $000**	**Variance $000**
Net Cashflow from Operating	26,424	(4,910)	31,334
Non operating financial asset items	(101)	-	(101)
Non operating non financial asset items	(2,726)	(2,295)	(431)
Non cash PPE movements	(24,469)	(24,182)	(287)
Working Capital Movement			
Inventory	617	-	617
Receipts and Prepayments	15,724	12,100	3,624
Payables and Accruals	(50,616)	(4,503)	(46,113)
Total Working Capital movement	**(34,275)**	**7,597**	**(41,872)**
Operating balance	**(35,147)**	**(23,790)**	(11,357)

Current Ratio – This ratio determines the DHB's ability to pay back its short term liabilities.
DHB's current ratio is 0.30 (March - 0.34)

Improved Debt to Equity Ratio - This ratio determines how the DHB has financed the asset base.
DHB's total liability to equity ratio is 0.78 : 1 (March - 0.78 : 1).

Debt Management / Cash Forecast – March 2021

Aged Debtors report ($'000)	Total	Current	1-30	31 - 60	61 - 90	91+	Previous Period
Ministry of Health	7,083	5,541	(36)	(128)	53	1,653	23,306
Other DHB's	5,867	1,390	1,159	106	73	3,139	9,567
Kenepuru A&M	230	30	24	20	156	0	219
ACC	64	700	(751)	1	(71)	185	226
Misc Other	3,446	1,159	440	122	16	1,709	4,082
Total Debtors	**16,690**	**8,820**	**836**	**121**	**227**	**6,686**	**37,400**
less : Provision for Doubtful Debts	(3,585)						(2,531)
Net Debtors	13,105						34,869



Debt Management

- $1,653K 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.
- $3,139K The single largest debtor in 'Other DHB's' outstanding is HVDHB.
- $135K Kenepuru A&M includes significant number of low value patient transactions.
- 'Misc Other' debtors includes non resident debt of approx. $2.1m. About 83% of the non resident debt have payment arrangements in place. The balance will be referred to collection agencies if unpaid.

Cash Management

The DHB may **not** require equity injection for FY21. Cash forecast June21: High:+$63m, Low:-$51m, improved by cash management process.

Balance Sheet / Cashflow – as at 31 March 2021

Feb 2021	Month : Mar 2021				Variance		Capital & Coast DHB Balance Sheet
Actual	Actual	Budget	At Mar 2020	At Jun 2020	Actual vs Budget	Actual vs Mar 2020	YTD Mar 2021
31	31	31	31	31	0	0	Bank
212	10,270	(0)	0	6,523	10,270	10,270	Bank NZHP
12,995	13,216	11,683	12,128	11,683	1,533	1,088	Trust funds
70,448	46,926	49,375	37,421	46,342	(2,450)	9,504	Accounts receivable
9,553	9,613	8,995	9,911	8,995	617	(298)	Inventory/Stock
9,935	8,929	6,257	9,069	6,257	2,672	(140)	Prepayments
103,173	**88,984**	**76,341**	**68,559**	**79,831**	**12,643**	**20,425**	**Total current assets**
510,173	508,904	546,099	521,607	522,978	(37,195)	(12,703)	Fixed assets
14,847	14,847	14,847	9,859	11,626	0	4,988	Work in Progress - CRISP
84,026	86,398	54,096	55,609	57,317	32,301	30,789	Work in progress
609,045	**610,149**	**615,042**	**587,075**	**591,921**	**(4,893)**	**23,073**	**Total fixed assets**
1,150	1,150	1,150	1,150	1,150	1	1	Investment in Allied Laundry
1,150	**1,150**	**1,150**	**1,150**	**1,150**	**1**	**1**	**Total investments**
713,368	**700,283**	**692,532**	**656,784**	**672,901**	**7,751**	**43,499**	**Total Assets**
9,743	0	47,311	4,707	0	47,311	4,707	Bank overdraft HBL
102,297	96,072	64,504	69,018	76,604	(31,569)	(27,054)	Accounts payable, Accruals and provisions
2,985	4,603	4,925	5,803	(252)	322	1,199	Capital Charge payable
593	593	593	593	593	0	0	Insurance liability
11,106	11,455	36,144	23,997	36,144	24,689	12,542	Current Employee Provisions
167,027	171,625	140,857	119,585	140,857	(30,767)	(52,040)	Accrued Employee Leave
12,205	15,720	7,299	12,451	7,299	(8,421)	(3,269)	Accrued Employee salary & Wages
305,956	**300,068**	**301,634**	**236,153**	**261,245**	**1,566**	**(63,915)**	**Total current liabilities**
99	97	95	85	95	(2)	(12)	Restricted special funds
605	605	605	605	605	0	0	Insurance liability
6,564	6,564	6,564	6,296	6,564	0	(269)	Long-term employee provisions
7,268	**7,266**	**7,264**	**6,986**	**7,264**	**(2)**	**(280)**	**Total non-current liabilities**
313,225	**307,335**	**308,898**	**243,139**	**268,510**	**1,564**	**(64,196)**	**Total Liabilities**
400,144	392,948	383,634	413,645	404,391	9,314	(20,697)	Net Assets
817,122	832,493	812,773	797,172	813,224	19,720	35,321	Crown Equity
0	0	0	0	(3,484)	0	0	Capital repaid
15,370	953	0	0	0	953	953	Capital Injection
130,659	130,659	130,660	131,395	130,659	(1)	(736)	Reserves
(563,009)	(571,157)	(559,799)	(514,923)	(536,008)	(11,359)	(56,234)	Retained earnings
400,143	**392,948**	**383,634**	**413,645**	**404,392**	**9,313**	**(20,697)**	**Total Equity**

