PUBLIC

HUTT VALLEY DHB / Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**AGENDA v.5** Held on Thursday 3 December Location: Helen Smith Community Meeting Room, Pātaka, Cnr Norrie & Parumoana streets, Porirua Zoom link: **889 4061 3779** Time: 9am
	MEETING

	Item	Action	Presenter	Min	Time	Pg
1	**PROCEDURAL BUSINESS**					
1.1	Karakia		All members	15	9:00am	
1.2	Apologies	**ACCEPT**	Chair			
1.3	Public Participation - Presentation of petition to Board	**VERBAL**	Public			
1.4	Continuous Disclosure 1.4.1 Combined Board Interest Register	**ACCEPT**	Chair			
	1.4.2 Combined ELT Interest Register					
1.5	Minutes of Previous Concurrent Meeting	**ACCEPT**	Chair			
1.6	Matters Arising from Previous Concurrent Meetings	**NOTE**	Chair			
1.7	Chair's Report and Correspondence	**NOTE**	Chair			
1.8	Chief Executive's Report	**NOTE**	Chief Executive			
1.9	Board Work Plan 2021 1.9.1 Detailed Work Plan	**DISCUSS**	Chair	20	9:15am	
2	**DHB Performance and Accountability**					
2.1	HVDHB September 2020 Financial and Operational Performance Report 2.1.1 Report	**NOTE**	Chief Financial Officer Director Provider Services	10	9.35am	
2.2	CCDHB September 2020 Financial and Operational Performance Report 2.2.1 Report	**NOTE**	Chief Financial Officer Director Provider Services			
3	**Updates**					
3.1	HSC Update and Items for Approval	**NOTE**	HSC Chair	20	9.45am	
3.2	Equity Definition, Goal and Principles	**DECISION**	Director of Māori Health			
3.3	Aligning Whakamaua: Ministry of Health Māori Action Plan with Te Pae Amorangi and Taurite Ora	**NOTE**	Directors of Māori Health			
3.4	Pacific Health Report	**NOTE**	Director of Pacific Peoples Health			
3.5	Sub-Regional Pacific Health Strategy Group Update	**PRESENT**	Chair of SRPHSG	30	10.20am	
4	**OTHER**					
4.1	General Business	**NOTE**	Chair	5	10.50am	
4.2	Resolution to Exclude the Public	**ACCEPT**	Chair			
11:00 am - MORNING TEA – 15 min						

DATE OF NEXT FULL BOARD MEETING:
3 March 2021, Zoom: TBC, Location: TBC

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

27 July 2020

Name	Interest
Mr David Smol *Chair*	• Director, Contact Energy • Director, Viclink • Director, New Zealand Transport Agency • Independent Consultant • Sister-in-law is a nurse at Capital & Coast District Health Board
Dr Ayesha Verrall *Deputy Chair*	• Labour Party List Candidate for 2020 General Election • Member, PHARMAC Pharmacology and Therapeutics Advisory Committee's Immunisations Subcommittee • Member, Association of Salaried Medical Specialists • Member, Australasian Society for Infectious Diseases • Employee, Capital & Coast District Health Board • Employee, University of Otago
Mr Wayne Guppy *Deputy Chair*	• Mayor, Upper Hutt City Council • Director, MedicAlert • Chair, Wellington Regional Mayoral Forum • Chair, Wellington Regional Strategy Committee • Deputy Chair, Wellington Water Committee • Deputy Chair, Hutt Valley District Health Board • Trustee, Ōrongomai Marae • Wife is employed by various community pharmacies in the Hutt Valley
Dr Kathryn Adams	• Contracted Vaccinator, Kokiri Marae Hauora Clinic, Lower Hutt • Fellow, College of Nurses Aotearoa (NZ) • Reviewer, Editorial Board, Nursing Praxis in New Zealand • Member, Capital & Coast District Health Board • Member, National Party Health Policy Advisory Group • Workplace Health Assessments and seasonal influenza vaccinator, Artemis Health • Director, Agree Holdings Ltd, family owned small engineering business, Tokoroa
Dr Roger Blakeley	• Board Member, Transpower New Zealand Ltd • Director, Port Investments Ltd • Director, Greater Wellington Rail Ltd • Deputy Chair, Wellington Regional Strategy Committee • Councillor, Greater Wellington Regional Council • Economic Development and Infrastructure Portfolio Lead, Greater Wellington Regional Council

	• Member of Capital & Coast District Health Board • Member, Harkness Fellowships Trust Board • Member of the Wesley Community Action Board • Independent Consultant • Brother-in-law is a medical doctor (anaesthetist), and niece is a medical doctor, both working in the health sector in Auckland • Son is Deputy Chief Executive (insights and Investment) of Ministry of Social Development, Wellington
Hamiora Bowkett	• Deputy Chief Executive, Te Puni Kōkiri • Former Partner, PricewaterhouseCoopers • Former Social Sector Leadership position, Ernst & Young
Josh Briggs	• Councillor, Hutt City Council • Wife is an employee of Hutt Valley District Health Board / Capital & Coast District Health Board
Keri Brown	• Councillor, Hutt City Council • Council-appointed Representative, Wainuiomata Community Board • Director, Urban Plus Ltd • Member, Arakura School Board of Trustees • Partner is associated with Fulton Hogan John Holland
'Ana Coffey	• Father, Director of Office for Disabilities • Brother, employee at Pathways, NGO Project Lead Greater Wellington Collaborative • Shareholder, Rolleston Land Developments Ltd
Yvette Grace	• General Manager, Rangitāne Tu Mai Rā Treaty Settlement Trust • Member, Hutt Valley District Health Board • Member, Wairarapa District Health Board • Member, Steering group, Wairarapa Economic Development Strategy • 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 • Stepson works in middle management of Fletcher Steel
Ken Laban	• Chairman, Hutt Valley Sports Awards • Broadcaster, numerous radio stations • Trustee, Hutt Mana Charitable Trust • Trustee, Te Awaikairangi Trust • Member, Hutt Valley District Health Board • Member, Ulalei Wellington • Member, Greater Wellington Regional Council • Member, Christmas in the Hutt Committee • Member, Computers in Homes • Commentator, Sky Television
Prue Lamason	• Councillor, Greater Wellington Regional Council • Chair, Greater Wellington Regional Council Holdings Company • Deputy Chair, Hutt Mana Charitable Trust • 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 • Development Officer, Wellington Softball Association • Trustee, Hutt City Communities Facility Trust

Vanessa Simpson	• Director, Kanuka Developments Ltd • Relationship & Development Manager, Wellington Free Ambulance • Member, Kapiti Health Advisory Group
Dr Richard Stein	• Chairman and Trustee, Crohn's and Colitis NZ Charitable Trust • Member, Executive Committee of the National IBD Care Working Group • Member, Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy • Clinical Senior Lecturer, University of Otago Department of Medicine, Wellington • Assistant Clinical Professor of Medicine, University of Washington, Seattle • Locum Contractor, Northland DHB, HVDHB, CCDHB • Gastroenterologist, Rutherford Clinic, Lower Hutt • Medical Reviewer for the Health and Disability Commissioner

CAPITAL & COAST AND HUTT VALLEY DISTRICT HEALTH BOARDS

Interest Register

EXECUTIVE LEADERSHIP TEAM

30 SEP 2020

Fionnagh Dougan *Chief Executive Officer*	• Board member, Children's Hospital Foundation, Queensland • Trustee, Wellington Hospital Foundation • Adjunct Professor University of Queensland
Nigel Fairley *3DHB General Manager MHAIDS*	• President, Australian and NZ Association of Psychiatry, Psychology and Law • Trustee, Porirua Hospital Museum • Fellow, NZ College of Clinical Psychologists • Director and shareholder, Gerney Limited
Joy Farley *2DHB Director Provider Services*	• None
Debbie Gell *HVDHB General Manager Quality, Service Improvement and Innovation*	• Member of Consumer Council for Healthy Homes Naenae
Arawhetu Gray *CCDHB Director, Māori Health*	• Co-chair, Health Quality Safety Commission – Maternal Morbidity Working Group • Director, Gray Partners • Chair, Te Hauora Runanga o Wairarapa • Chair, Tangata Whenua Advisory Group, Te Hiringa Hauora, Health Promotion Agency
Rachel Haggerty *2DHB Director, Strategy Planning & Performance*	• Director, Haggerty & Associates • Chair, National GM Planner & Funder
Emma Hickson *CCDHB Chief Nursing Officer*	• None
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