Balance Sheet

1. For the first time in three years, DHB's cash balance has turned to positive.
2. Accounts receivable is lower than the budgeted recoverable debts.
3. There is a $1.3m assets disposal; however, we have identified an opportunity to improve and optimise our fixed asset capitalisation procedures.
4. Accounts payable, accruals and provisions is higher than the budget primarily due to a timing differences
5. Employee liabilities are higher than budgeted. This is due to an unbudgeted employee costs (MHAIDs) approx. $3m per month;

Cash flow

1. The net cash flow from operating activities is favourable to budget. This is mainly received payment from HVDHB;
2. The net cash flow from investment activities is almost line up to budget;

Capital Expenditure Summary March 2021

			Actual spend on live projects						Forecast spend on approved projects			
Asset Category	Approved Capex Budget	PY Spend to 30 June 2020	September Quarter actual spend	December Quarter actual spend	March Quarter actual spend	Actual YTD Spend	Actual LTD Spend	To spend	Apr-21	May-21	Jun-21	Forecast cash spend to June 21*
Buildings	10,822,766	-	225,088	820,879	479,840	1,525,807	1,525,807	9,296,959	434,420	576,887	667,011	3,204,125
Clinical Equipment	8,647,339	-	643,250	1,506,284	1,113,275	3,262,809	3,262,809	5,384,530	628,641	779,037	831,244	5,501,731
ICT	2,201,844	-	41,960	142,786	373,375	558,122	558,122	1,643,723	187,404	221,556	265,459	1,232,540
2020-21 projects	**21,671,949**	-	**910,298**	**2,469,950**	**1,966,490**	**5,346,738**	**5,346,738**	**16,325,211**	**1,250,465**	**1,577,480**	**1,763,714**	**9,938,396**
Buildings	17,890,332	8,814,096	1,395,429	934,819	806,729	3,136,976	11,951,072	5,939,260	290,646	243,041	227,269	3,897,933
Clinical Equipment	44,165,614	21,222,465	7,018,217	5,846,681	1,209,371	14,074,268	35,296,733	8,868,881	351,271	1,179,588	930,166	16,535,293
ICT	9,172,562	6,711,200	1,266,724	348,068	263,844	1,878,636	8,589,836	582,726	92,628	90,761	90,761	2,152,785
Prior Year projects	**71,228,508**	**36,747,760**	**9,680,370**	**7,129,568**	**2,279,943**	**19,089,880**	**55,837,640**	**15,390,867**	**734,545**	**1,513,390**	**1,248,195**	**22,586,011**
Total	**92,900,457**	**36,747,760**	**10,590,667**	**9,599,517**	**4,246,434**	**24,436,618**	**61,184,378**	**31,716,079**	**1,985,010**	**3,090,870**	**3,011,909**	**32,524,407**

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

- The development of business cases from the 2020/21 Capital Plan are at various stages. It was anticipated that $3m-$4m be presented for approval each month. Only $21.7m in projects have been approved to March 2021. Delays in three large projects has given rise to a lower overall approval rate. Two are scheduled to be submitted for approval in May and the third in June
- Total spend to the end of March 2021 was $24.4m which mostly related to prior year approved projects
- In December 2020, $41m-$43m was forecasted as the cash spend for the year. This has been revised to $32m-$34m
- Over $440k credit and recharge was received in March from previous quarters' spending. This has offset part of March quarter's spending.
- The slower spend rate is due to delays in business case development mentioned above, shipping in clinical equipment for both assessment and delivery (can take up to 14 weeks), a handful of larger projects being revised. The timing to complete some building projects will take longer than initially anticipated (CSB lift renewal & seismic upgrade, ceiling tile replacement, passive fire)
- Efforts are being made to ensure the spend rate on capital spending is improved to cash spend is in line with budget

Board Decision

2 June 2021

Committee membership and amended Committee Terms of Reference

Action Required

The Boards approve:

a) Appointing Ria Earp as a member of the Heath Systems Committee

b) Appointing Brendon Boyle as a member of the Major Capital Projects Advisory Committee (MCPAC).

The Capital & Coast Board approves:

c) Appointing Stacey Shortall as a member of the CCDHB Finance Risk and Audit Committee (FRAC).

d) The Terms of Reference of the Chief Executive Employment Committee (Attachment 1) to replace the Terms of Reference for the Capital & Coast DHB Remuneration Committee.

The Hutt Valley Board approves:

e) The Terms of Reference of the Chief Executive Employment Committee (Attachment 2) to replace the Terms of Reference for the Hutt Valley DHB Human Resources and Remuneration Committee.

The Boards note:

MPAC:

f) The Terms of Reference for MCPAC provide that the Chair of the Boards appoint the Chair of MCPAC.

g) In order for the membership to comply with the Terms of Reference for MCPAC the Chair will (effective from the date the Chair advises the Board Secretary):

i. resign as the member from CCDHB (but remain on the Committee as one of two HVDHB members)

ii. resign as the Chair of MCPAC and appoint Brendon Boyle as Chair

The Boards note:
FRAC:

h) The Terms of Reference for the Capital and Coast and Hutt Valley Finance Risk and Audit Committees provide that each committee shall have between 4 and 6 members, and in addition requires that each has an equal number of members.

i) David Smol will resign as a member of CCDHB FRAC (and remain as a member of HVDHB FRAC) effective from the appointment of Stacey Shortall in (c) above.

Chief Executive Employment Committees

j) The Committee Terms of Reference agreed in (d) and (e) above, appoint the Board Chair and Deputy Chair to each Committee.

k) The Committees will meet concurrently and practically operate as 'one committee' and have the delegated authority to:

i. monitor the Chief Executive's performance

ii. undertake the annual performance and remuneration review as required under the Chief Executive's Individual Employment Agreement (subject to guidance and requirements of the Public Service Commission)

iii. make recommendations to the Board regarding remuneration

iv. meet the Boards' good employer obligations

l) The Chair of the Boards, supported by the two Deputy Chairs, will consult as appropriate with the Boards prior to considering matters under the Committees' delegated authority and will also report decisions of the Committees to the Boards.

Strategic Alignment	Effective governance is required to support the Boards Strategic direction and priorities
Author	Sally Dossor, Director Office of the Chief Executive and Board Secretary
Endorsed by	Board Chair, David Smol
Contributors	Roger Palairet , Chief Legal Officer, CCDHB and HVDHB
Consultation	N/A

Executive Summary

Committee Membership

The Minister of Health appointed 3 new Board members, to fill 2 vacancies on the Capital & Coast District Health Board and 1 vacancy on the Hutt Valley District Health Board. The appointments were notified in the NZ Gazette on 16 April 2021 and the Board members attended their first Board meeting on 5 May 2021.

Following discussion with the new members, and the Committee Chairs, the following appointments are proposed by the Chair. In some cases, the Terms of Reference of the Committees give rise to some consequential changes to Committee membership identified in the table as follows:

Committee	New Board member	Which Board appoints	Terms of Reference parameters
Health Systems Committee	Ria Earp	Both Boards	n/a
MPAC	Brendon Boyle (member and Chair)	Both Boards	Membership must be 2 from each Board – and the Chair of the Boards appoints the Chair (from the members). The current membership from each is: • HVDHB (Wayne Guppy and David Smol) • CCDHB (Hamiora Bowkett and David Smol) In order to comply with the Terms of Reference the Chair will resign from MCPAC (in his capacity as a CCDHB member) though remain as a HVDHB appointee.

Committee	New Board member	Which Board appoints	Terms of Reference parameters
CCDHB FRAC	Stacey Shortall	CCDHB Board	Membership of both FRACs must be between 4 and 6 from each Board and there must be an equal number appointed from each Board. The current membership from each is: • HVDHB (Wayne Guppy, Yvette Grace, Prue Lamason, John Ryall and David Smol) • CCDHB (Roger Blakeley, Kathryn Adams, Hamiora Bowkett Tristram Ingham and David Smol) The appointment of an additional member on the CCDHB FRAC requires either an additional appointee on the HVDHB FRAC or for a CCDHB member to resign their position on CCDHB FRAC. The Chair proposes to resign from CCDHB FRAC (and remain as a member of HVDHB FRAC) to maintain committee numbers and comply with the Terms of Reference.

Chief Executive Employment Committee

The Chair has considered the current Committee structure that governs the relationship with the 2DHB Chief Executive, in particular how to meet the Boards' good employer obligations over the period of transition under the Health System reforms. The current Terms of Reference (refer Board Manuals) are not fit for purpose and it is proposed that they are replaced with the Terms of Reference in attachments 1 and 2. The Chair of the Boards, supported by the two Deputy Chairs, will consult as appropriate with the Boards prior to considering decisions to be made under the Committees' delegated authority and will also report decisions and recommendations of the Committees to the Boards. The Committee will be guided by Public Service Commission requirements, and in particular the guidance and directives applicable to the transition period.