1 September 2020

Chris Kerr *Director of Nursing*	• 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 • Auditor for Health Care with the DAA Group Ltd
Christine King *2DHB Chief Allied Health Professions Officer*	• Brother works for Medical Assurance Society (MAS) • Sister is a Nurse for Southern Cross
Helen Mexted *2DHB Director, Communications and Engagement*	• Director, Wellington Regional Council Holdings, Greater Wellington Rail • Board member, Walking Access Commission • Partner owns Mexted Motors (supplies/services vehicles for the CCDBH)
Roger Palairet *Chief Legal Officer*	• Chair and Trustee of Carers NZ (non-profit organisation promoting the interests of family carers; funders include MoH, MSD and Waitemata DHB) • Chair and Trustee of the Wellington Community Trust • Sister-in-law is a paediatric nurse at CCDHB
Rosalie Percival *2DHB Chief Financial Officer*	• None
Judith Parkinson *HVDHB General Manager, Finance and Corporate Services*	• Director of Allied Laundry
Tofa Suafole-Gush *HVDHB Director, Pacific Peoples* *Acting CCDHB Director, Pacific Peoples*	• Pacific Member, Board of Compass Health • Director, Pacific Peoples, Wairarapa DHB • Husband is an employee of Hutt Valley DHB
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
Tracy Voice *3DHB Chief Digital Officer*	• Secretary, New Zealand Lavender Growers Association • Board member, Primary Growth Partnership with PGG Wrightsons/Grassland Seed Technology Innovation
Kiri Waldegrave *HVDHB Acting Director of Māori Health*	• TBC
Declan Walsh *2DHB Director People, Culture and Capability*	• None
Sandy Blake *CCDHB Executive Director, Quality Improvement*	• Advisor to Patient Safety and Reportable Events programme, Health Quality Safety Commission

& Patient Safety	• Adviser to ACC re adverse events • Son is Associate Director of Deloittes
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BOARD MEETING **PUBLIC**

	MINUTES Held on Wednesday 4 November Location Lower Hutt Event Centre, 30c Laings Road, Lower Hutt Zoom link: **973 0468 9420** Time: 9am
BOARD MEETING	**PUBLIC**

IN ATTENDANCE

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

Hutt Valley and Capital & Coast DHB

Fionnagh Dougan	Chief Executive
Joy Farley	Director Provider Services
Rosalie Percival	Chief Financial Officer
Nigel Fairley	GM Mental Health, Addictions and Intellectual Disability Services
Declan Walsh	Director People, Culture and Capability
Helen Mexted	Director of Communication and Engagement
Christine King	Director Allied Health
Amber Igasia	Board Liaison Officer

CCDHB

John Tait	Chief Medical Officer
Emma Hickson	Chief Nursing Officer
Sandy Blake	Executive Director Quality Improvement and Patient Safety
Arawhetu Gray	Director Maori Health Services

HVDHB

Debbie Gell	General Manager, Quality Service Improvement and Innovation
Kiri Waldegrave	Director of Māori Health

APOLOGIES

John Ryall

BOARD MEETING **PUBLIC**

1 PROCEDURAL BUSINESS

1.1 KARAKIA

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

1.2 APOLOGIES

As noted above.

1.3 PUBLIC PARTICIPATION

NIL.

1.4 CONTINUOUS DISCLOSURE

1.4.1 COMBINED BOARD INTEREST REGISTER

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

1.4.2 COMBINED EXECUTIVE LEADERSHIP TEAM INTEREST REGISTER

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

1.5 MINUTES OF PREVIOUS CONCURRENT MEETING

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

	Moved	**Seconded**
HVDHB	Ken Laban	Naomi Shaw
CCDHB	Chris Kalderimis	Sue Kedgley

1.6 MATTERS ARISING FROM PREVIOUS CONCURRENT MEETINGS

20-P0009: Complete

1.7 CHAIR'S REPORT AND CORRESPONDENCE

The Chair provided an update on the following:

- Ayesha Verrall, Deputy Chair of CCDHB Board, has resigned following her success in the election. The Boards thanked Ayesha for her time as a member and recognised her expert knowledge throughout the COVID-19 response.
- Minister Little is the new primary Minister of Health.

A question was raised about the process of new Board members to fill the outstanding vacancies and it was noted it is a decision for the Minister.

1.8 CHIEF EXECUTIVE'S REPORT

The Chief Executive provided an update on the following:

- Take the report as read.
- Meeting with mayors and chief executives around the region.

1.9 BOARD WORK PLAN 2020

The work plan was received and feedback is to be sent to the Board Liaison Officer.

BOARD MEETING **PUBLIC**

2 DHB PERFORMANCE AND ACCOUNTABILITY

2.1 CCDHB AUGUST 2020 FINANCIAL AND OPERATIONAL PERFORMANCE REPORTS

This report was taken as **READ.**
It was noted there is reduced bed stock for improving patient flow which has created a challenging environment. Providers have made a cautious financial start to the year.
There are discussions underway with the Ministry of Health to clarify what is considered a COVID-19 impact. For example, there is increased leave accrual as people can't travel or take the leave they had planned.

	Moved	**Seconded**
CCDHB	Roger Blakeley	Chris Kalderimis

2.2 HVDHB AUGUST 2020 FINANCIAL AND OPERATIONAL PERFORMANCE REPORTS

This report was taken as **READ.**
It was noted all work areas have returned to pre-COVID activity levels with the exception of surgical.

	Moved	**Seconded**
HVDHB	Prue Lamason	Ken Laban

3 UPDATES

3.1 2DHB MAJOR CAPITAL PROJECTS ADVISORY COMMITTEE (MCPAC) UPDATE

NOTES:

- Two projects were brought to the Committee, Copper Pipes Remediation and the New Children's hospital.
- There were no major issues of concern for these two projects.

4 OTHER

4.1 GENERAL BUSINESS

4.2 RESOLUTION TO EXCLUDE THE PUBLIC

	Moved	**Seconded**
HVDHB	Ken Laban	Prue Lamason
CCDHB	Vanessa Simpson	Roger Blakeley

5 NEXT MEETING

Thursday, 4 December 2020. Details to be confirmed.

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

DATED this day of 2020
David Smol
BOARD CHAIR

Chief Executive's Report

Prepared by: Fionnagh Dougan, Chief Executive

1 Introduction

This report covers the period from 22 October to 18 November 2020.

2 COVID-19 Update

2.1 Current cases (to 23/11)

Number of cases: 2
Number of days without cases, HVDHB: 16
Number of days without cases, CCDHB: 12

2.2 Managed Isolation Facilities (to 23/11)

Number of COVID-19 cases: 2
Number of guests (as 23/11): 149

- Bay Plaza: 53
- Grand Mercure: 96

2.3 Testing statistics (to 23/11)

	2DHB	HVDHB	CCDHB
Tests performed to date	86,932	23,662	63,270
People tested to date	71,451	19,971	51,480
Testing coverage	15.0%	13.2%	15.8%
Tests performed last week (17/11 – 23/11)	2,505	636	1,869
Test performed since 11 August (Auckland cluster)	46,002	1,900	34,102

2.4 Testing statistics by ethnicity (to 23/11)

	2DHB		HVDHB		CCDHB	
	Maori	Pacific	Maori	Pacific	Maori	Pacific
Tests performed to date	10,217	7,175	3,690	2,178	6,527	4,997
People tested to date	8,381	5,881	3,116	1,784	5,265	4,097
Testing coverage	17.0%	18.2%	15.4%	16.1%	18.1%	19.3%
Tests performed last week (17/11 – 23/11)	243	206	88	59	155	147
Test performed since 11 August (Auckland cluster)	4,927	3,957	1,672	1,238	3,255	2,719

3 Communications and Engagement

3.1 External engagement with partners and stakeholders

We have a number of key external events in the coming weeks.