Strategic Considerations

Service	Governance
People	The amended Terms of Reference recognises the importance of the relationship between the Boards the Boards' only employee – the Chief Executive.
Financial	None
Governance	The Board

Attachment (s)

- Attachment 1: Capital & Coast District Health Board Chief Executive Employment Committee
- Attachment 2: Hutt Valley Health District Health Board Chief Executive Employment Committee

Attachment 1: Capital & Coast District Health Board Chief Executive Employment Committee

Purpose
The Chief Executive Employment Committee has the responsibility for the effective monitoring of the 2DHB Chief Executive's performance and has the authority to undertake the annual remuneration review.

The Chief Executive Employment Committee is a committee of the Board of Capital & Coast DHB, and is the successor to the Remuneration Committee that was established from 1 July 2003 under clause 38 of Schedule 3 of the New Zealand Public Health and Disability Act 2000.

Reports to: The Board

Membership: The Chair and Deputy Chair

Chairperson The Committee will be chaired by the Chair of the Capital & Coast District Health Board.

Meeting concurrently: The Committee will at all times will meet concurrently with the Hutt Valley District Health Board Chief Executive Employment Committee

Meeting frequency: Two times per annum, or as required

Quorum: The quorum for each Committee is 2, and as meetings must be held concurrently, each Committee must have a quorum for meetings to proceed.

Responsibilities
The Chief Executive Employment Committee will have responsibility and authority to:

1. Agree with the Chief Executive the annual performance objectives.
2. Conduct the performance review required in the employment agreement between the Board and the Chief Executive.
3. Undertake the annual remuneration review required in the employment agreement between the Board and the Chief Executive and make recommendations to the Board regarding remuneration.
4. Represent the Board in regard to any issues which may arise in respect to the Chief Executive's job description, agreement, performance objectives or other similar matters.

Approved by resolution of the Board: / / 2021

Attachment 2: Hutt Valley Health District Health Board Chief Executive Employment Committee

Purpose
The Chief Executive Employment Committee has the responsibility for the effective monitoring of the 2DHB Chief Executive's performance and has the authority to undertake the annual remuneration review.

The Chief Executive Employment Committee is a committee of the Board of Hutt Valley DHB, and is the successor to the Remuneration Committee that was established from 1 July 2003 under clause 38 of Schedule 3 of the New Zealand Public Health and Disability Act 2000.

Reports to: The Board

Membership: The Chair and Deputy Chair

Chairperson: The Committee will be chaired by the Chair of the Hutt Valley District Health Board

Meeting concurrently: The Committee will at all times will meet concurrently with the Capital & Coast District Health Board Chief Executive Employment Committee

Meeting frequency: Two times per annum, or as required

Quorum: The quorum for each Committee is 2, and as meetings must be held concurrently, each Committee must have a quorum for meetings to proceed.

Responsibilities
The Chief Executive Employment Committee will have responsibility and authority to:

1. Agree with the Chief Executive the annual performance objectives.
2. Conduct the performance review required in the employment agreement between the Board and the Chief Executive.
3. Undertake the annual remuneration review required in the employment agreement between the Board and the Chief Executive and make recommendations to the Board regarding remuneration.
4. Represent the Board in regard to any issues which may arise in respect to the Chief Executive's job description, agreement, performance objectives or other similar matters.

Approved by resolution of the Board: / / 2021

Board Decision – Public EXCLUDED

2 June 2021

Risk Mitigation-CCDHB securing a right of way over Te Hopai Home Trust Board Land and Te Hopai Home Trust Board requiring CCDHB approval to grant a ground lease over CCDHB land

Action Required

It is recommended that the Board:

(a) **Note** the contents of this paper.

(b) **Approve** CCDHB entering into a right of way easement with Te Hopai Home Trust Board (Te Hopai) to secure a legal right of way over Te Hopai land legally described as Lot 4 Deposited Plan 44405 and held in record of title WN33A/651 (Te Hopai Land) for a term of 35 years.

(c) **Approve** CCDHB granting a ground lease to Te Hopai over CCDHB land legally described as Town Belt of Wellington and held in record of title WN474/9 (CCDHB Land) for an initial term of 35 years with one right of renewal of 15 years, for the purposes of Te Hopai building an aged care and dementia facility.

(d) **Agree** to delegate authority to the Chief Executive to execute the Right of Way Easement over Te Hopai Land and the ground lease over CCDHB Land.

The CCDHB Board note:

(a) **Note** that the CCDHB need to secure a right of way easement over Te Hopai Land to legally secure access to its bulk oxygen tanks (outlined in orange on Appendix 1); underground pipes (outlined in blue on Appendix 2) relating to the reservoir which is used for the Hospital emergency water supply (reservoir outlined in black on Appendix 1); and for the delivery of dosing chemicals to the water towers in TEC that supply chilled water plant (outlined green on Appendix 1).

(b) **Note** that the right of way easement will be over approximately 1716m² of Te Hopai land as shown in red on Appendix 1.

(c) **Note** that CCDHB will be required to pay Te Hopai approximately $184,877 per annum, plus GST for this right of way easement.

(d) **Note** that it is likely that the right of way easement will include market rent reviews.

(e) **Note** that CCDHB will be seeking a right of way easement for 35 years to ensure long term access rights.

(f) **Note** that Property have thoroughly investigated the option of purchasing the Te Hopai Land or obtaining a right of way easement for a term exceeding 35 years, however Te Hopai are unable to do neither. Please refer to 'Background, Paragraph 5' for an explanation as to why this is not possible.

(g) **Note** that all costs associated with the right of way easement will be split evenly between CCDHB and Te Hopai.

(h) **Note** that CCDHB Land which Te Hopai would like to use to build an aged care and dementia facility is approximately 1542m² and is shown in blue on Appendix 1.

(i) **Note** that the University of Otago (University) currently have a building on CCDHB Land which they are looking to vacate. Therefore, any ground lease with Te Hopai will be

conditional on the University vacating a building which is owned by the University and is situated on the CCDHB Land Te Hopai wish to occupy.

(j) **Note** that if CCDHB were to grant a ground lease to Te Hopai, the market rental value for the Land has been valued as at 19 April 2021 to be $267,152 per annum, plus GST.

(k) **Note** that any ground lease negotiated between CCDHB and Te Hopai will include market rent reviews.

(l) **Note** that if a ground lease for an initial term of 35 years with one right of renewal of 15 years is negotiated with Te Hopai, legal costs to execute the ground lease will be split evenly between CCDHB and Te Hopai but costs relating to subdivision and preparing a notice for the Port Nicholson Block will be met by Te Hopai.

(m) **Note** that Property have investigated the possibility of disposing of the CCDHB Land to Te Hopai. However, this is not a preferred option due to the legal complexities and costs involved. Refer to the text below for a further explanation.

(n) **Note** the execution of the right of way easement and ground lease is dependent on the Minister of Health's consent due to the terms associated with the arrangements.

(o) **Note** that external legal advice was obtained throughout the discussions with Te Hopai and the drafting of this Board paper.

Strategic Alignment	To ensure CCDHB maintain a market driven rent revenue stream at the same time as supporting Te Hopai to build a new facility to assist with dementia and aged care patients To ensure CCDHB has legal access to its service supplies, thereby reducing the risk of CCDHB loosing this access
Author	Hanita Shantilal, Senior Property Manager, Property & Asset Management
Endorsed by	Phil Butter, General Manager Property & Asset Management Steve Crombie- Director Property & Facilities Rosalie Percival, 2DHB Chief Financial Officer
Presented by	Fionnagh Dougan, Chief Executive
Purpose	The purpose of this paper is to obtain endorsement and approval to enter into a right of way easement and ground lease with Te Hopai
Contributors	Philip Butter, General Manager , Property & Asset Management
Consultation	Greenwood Roche (Solicitors) Te Hopai Home Trust Board

Executive Summary

1. Te Hopai approached CCDHB about the CCDHB land as outlined in blue on Appendix 1 with the intention to purchase the land or enter into a long term ground lease of 50 years or more, so that they could build an aged care and dementia facility on the land.
2. Currently the University have a building which is owned by them, situated on CCDHB Land. Note that the University has not entered into a ground lease for this arrangement and have never paid a ground rental due to the University's desire to enter into a separate ground lease from their other leased areas with the CCDHB. The University has expressed their intention to vacate this building once their new fit out is complete (approximately 2 years away). On

vacating the building, they will be required to demolish the building and reinstate the CCDHB Land.

3. The CCDHB need to legalise a long term right of way over the Te Hopai land (outlined in red on Appendix 1) in order to secure access rights to its bulk oxygen tanks (outlined in orange on Appendix 1); underground pipes (outlined in blue on Appendix 2) relating to the reservoir which is used for the Hospital emergency water supply (reservoir outlined in black on Appendix 1); and for the delivery of dosing chemicals to the water tanks in TEC that supply chilled water towers (outlined in green on Appendix 1).
4. Both Te Hopai and CCDHB discussed the potential of doing a land swap which would enable Te Hopai and CCDHB to obtain ownership of the land it needs. However, legal advice confirmed that Te Hopai is unable to dispose of any land it owns due to the way their Trust is set up. CCDHB could dispose of its land to Te Hopai but this would trigger a subdivision under the Resource Management Act 1991 (RMA), the offer back provisions under the Public Works Act 1981 (PWA) and the right of first refusal under Port Nicholson Block Claims Settlement Act 2009 (PNBCSA).
5. Legal advice has indicated that CCDHB could dispose of its land to Te Hopai as it is likely that the purpose of the disposal (being for 'health related purposes') would render the disposal exempt from offer back under the PWA and first right of refusal under the PNBCSA as stated in the New Zealand Public Health and Disabilities Act 2000 (NZPHDA). However, this process would be cumbersome as CCDHB would need to undertake a subdivision, revoke the reserve status of the land which would require approval from both the Minister of Conservation and the Minister of Health and notify/consult PNBCSA.
6. In order to grant a ground lease to Te Hopai, CCDHB will need to obtain a certificate of compliance in respect of the subdivision of the land in accordance with Section 218 of the RMA. CCDHB will also need to obtain a notice under Section 109 of the PNBCSA from the Minister of Health confirming that, in the Minister's opinion, the ground lease is to achieve or assist in achieving the objectives for the CCDHB.