Following on from my October presentation to the Mayoral Forum on our Health System strategy, 2DHB Director of Māori Health Arawhetu Grey and CCDHB Chief Medical Officer John Tait will present to the group on 27 November regarding the impact of equity issues in the region. These forums are providing us with a valuable opportunity to discuss matters of note with local leaders.

On 3 December, and in conjunction with our Pacific providers, we launch the Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020 to 2025 to our community and dignitaries. The Minister for Pacific Peoples, Hon Aupito William Sio, will be attending.

Plans are also well advanced for a 4 December event to mark the establishment of the Kāpiti Community Health Network, the first of its kind in the Wellington and Hutt region.

3.2 External communications and engagement

Key activity for the period has included an ongoing active social media presence, website information services and responses to Official Information Act requests and media inquiries. We expect to have increased proactive media over coming months as we use the summer period to share the many winners and finalists from the Celebrating Success awards across our 2DHBs.

3.3 Social media and news stories

We continue to engage with our community in relation to the stories and the work our people do in our hospitals and communities, as well as a number of health promotion campaigns. CCDHB's Celebrating Success week and awards were featured prominently for the month (HVDHB's Awards will feature in next month's report). A sample of the key messages and performance of our channels is outlined below.

CCDHB impressions	HVDHB impressions	RPH impressions
• Facebook: 130,751 • CE Facebook: 8,415 • Twitter: 5,035 • LinkedIn: 17,123	• Facebook: 166,255 • Hutt Maternity Facebook: 12,385 • CE Facebook: 8,415 • Twitter: 11,570 • Instagram: 5,561 • LinkedIn: 10,207	• Facebook: 39,169

3.4 Social media health promotion campaigns

Bowel screening

Smoking cessation

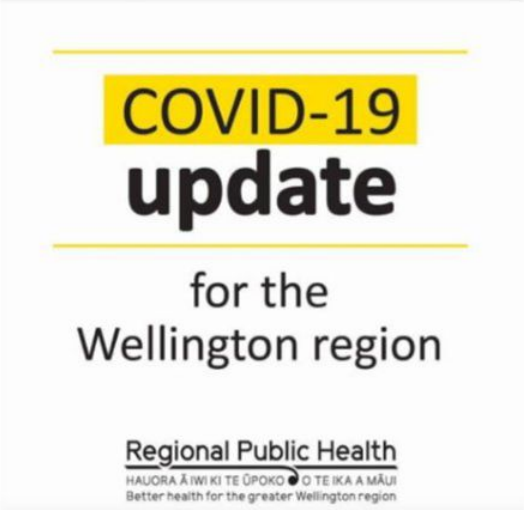
Top social media posts

HUTT VALLEY DHB

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

Regional Public Health
11 November at 16:34 ·

We can confirm that there is another case of COVID-19 in our Wellington region. This is a case that is already in quarantine in a Managed Isolation Facility and is a close contact of Case B. This new case (Case C) has been in isolation since being identified as a contact of Case B. Household contacts for Case C are in isolation and have returned negative results. There are very few contacts of the new case, and all have been identified and are isolated.
https://www.health.govt.nz/.../media-.../3-new-cases-covid-19-12



22 3 comments 39 shares

Regional Public Health
5 November at 12:10 ·

A big ngā mihi nui kia koutou to everyone who attended our second Kai & Our Community hui last week. It was wonderful to hear so many inspiring ideas and suggestions as we mapped our vision for a sustainable food network. We look forward to this ongoing mahi to improve the food resiliency of our community in the greater Wellington region.

Another big thank you to our partners on this initiative – The Common Unity Project Aotearoa. We'd also like to thank our amazing host Ranei Wineera-Parai (Ora Toa), thank you too to Mary-Jane Rivers for facilitating the workshop.

We're taking this hui on tour by replicating this event for our Wairarapa community. Stay tuned for more details – we look forward to connecting with our sustainable food community in Wairarapa soon!

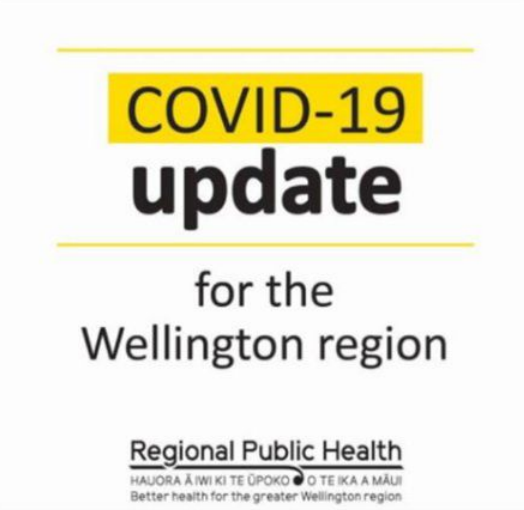
1

Regional Public Health
9 November at 20:31 ·

We'd like to reassure our greater Wellington communities, that currently the risk of community transmission of COVID-19 is low.

Of the Wellington case's 55 identified close contacts, 48 have returned a negative result, and the rest are pending.

RPH and the Ministry of Health has made contact with all close contacts who need to self-isolate within the greater Wellington region.... See more



30 2 comments 25 shares

Regional Public Health
29 October at 17:01 ·

If you're expecting some scary visitors this weekend - to keep everyone safe - it's easy to print off a QR code poster for your home from the Unite Against COVID-19 website: https://covid19.govt.nz/business.../.../get-your-qr-code-poster/

If you're trick-or-treating or going out to a Halloween party, scan for ghosts and QR codes to track your local haunts. Pack some hand sanitiser, and use regularly.

If you're feeling unwell, please don't hand out treats (or tricks!)
Stay home if you're spooked or sick, and call Healthline, your GP or iwi health provider for advice about getting a test.

6 2 shares

3.5 Website page views and stories

CCDHB	HVDHB	RPH	MHAIDS
109,987 page views	28,348 page views	12,959 page views	11,688 page views

Our website banners (featured below) as well as feature stories continue to be a strong source of information to the public, with the main homepages commonly visited, as per the analysis below.

Top five webpages CCDHB

- Staff login
- COVID-19 Community based assessment centres (CBACs)
- Careers with CCDHB
- Wellington Regional Hospital
- After hours and emergency care

Top five webpages HVDHB

- Webmail and applications
- COVID-19 Community based assessment centres (CBACs)
- Contact Us
- Hutt Hospital campus map
- Careers with HVDHB

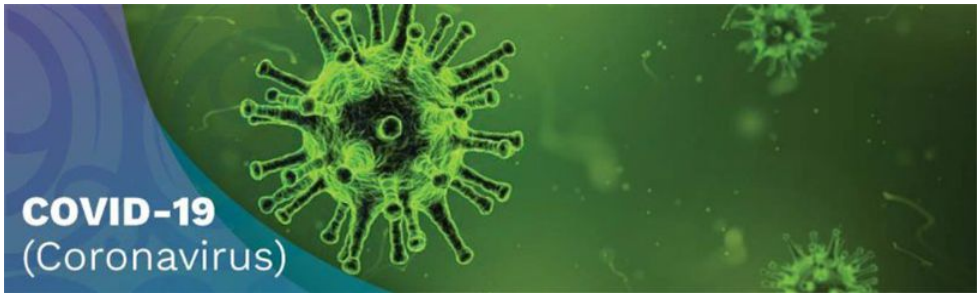
Top five webpages RPH

- Coronavirus (COVID-19) frequently asked questions
- Early childhood centers - Current illnesses
- Gastroenteritis
- Fruit and Vege Co-ops
- Coronavirus (COVID-19)