Background

Te Hopai was established in 1888 for the purposes of providing care for the aged and needy and the land they currently own (as outlined in purple on Appendix 1) was deeded to the Trust for this purpose by a specific Act of Parliament being the 'Wellington Asylum, Home, Hospital and Orphanage Reserves Act 1888.

Te Hopai operates under the 'Age Related Residential Care Contract' with CCDHB and currently has 151 beds (16 Dementia beds; 44 rest home beds; and 91 Hospital level beds). The need for Te Hopai's services remain at a high level with them having 96% occupancy rates consistently and there is specific pressure for increased service capacity in the areas of palliative, dementia and respite care, hence the need to build an aged care and dementia facility.

Te Hopai have indicated that the new facility will allow them to not only provide services under the Trust Deed to the 'aged and needy', but will allow them to grow in areas such as additional dementia units, palliative care, rental accommodation for the aged (supported housing) and health services.

Over the years, there has been significant undocumented incursions across Te Hopai's land by CCCDHB, mainly for services (access, water, cabling). If Te Hopai were to build an aged care and dementia facility on their own land, it would negatively impact the CCDHB services and access. Therefore, Te Hopai and Property believe Te Hopai building on the CCDHB land is the better alternative.

Furthermore, it is of upmost importance that the CCDHB legally secure rights over Te Hopai land to access its infrastructure. Although Property's preference would be to have ownership of this land, Te Hopai is unable to dispose of land as all land owned by Te Hopai has been placed in Trust. In order to dispose of any land, Te Hopai would need to dissolve the Trust. This would put them in a position where all land under its ownership would need to go through offer back and first right of refusal processes.

Although a 'land swap' scenario was suggested by Te Hopai, Property believe it is in CCDHB's best interests to keep the right of way easement and ground lease transactions separate from each other as CCDHB's ability to grant Te Hopai a ground lease is dependent on the University vacating the land. Property are currently working with the University to formalise through a legal agreement. Note that the University will be required to move their building from CCDHB land upon exiting the building.

Property will attempt to secure the right of way easement once an agreement is executed with the University and a memorandum of understanding (MoU) is executed with Te Hopai. Property believe that the MoU combined with an agreement with the University specifying when the University will be vacating the land, will provide Te Hopai with the confidence to grant the right of way easement to CCDHB prior to the commencement of their ground lease.