Top five webpages MHAIDS

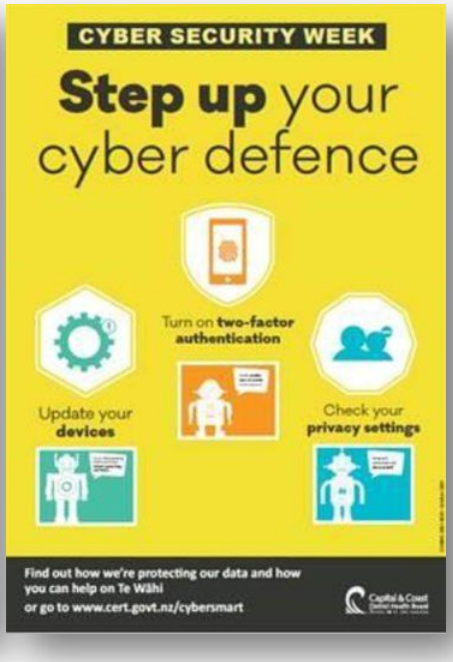
- Child and Adolescent Mental Health Services (CAMHS and ICAFS)
- Do you, or does someone you know, need help now? Contact Te Haika
- Community Mental Health Teams (General Adult)
- Central Region Eating Disorder Services (CREDS)
- How to contact our services

New Website Banners



3.5.1 Internal Engagement and Communication

Staff lift posters



3.6 Intranet page views and stories

Top intranet stories

CCDHB	HVDHB
245,576 page views	158,066 page views

Child Development Service welcomes new purakau

This year our Child Development Service set up a pro-equity Māori responsiveness working group to develop short, medium, and long-term goals such as weekly te reo practice, Treaty of Waitangi staff education, workshop, increased practice and use of karakia, and more.

The group also made a conscious effort to help its physical environment better reflect the local community. Local artist Xoe Hall (Kai Tahu) suggested finding a local purakau/story to help guide this which led the group to the purakau of Awarua, the taniwha of Porirua Harbour. This purakau is relevant to Porirua and illustrates values to help guide service delivery and engagement with whānau. Ngati Toa gave approval to use the story in this way.

The Child Development Service acknowledges and is grateful for the support of the team at Te Whare Marie, Child Health operations manager Mal Joyce, and Director of Maori Health Arawhetu Gray.

This purakau represents our service's conscious effort to do better by Māori patients and whanau, and also the local landscape and history and the support we aim to give our community.

Te Tohu Wai Awards support palliative medicine

Three University of Otago medical students were recognised in the annual Te Tohu Wai awards ceremony earlier this month.

Students were awarded a Certificate of Excellence in Palliative Medicine for their work, including producing a piece of creative work, such as a sculpture, painting or poem, after spending time with a person undergoing palliative care.

"When we encounter suffering, it touches us all," says palliative medicine specialist and lecturer Dr Sinéad Donnelly. "We ask students to produce a creative response as a way of accessing that. Art helps them reflect and express the impact of meeting someone close to death. The resulting artworks are inspiring." An exhibition of works is planned for next year.

The Māori Health Development Group (MHDG) collaborated with Otago University to establish Te Tohu Wai awards as part of the Te Wai initiative, which assists healthcare staff and whānau when patients die in the hospital.

Te Wai is a symbol placed on the wall on wards or areas where a patient has died, acting as a discreet message to staff and visitors to be aware and considerate of the death. In the past year, it's been rolled out across Wellington Regional Hospital and is now used on almost every ward.

The symbol is also placed on bereavement cards which are sent to the family, and on quilts that cover the deceased on the mortuary trolley. It also appears on the certificate awarded to the students, as it will be an important part of their work in caring for patients who die and supporting their whānau.

The awards were presented to the students by Cheryl Goodyer, capability manager of MHDG, and Otago University Associate Professor Bridget Robson, at a ceremony opened by Peter Jackson, CCDHB Kaihautū.

Xinyl Wang was one of those recognised for her work, along with Ben Kaveney-Gibb and Han Zhang. Her work included making a pair of earrings with a bicycle motif, as the palliative care patient she spent time with had previously enjoyed cycling. "Spending time with her was a privilege and very insightful," she says. "It's an important specialty to support patients at the end of their life."

Graduates celebrate 'life-affecting' programme

The sixth cohort of Te Tohu Whakawaiora, a cultural competence programme for CCDHB staff, graduated in a ceremony last week.

Te Tohu Whakawaiora is a workplace-focused Māori cultural competence programme supporting CCDHB staff to offer culturally safe care. Students get a grounding in Te Reo and tikanga Māori, apply the principles of Te Tiriti o Waitangi to their practice, and take part in experiential learning on a marae. They receive an NZQA-aligned qualification on graduating.

"It's a course – but also a lifetime of learning," said director of the Māori Health Development Group, Arawhetu Gray, addressing graduates at the ceremony. "I hope it enriched your life, because now you get the opportunity to enrich the lives of Māori. It's incredibly important."

Workforce development was one of the key focus areas identified to help achieve health equity for Māori in Taurite Ora, CCDHB's Māori Health Strategy 2019 - 2030. "This course contributes to achieving the goals of the strategy," said Arawhetu.

Katherine Reweti-Russell of Skills Active, which supports this qualification, echoed Arawhetu in acknowledging the work of the Māori Health Development Group, who run this programme at CCDHB. "A lot of time, love, effort and soul has gone into delivering this course."

To the graduates she said - "You are now champions in your areas. You will take this learning and share it with your colleagues."

Melita Macdonald, one of the members of the capability development team who have took part in the programme, said her department had indeed been trying to implement the learnings in their work. Her colleague Andrew Shepherd said "We can now contribute to change, in healthcare and wider life."

Chief Nursing Officer Emma Hickson, who was one of this year's graduates and the first ELT member to undertake the programme, called it life-affecting. "This is a great way to support yourself on a lifelong journey. It gave me the impetus to influence my ELT colleagues to do the same, and we are now encouraging our nurses and midwives to do the programme."

Blessing of new name for Specialist Youth AOD CEP Service

The MHAIDS' Specialist Youth AoD/CEP service now has a new name, Te Roopu Kaitiaki.

The new name, 'Te Roopu Kaitiaki", was gifted to the team from Te Wera Kotua, a name he saw as fitting the kaupapa of the service - meaning of "a group that strengthens, guides and keeps safe for future prosperity". On 24 September Kaumatua Kuni Shepherd and Kaumatua, Kuia and other members of Te Whare Marie and Te Whare o Rangatahi, joined the team for a blessing of the new name. This was a moving ceremony that also provided a chance to remember Te Wera and the gifting of the name which can now be formally used by the service.

The service which has been operating for around two years, consists of three community based co-existing enhanced practitioners who provide services to support rangatahi in the Wellington sub-region who are experiencing addiction issues. Taking a consultation-liaison approach, the service supports clinicians in other services that are working with rangatahi experiencing addiction-related problems. It also provides time-limited addiction interventions for rangatahi and their whānau.

Working alongside Younger Person Sector colleagues within MHAIDS, the team also works closely with the primary care and NGO sector through the 'Wellington Youth AoD/CEP Collaborative', which includes the local Youth One Stop Shops (YOSS's - Evolve, VIBE and Kapiti Youth Support), PACT, and other regional youth AoD providers. The Collaborative's aim is to work together to improve the consistency and accessibility of treatment to rangatahi within our region, along with working to build our local workforce.

Kia Ora Hauora encourages rangatahi into health careers

Three Wellington region students have completed a work observation week at CCDHB as part of Kia Ora Hauora (KOH), a national Māori health workforce programme aimed at increasing the number of Māori working in the health sector.

The programme has gone from strength to strength, with tertiary students now spending time observing a variety of work across the 3DHBs at a time when they are considering future careers. "This is the first year all three DHBs in the Wellington region have participated in this type of hospital exposure at the same time," said Leigh Andrews, KOH Central Region co-ordinator of the programme.

"The ideal would be that all these students go on to pursue a career in health and ultimately return to work here as qualified health professionals."

The project is a brainchild of the Ministry of Health and Te Tumu Whakarae, a group of DHB Māori managers and directors, endorsed by the national DHB CEOs. They recognised that under-representation of Māori in the workforce contributed to health inequities that Māori experience when trying to navigate the health system. "We are short of Māori staff in proportion to the community we serve," says dietitian and CCDHB Associate Director Allied Health, Scientific and Technical – Māori health, Chelsea Marsh.

At CCDHB, three students spent time observing the Allied Health, Scientific and Technical professions during October. This included sitting in on patient appointments, observing nursing training, and even spending time in the flight simulator.

Correspondence student Grace Dixon was struck by the relationships that are built between healthcare staff and patients, and was interested to find out 'what goes on behind the scenes'. She spent time with Chelsea as part of her dietitian work, and found it "really interesting to learn about the different sorts of feeding."

Victoria University student Nai Mullane-Ronaki, who joined physiotherapist Wyllis Korent on a home visit, was struck by the number of professions in healthcare. "It's given me an appreciation of clinicians and front-line workers, and how the different professions work together."

Wellington Girls College student and aspiring lawyer Rebekah Raihania was interested to spot the connections between medicine and law, and to discover that healthcare is about 'more than just doctors'. She also found it insightful spending time with patients undergoing physiotherapy after an accident.

"It's so valuable to have students come in and experience the type of work that goes on in our hospital and community DHB services, and to learn about all the career options available," said chief allied professions officer Chris King. "It's an experience you can't get from a brochure.

"We will be looking to run events like this more regularly to keep our local rangatahi well informed about health career options."

BOARD **Work Plan**

	Year	2020	2021	2021	2021	2021	2021	2021	2021
	Month	December	January	February	March	April	May	June	July
	Board Only Time - DATE	3-Dec	27-Jan	No Meeting	3-Mar	7-Apr	5-May	2-Jun	7-Jul
	Hutt Valley Board		WORKSHOP		Hutt Valley Board		Hutt Valley Board		Hutt Valley Board
	Capital and Coast Board	Capital and Coast Board only time				Capital and Coast Board		Capital and Coast Board	
Prior Committee	Regular Reporting	3-Dec	27-Jan	No Meeting	3-Mar	7-Apr	5-May	2-Jun	7-Jul
	Workplace Health and Safety Report	Workplace Health and Safety Report	WORKSHOP			Workplace Health and Safety Report		Workplace Health and Safety Report	
	People, Capability and Culture Report	People, Capability and Culture Report			People, Capability and Culture Report		People, Capability and Culture Report		People, Capability and Culture Report
ECS	Facilities and Infrastructure Report inc. Enviro Sustainability		WORKSHOP		Facilities and Infrastructure Report			Facilities and Infrastructure Report	
ECS	Digital Report	Digital Report				Digital Report			Digital Report
	Children's Hospital								
	Pacific Health Report	Pacific Health Report	WORKSHOP				Pacific Health Report		
	Engagement	3-Dec	27-Jan	No Meeting	3-Mar	7-Apr	5-May	2-Jun	7-Jul
	Māori Partnership Board (CCDHB)	Māori Partnership Board (CCDHB) HOLD				Māori Partnership Board (CCDHB)		Māori Partnership Board (CCDHB)	
	Iwi Relationship Board (HVDHB)		WORKSHOP						
	Clinical Council								
	Citizen's Health Council								
	Sub-Regional Pacific Health Strategy Group	Sub-Regional Pacific Health Strategy Group	WORKSHOP		Sub-Regional Pacific Health Strategy Group		Sub-Regional Pacific Health Strategy Group		
	Wellington Hospital Foundation	Wellington Hospital Foundation			Wellington Hospital Foundation			Wellington Hospital Foundation	
	Intermittent Items	3-Dec	27-Jan	No Meeting	3-Mar	7-Apr	5-May	2-Jun	7-Jul
	Budgets				Budgets			Budgets	
	Annual Plan		WORKSHOP		Annual Plan			Annual Plan	
	Annual Reports								
	Planned Care Plan								
	Internal Audit Plan		WORKSHOP						
	Maternity Plan								
	Master Site Plan								
	Regular Items - every meeting	3-Dec	WORKSHOP	No Meeting	3-Mar	7-Apr	5-May	2-Jun	7-Jul
	Quality and Safety Report	Quality and Safety Report			Quality and Safety Report	Quality and Safety Report	Quality and Safety Report	Quality and Safety Report	Quality and Safety Report
	Finance and Operational Performance Report	Finance and Operational Performance Report			Finance and Operational Performance Report	Finance and Operational Performance Report	Finance and Operational Performance Report	Finance and Operational Performance Report	Finance and Operational Performance Report
	Patient Story	Patient Story	WORKSHOP		Patient Story	Patient Story	Patient Story	Patient Story	Patient Story
MCPAC	Major Capital Projects Advisory Committee Report				Major Capital Projects Advisory Committee Report		Major Capital Projects Advisory Committee Report		Major Capital Projects Advisory Committee Report
FRAC	FRAC items for Board Approval				FRAC items for Board Approval		FRAC items for Board Approval		FRAC items for Board Approval
HSC	HSC items for Board Approval including below	HSC items for Board Approval including below	WORKSHOP		HSC items for Board Approval including below	HSC items for Board Approval including below		HSC items for Board Approval including below	
	Te Pae Amorangi Quarterly Report	Te Pae Amorangi Quarterly Report			Te Pae Amorangi Quarterly Report			Te Pae Amorangi Quarterly Report	
	Taurite Ora Quarterly Report	Taurite Ora Quarterly Report							
	Pacific Health and Wellbeing Strategic Plan Quarterly Report				Pacific Health and Wellbeing Strategic Plan Quarterly Report			Pacific Health and Wellbeing Strategic Plan Quarterly Report	
DSAC	DSAC items for Board Approval		WORKSHOP		DSAC items for Board Approval	DSAC items for Board Approval			DSAC items for Board Approval

2021	2021	2021	2021	2021
August	September	October	November	December
4-Aug	1-Sep	6-Oct	3-Nov	1-Dec
	Hutt Valley Board		Hutt Valley Board	
Capital and Coast Board		Capital and Coast Board		Capital and Coast Board
4-Aug	1-Sep	6-Oct	3-Nov	1-Dec
Workplace Health and Safety Report		Workplace Health and Safety Report		Workplace Health and Safety Report
	People, Capability and Culture Report		People, Capability and Culture Report	
	Facilities and Infrastructure Report			Facilities and Infrastructure Report
		Digital Report		
Pacific Health Report			Pacific Health Report	
4-Aug	1-Sep	6-Oct	3-Nov	1-Dec
Māori Partnership Board (CCDHB)		Māori Partnership Board (CCDHB)		Māori Partnership Board (CCDHB)
Sub-Regional Pacific Health Strategy Group			Sub-Regional Pacific Health Strategy Group	
	Wellington Hospital Foundation			Wellington Hospital Foundation
4-Aug	1-Sep	6-Oct	3-Nov	1-Dec
		Budgets		
		Annual Plan		
4-Aug	1-Sep	6-Oct	3-Nov	1-Dec
Quality and Safety Report	Quality and Safety Report	Quality and Safety Report	Quality and Safety Report	Quality and Safety Report
Finance and Operational Performance Report	Finance and Operational Performance Report	Finance and Operational Performance Report	Finance and Operational Performance Report	Finance and Operational Performance Report
Patient Story	Patient Story	Patient Story	Patient Story	Patient Story
	Major Capital Projects Advisory Committee Report		Major Capital Projects Advisory Committee Report	
	FRAC items for Board Approval		FRAC items for Board Approval	
HSC items for Board Approval including below		HSC items for Board Approval including below		HSC items for Board Approval including below
Te Pae Amorangi Quarterly Report				Te Pae Amorangi Quarterly Report
	Pacific Health and Wellbeing Strategic Plan Quarterly Report			Pacific Health and Wellbeing Strategic Plan Quarterly Report
		DSAC items for Board Approval		DSAC items for Board Approval

Board Information - Public

December 2020

Hutt Valley DHB September 2020 Financial and Operational Performance Report

Action Required

The Hutt Valley DHB Board note:

(a) The release of this report into the public domain.