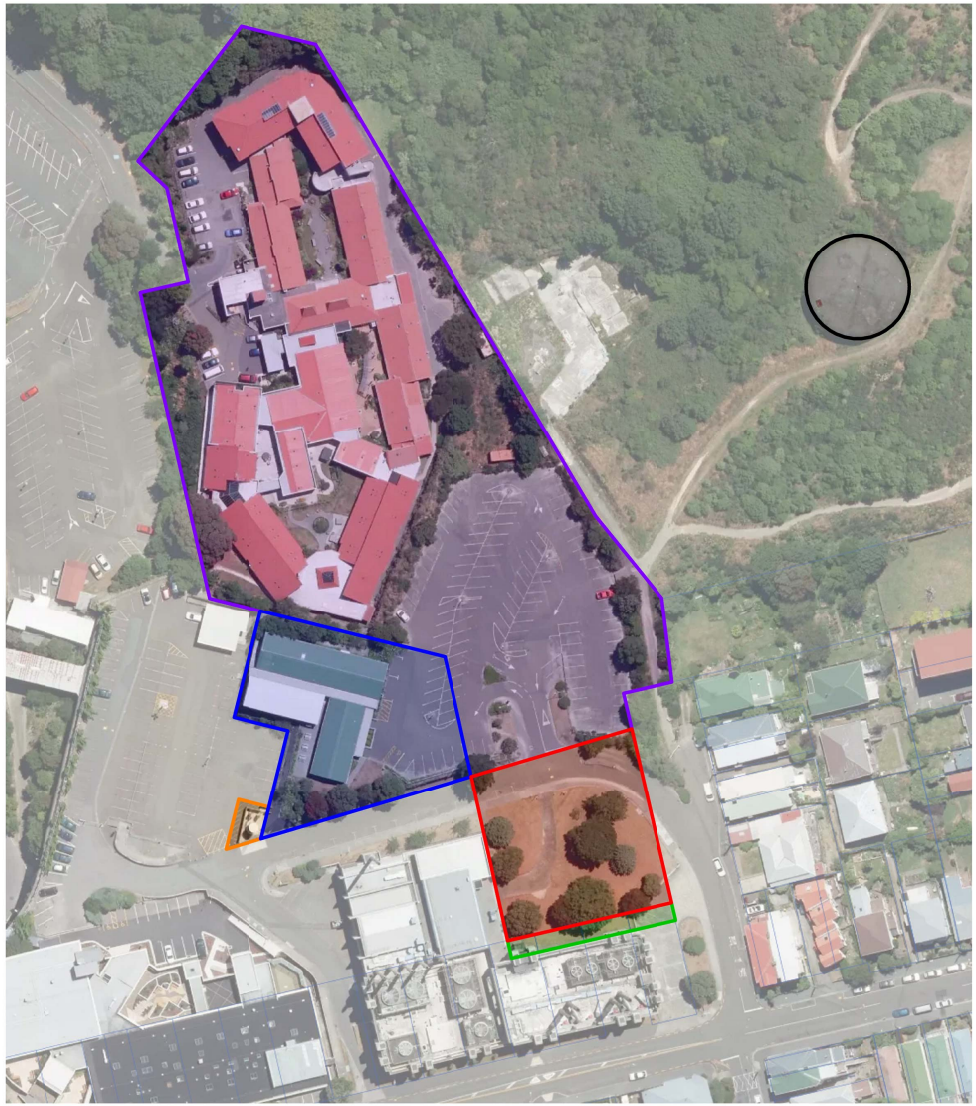
Strategic Considerations

Service	Mitigate the risk of losing access to critical supply lines
People	Nil
Financial	Low-Minimal difference between ground lease charges
Governance	Nil

Identified Risks

Risk 1: The University do not exit CCDHB land as they have advised verbally.

Mitigation: Property have intentionally made sure that the right of way easement CCDHB are seeking over Te Hopai Land is a separate transaction from the ground lease Te Hopai are seeking over CCDHB Land as the granting of the ground lease is dependent on the University vacating CCDHB Land. Property are currently in the process of formalising a legal document with the University that will confirm that they wish to vacate the CCDHB Land, a timeframe for doing so, and that they will reinstate the CCDHB Land by removing their building which is currently situated on the CCDHB Land.



CCDHB RESERVOIR

EXISTING TE HOPAI FACILITY ON LAND OWNED BY TE HOPAI

CCDHB LAND, TE HOPAI WANT TO BUILD DEMENTIA & AGED CARE FACILITY ON.