(b) The DHB had a ($481k) deficit for the month of September 2020, being $141k favourable to budget.

(c) The DHB year to date had a deficit of ($2m), being ($705k) favourable to budget.

(d) The Funder result for September was $0.5m favourable, Governance $0.1m favourable and Provider ($0.5m) unfavourable to budget.

(e) Total Case Weighted Discharge (CWD) Activity was 9.3% ahead of plan.

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

Executive Summary

For September, the Hutt Valley DHB has a deficit of $0.5m which is $0.1m favourable to budget. Of this deficit $1.2m is in the provider arm services. Activity is 9.3% ahead of that planned. Total FTE are 107 below budget (56 FTE relate to the MHAIDs move to CCDHB).

In September both surgical and medical discharges were higher than last year and high than plan (9% and 16% respectively) translating to higher Operating Room throughput and higher occupancy in the hospital with days of 100% bed occupancy. This adds to a busy month which is reflected in the operational result.

The number of patients waiting more than 120 days for treatment has marginally decreased from last month, likewise we have made inroads into the number of people waiting more than 120 days for assessment.

We continue to work on strategies to address the Hospital provider arm performance include improved access to assessment beds to free up ED and provide a more positive patient journey, expand the capacity of the Early Supported Discharge team to improve efficiency of discharge planning and "pull" patients home from ED and wards, and addressing delays in the Care coordination pathway.

The 2DHB Care Coordination pathway and guidelines are developed for imminent release. Joint work with CareCo has identified joint process issues for improvement activities, and integrating NASC

processes into discharge planning processes in a more timely way. This is to respond to the needs of a small number of clients / patients whose presenting needs are complex often requiring high levels of expert and unique support beyond individual service capacity and capability to deliver that incur high one on one care whilst in hospital

Key areas of funder performance include:

- The continued roll out of the Healthcare Home remains important to improving performance in managing avoidable hospital admissions, childhood immunisations and diabetes.
- Support for older people with long-term conditions and disabilities to remain in their homes for longer

The Regional Public Health Unit are supporting Auckland with staff travelling to Auckland as well as remote support for contact tracing. MoH funding levels have not been finalised for ongoing COVID-19 work for 2020/21.

Strategic Considerations

Service	Financial performance and funding is a key to delivering the services for the Hutt Valley population.
People	Staff numbers are 107 below plan with additional costs in outsourced personnel for roles employed by CCDHB, and MHAIDs costs in outsourced services.
Financial	Planned deficit $10.6 million, with no COVID-19 or Holidays Act provision impacts included.
Governance	The committee is accountable for scrutinising the financial and operational performance on behalf of the board, and reporting back to the board on issues as identified by the committee.

Engagement/Consultation

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

Identified Risks

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

Attachment

3.2.1 Hutt Valley DHB September 2020 Financial and Operational Performance Report

Monthly Financial and Operational Performance Report

For period ending
30 September 2020

Reported in October 2020

Contents

Section 1

Financial and Performance Overview and Executive Summary

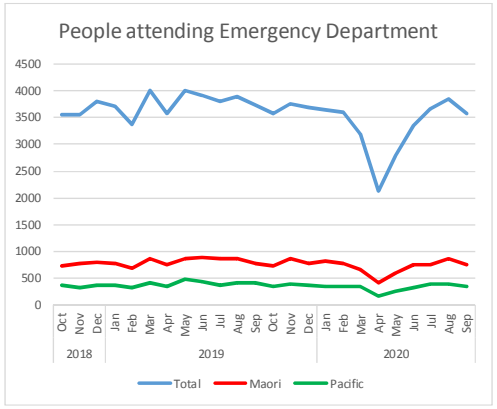
Executive Summary

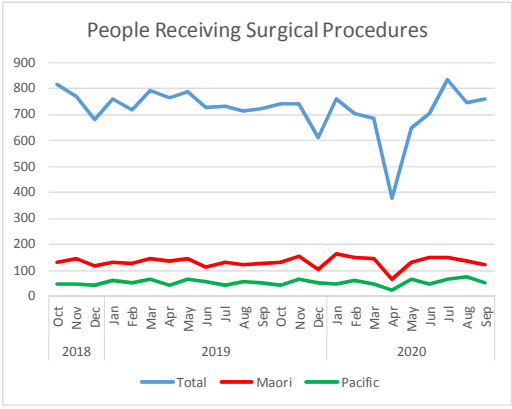
- In September both surgical and medical discharges were higher than last year and high than plan (9% and 16% respectively) translating to higher Operating throughput and higher occupancy in the hospital with days of 100% bed occupancy. This adds to a busy month which is reflected in the operational result.
- The number of patients waiting more than 120 days for treatment has marginally decreased from last month, likewise we have made inroads into the number of people waiting more than 120 days for assessment.
- We continue to work on strategies to address the Hospital provider arm performance include improved access to assessment beds to free up ED and provide a more positive patient journey, expand the capacity of the Early Supported Discharge team to improve efficiency of discharge planning and "pull" patients home from ED and wards, and addressing delays in the Care coordination pathway.
- The 2DHB Care Coordination pathway and guidelines are developed for imminent release. Joint work with CareCo has identified joint process issues for improvement activities, and integrating NASC processes into discharge planning processes in a more timely way. This is to respond to the needs of a small number of clients / patients whose presenting needs are complex.
- Funder key areas of performance with a focus on core services and achieving equity;
    - Childhood immunisation rates are below targets but have continued to improve for achievements of rates by milestone age.
    - Ambulatory sensitive hospitalisations remain poor, particularly for Maori and Pacific. The impacts of social determinants cannot be underestimated but the impact of the Healthcare Home roll out across General Practise is critically important to improving primary care access and performance.
    - Fewer people are entering Age Residential Care as people are supported to stay in their home. The ongoing increasing in the demand for dementia care remains challenging. Developing a wider range of services for older people is a current priority.
- For September, the Hutt Valley DHB has a deficit of $0.5m which is $0.1m favourable to budget. Of this deficit $1.2m is in the provider arm services. Activity is 9.3% ahead of that planned. Total FTE are 107 below budget (56 FTE relate to the MHAIDs move to CCDHB). More detail can be found in the Provider Arm summary.

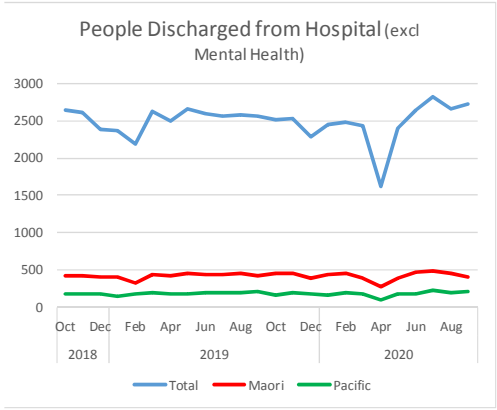
Performance Overview: Activity Context (People Served)

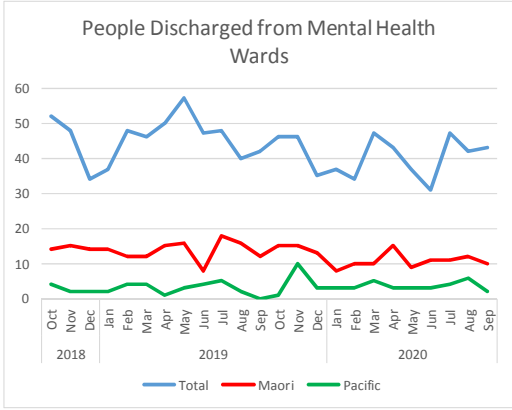
The numbers below count individuals once and are based on Hutt Valley DHB being the DHB of Service. Our services have returned to delivering services to our population without the restrictions due to COVID-19. Services continue to take necessary precautions.

People attending ED	**3,565**	743 Maori, 353 Pacific
People receiving Surgical Procedures	**762**	121 Maori, 53 Pacific
People discharged from Hospital (excl Mental Health)	**2,717**	409 Maori, 205 Pacific
People discharged from Mental Health wards	**43**	10 Maori, 2 Pacific



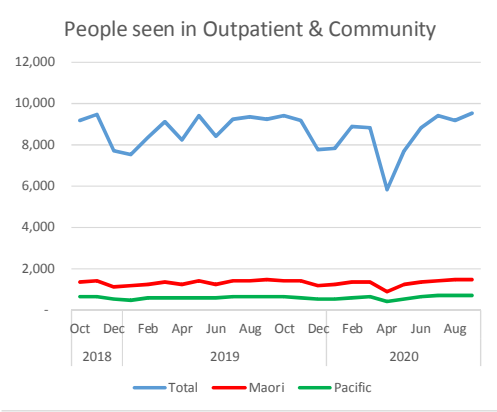


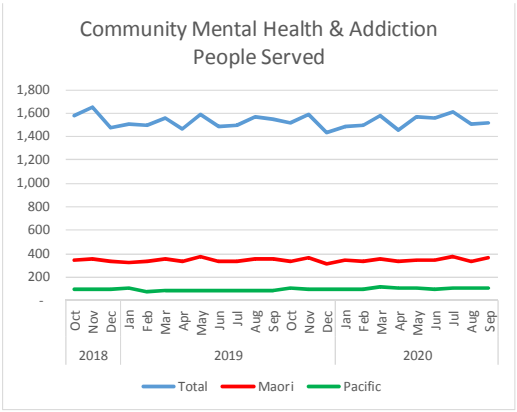


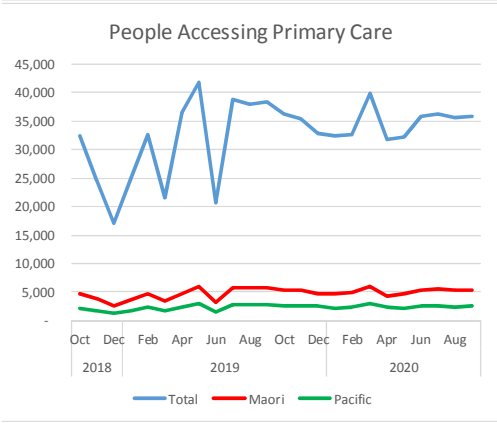


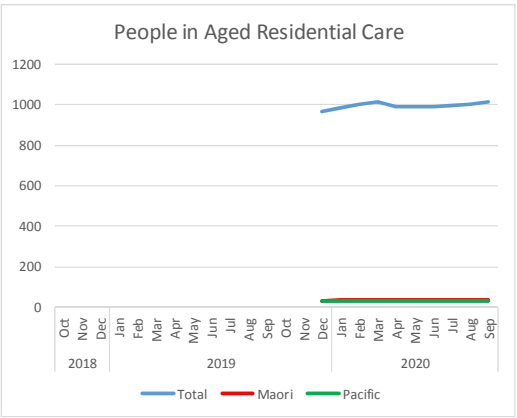
Performance Overview: Activity Context (People Served)

People seen in Outpatient & Community	**9,541**	1,468 Maori, 687 Pacific
Mental Health and Addiction Contacts	**1,522**	360 Maori, 103 Pacific
Primary Care Contacts	**35,826**	5,264 Maori, 2,493 Pacific
People in Aged Residential Care	**1,014**	36 Maori, 32 Pacific









Financial Overview – September 2020

YTD Operating Position	YTD Provider Position	YTD Funder Position	YTD Capital Exp
$2.0m deficit	$4.1m deficit	$2.0m surplus	$2.7m
Against the budgeted deficit of $2.7m.	Against the budget deficit of $2.7m.	Against the budget deficit of $0.0m.	

YTD Activity vs Plan (CWDs)	YTD Paid FTE	Annual Leave Accrual
9.3% ahead	1,950	$20.8m
313 CWDs ahead PVS plan for September. IDFs were 6 CWD below budget for the month	YTD 107 FTE below annual budget of 2,057 FTE. Note: The MHAIDS restructure contributed 56FTE to this variance	This is an decrease of $1.5m on prior period. Note: The MHAIDS and ITS contributed $1.6m to this decrease.

Hospital Performance Overview – September 2020

YTD Shorter stays in ED	People waiting >120 days for treatment (ESPI5)	People waiting >120 days for 1st Specialist Assmt (ESPI2)	Faster Cancer Treatment
87.20%	915	674	90.9%
8% below the ED target of 95%, 2% below September 19.	Against a target of zero long waits a monthly movement of 2.	Against a target of zero long waits a monthly movement -124	We achieved the 62 day target. The 31 day target was also achieved 89.7%

YTD Activity vs Plan (CWD)	YTD Standard FTE	Serious Safety Events
9.3% ahead	1,981	1
313 CWDs ahead PVS plan for September. IDFs were 6 CWD below budget for the month	54 below YTD budget of 2,035 FTE. Month FTE was 190 under budget an upwards movement from August of 59 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 $2.2m year to date, with revenue being ahead and offsetting variances in expenditure items.
- The overspend in pharmaceutical, laboratory and capitation investment is being further investigated to ensure it is normal variation. The IDF underspend is expected to be reversed based on current patients from HVDHB in Wellington Hospital with significant complexity.
- The surveillance of COVID-19 is ongoing. CBACs and primary capacity are operating at reduced capacity. MOH funding levels have not been finalised for ongoing COVID-19 work in 2020/21 but are behind expected expenditure.
- Regional Public Health is supporting the Auckland region providing staff to Auckland and remote contact tracing and follow-up. Funding sustainability for increased contact tracing capacity is still being reviewed by MoH.
- In this report we have also highlighted the below key areas of performance with a focus on our core services and achieving equity.
    - Childhood immunisation rates are below targets but have continued to improve for achievements of rates by milestone age.
    - Ambulatory sensitive hospitalisations remain poor, particularly for Maori and Pacific. The impacts of social determinants cannot be underestimated but the impact of the Healthcare Home roll out across General Practise is critically important to improving primary care access and performance.
    - Fewer people are entering Age Residential Care as people are supported to stay in their home and receive the support they need. The ongoing increasing in the demand for dementia care remains challenging. Developing a wider range of services for older people is a current priority.
- The implementation of key whole of system change is progressing slowly at Hutt Valley DHB. New energy will be brought to system transformation as Strategy, Planning and Performance is fully formed.