CCDHB OXYGEN TANKS

TE HOPAI LAND, CCDHB WANT A RIGHT OF WAY EASEMENT OVER

TE HOPAI LAND CCDHB NEED ACCESS TO FOR DOSING OF TOWERS

1 HIghlighted Site
1 : 500

7/05/2021 Issued 1

CAPITAL & COAST District Health Board
ŌPOKO KI TE URU HAUORA

DRAWING ORIGINATOR: CCDHB
DRAWN BY: SHS

SHEET NAME:
Highlighted Boundary

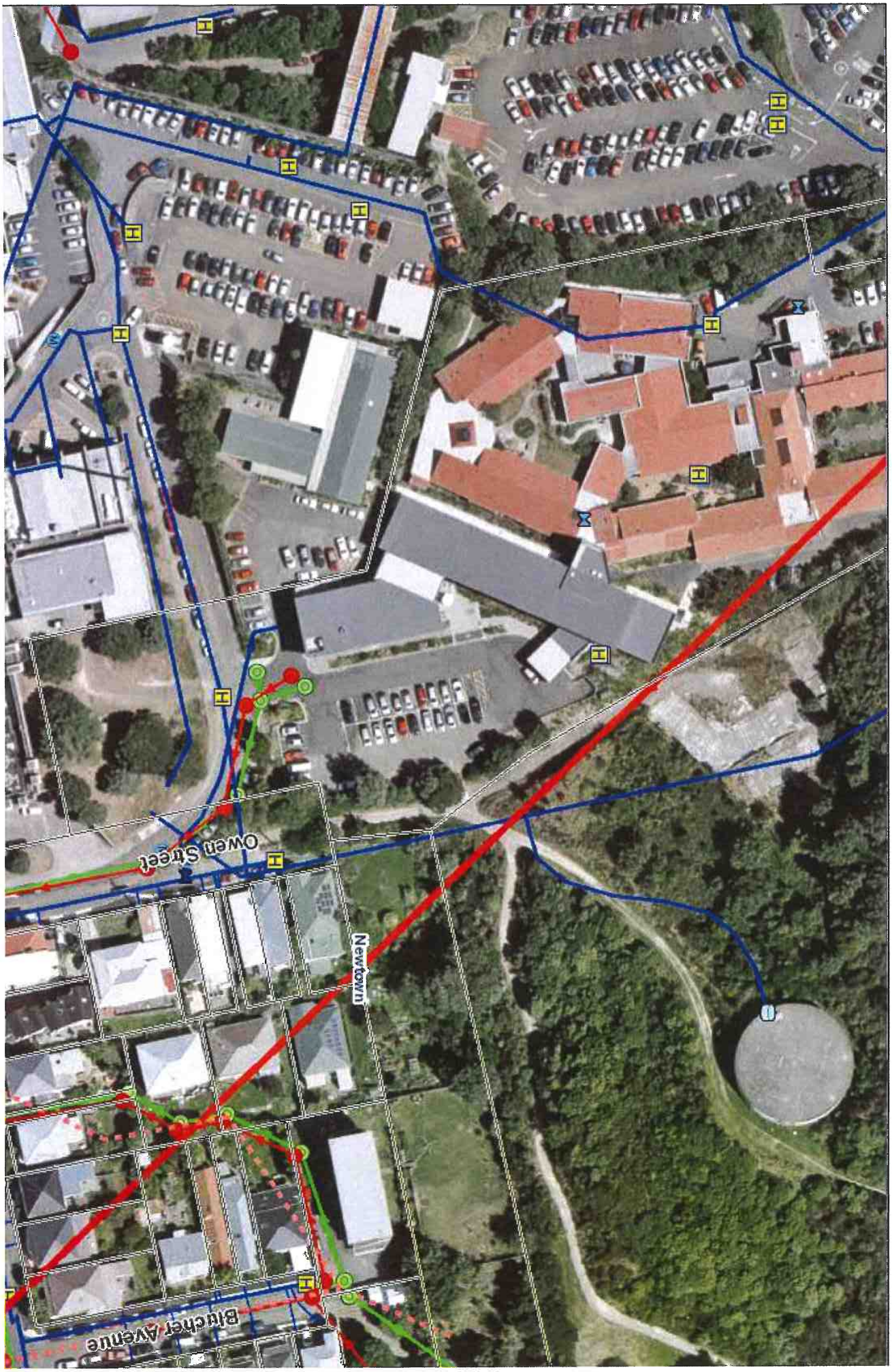
SITE CODE: WRH
BUILDING CODE: SITE

SHEET NUMBER: A101
REVISION: 1

WRH _SITE _A101 _1

C:\Users\394250\Local\Temp Revit\Site File.rvt
7/05/2021 2:54:42 PM

APPENDIX 2



Board Information

2 June 2021

Health System Committee (HSC) update from Committee meeting dated 26 May 2021

Action Required

The Boards note that the Committee received the following presentations and papers:

(a) Item 2.1: Update on 2DHB Hospital Network – Presentation

(b) Item 3.1: Acute Flow – Presentation

(c) Item 3.2: Planned Care Performance 2DHB

(d) Item 3.3: Bowel Screening – Presentation

Endorsed by	Fionnagh Dougan, Chief Executive Health System Committee
Presented by	Sue Kedgley, Health System Committee
Purpose	Provide the Boards with an update regarding the content of the meeting
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 papers can be located on the DHB websites or in the HSC Diligent Book for 26 May 2021, and the presentations can be found in the Resource Centre.

Strategic Considerations

Service	As noted in the HSC papers
People	As noted in the HSC papers
Financial	As noted in the HCC papers
Governance	As noted in the HSC papers

Engagement/Consultation

Patient/Family	As noted in the HSC papers
Clinician/Staff	As noted in the HSC papers
Community	As noted in the HSC papers

Identified Risks

Risk ID	Risk Description	Risk Owner	Current Control Description	Current Risk Rating	Projected Risk Rating
	As noted in the HSC papers				

Attachment/s

n/a

Capital and Coast DHB and Hutt Valley DHB

CONCURRENT Board Meeting

Meeting to be held on 2 June 2021

Resolution to exclude the Public

Moved that the public be excluded from the following parts of the proceedings of this meeting, namely:

- for the Agenda items and general subject matter to be discussed as set out in the first column in the table below,
- on the grounds under clause 34 of Schedule 3 to the New Zealand Public Health and Disability Act 2000 as set out in the second column in the table below and
- for the reasons set out in the third column of the table below (including reference to the particular interests protected by the Official Information Act, where applicable).

TABLE

Agenda item and general subject of matter to be discussed	Grounds under clause 34 on which the resolution is based	Reason for passing the resolution in relation to each matter, including reference to OIA where applicable
Confirmation of minutes of previous meeting (public excluded session) and Matters Arising from those minutes.	paragraph (a) i.e. the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982	OIA, section 9(2)(ba) to protect information which is subject to an obligation of confidence where the making available of that information would be likely to prejudice the supply of information from the same source, and it is in the public interest that such information should continue to be supplied. OIA, section 9(2)(j) to enable this organisation to carry on, without prejudice or disadvantage negotiations.
MHAIDS Quality and Safety Report	As above	As above
CCDHB Quality and Safety Report	As above	As above
HVDHB Quality and Safety Report	As above	As above
Staff Health and Safety Reports	As above	As above
HVDHB March 2021 Financial and Operational Performance Report	As above	As above
CCDHB March 2021 Financial and Operational Performance Report	As above	As above

Service Spotlight	As above	As above
2021/22 Statements of Performance Expectations, Budget and Delegations	As above	As above
FRAC Update and Items for Approval from meeting dated 25 May 2021	As above	As above
Bed Replacement Programme	As above	As above
Deferred Item 4.2 from 5 May 2021 meeting	As above	As above
People, Capability and Culture Report	As above	As above
MCPAC Update	As above	As above
Minutes of Previous Meeting	As above	As above
Matters Arising from Previous Meetings	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.