Funder Financial Statement – September 2020

DHB Funder (Hutt Valley DHB)
Financial Summary for the month of September 2020

Month					$000s	Year to Date					Annual	
Actual	Budget	Variance	Last Year	Variance		Actual	Budget	Variance	Last Year	Variance	Budget	Last Year
					Revenue							
37,970	37,970	0	34,549	3,421	Base Funding	113,909	113,909	0	104,204	9,705	455,637	416,816
2,770	2,341	429	3,996	(1,226)	Other MOH Revenue	8,118	7,022	1,096	9,573	(1,455)	28,090	38,006
67	36	31	(853)	920	Other Revenue	347	107	240	106	241	427	619
10,049	9,229	821	8,506	1,543	IDF Inflows	28,514	27,686	828	25,601	2,913	110,742	102,280
50,856	**49,575**	**1,281**	**46,199**	**4,657**	**Total Revenue**	**150,888**	**148,724**	**2,164**	**139,484**	**11,404**	**594,895**	**557,721**
					Expenditure							
416	416	0	383	(33)	DHB Governance & Administration	1,247	1,247	0	1,149	(98)	4,987	4,597
21,201	21,028	(173)	20,126	(1,075)	DHB Provider Arm	63,094	63,092	(2)	60,174	(2,920)	252,577	241,131
					External Provider Payments							
4,219	3,233	(986)	2,852	(1,367)	Pharmaceuticals	10,566	9,875	(691)	9,795	(770)	38,866	37,365
4,593	4,369	(224)	4,229	(364)	Laboratory	13,445	13,106	(339)	12,693	(752)	52,424	50,903
2,705	2,541	(163)	2,859	154	Capitation	7,944	7,624	(320)	7,770	(174)	30,495	29,563
1,193	1,195	3	998	(194)	ARC-Rest Home Level	3,680	3,666	(14)	3,032	(647)	14,543	11,877
1,634	1,858	223	1,692	58	ARC-Hospital Level	5,445	5,697	252	4,930	(516)	22,604	19,154
2,057	2,688	631	3,172	1,115	Other HoP & Pay Equity	7,022	8,064	1,041	7,782	759	32,354	35,108
392	1,081	689	508	116	Mental Health	2,275	3,243	968	2,117	(157)	13,045	9,580
490	482	(8)	743	253	Palliative Care / Fertility / Comm Radiology	1,439	1,445	6	2,226	787	5,782	5,788
1,467	1,373	(94)	1,132	(335)	Other External Provider Payments	5,229	4,208	(1,021)	3,659	(1,570)	17,420	19,247
9,798	9,151	(648)	7,778	(2,020)	IDF Outflows	27,542	27,452	(90)	24,415	(3,126)	109,807	101,298
0	0	0	0	0	Provision for IDF Wash-ups	0	0	0	15	15	0	0
50,164	**49,414**	**(750)**	**46,473**	**(3,691)**	**Total Expenditure**	**148,928**	**148,718**	**(210)**	**139,758**	**(9,170)**	**594,905**	**565,610**
692	**161**	**531**	**(274)**	**966**	**Net Result**	**1,960**	**6**	**1,953**	**(274)**	**2,233**	**(9)**	**(7,889)**

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 on target for the month.
- Other MOH revenue is favourable $429k for September, driven by additional funding for COVID-19.
- Other revenue is favourable $36k for the month.
- IDF inflows are $821k favourable for the month, driven by current year wash-ups .

Other MOH Revenue Variance	MTH $000's	YTD $000's
In- Between Travel	(50)	(262)
Capitation Funding	130	272
COVID-19 Funding	325	1,367
COVID-19 Funding - RPH	(127)	(382)
Well Child/Tamariki Ora Services	91	18
Crown funding agreements		
Other CFA contracts	(61)	(82)
Year to date Variance $000's	**429**	**1,096**

Expenditure:

Governance and Administration are on budget. Provider Arm payments are variances reflect COVID-19 funding to the Provider.

External Provider Payments:

Pharmaceutical costs are unfavourable ($986k) for the month and ($691k) YTD. This is reflects increased drug costs and possible timing issues.

Laboratory costs are unfavourable ($224k) for the month and ($339k) YTD. This is expected to reverse as the year progresses.

Capitation expenses are ($163k) unfavourable for the month, offset by changes to revenue.

Aged residential care costs are $226k favourable for the month.

Other Health of Older People costs are favourable by $631k for the month and $1,041k YTD.

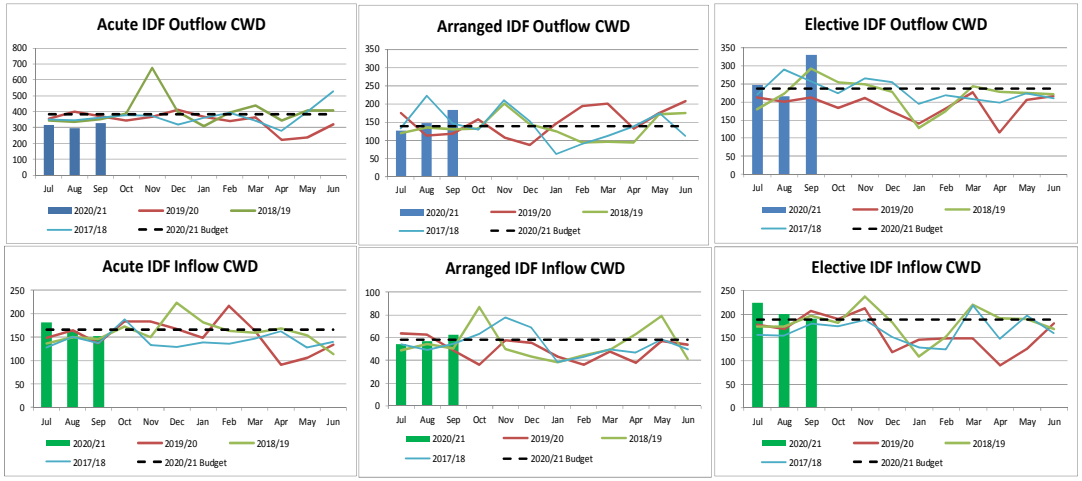
Mental Health costs are favourable $689k for the month, reflecting timing of contracts.

Palliative Care, Fertility and Community Radiology costs are unfavourable by ($8k) for the month.

Other external provider costs are unfavourable to budget ($94k) for the month.

IDF Outflows are unfavourable ($648k), due to Current Year Wash-up payments.

Inter District Flows (IDF)



IDF Wash-ups and Service Changes Sep 2020		
IDF Inflows ($000s)	Variance to budget	
	Month	YTD
CCDHB - GWRC Alcohol and Drug	(23)	(70)
CCDHB - Primary Mental Health	11	33
WAI - Mental Health Acute Beds	(0)	(100)
WAI - Child Epidemiology	1	1
CCDHB - Tx IDF Inflow (provider)	-	-
Wash-ups		
2020/21 Inflows	119	272
2019/20 Non-Casemix	-	(1)
2019/20 Inflows	-	-
2019/20 ATR	-	0
2019/20 Community Pharmacy	-	(44)
2019/20 Primary MH CCDHB	-	-
2019/20 PHO WU	-	-
2019/20 Wairarapa MH	(29)	3
2019/20 FFS	-	(8)
2019/20 HCSS	742	742
IDF Inflow variance	**821**	**828**

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):

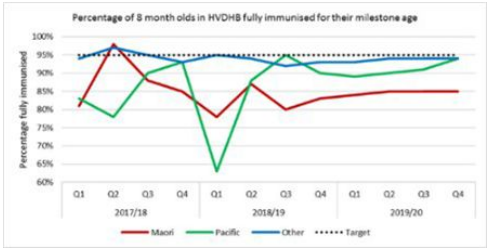
- Based on the data available, overall IDF inflows are above budget YTD by $828k, mainly in Plastics, Orthopaedics and Gastroenterology. This result is likely to change as data is updated. Services have been implementing recovery plans since June to catch up after COVID-19 restrictions.

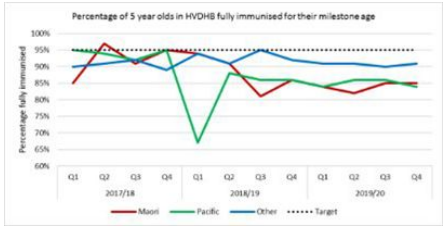
IDF Outflow (expense):

- Based on the data available, overall IDF outflows are over budget by $548k year to date, mainly due to inpatient outflows been over budget by ($152k). This result is likely to change as data is updated. We have 5 admissions currently in Capital & Coast DHB which are expected to cost at least $724k.

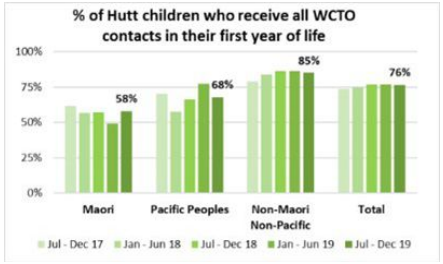
Children 0-4 years – Healthy start

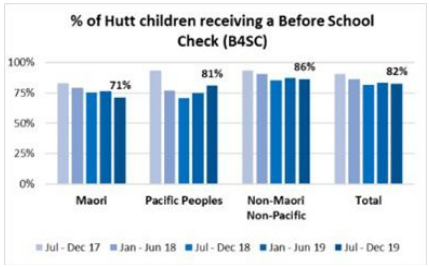
Receive all their scheduled immunisations



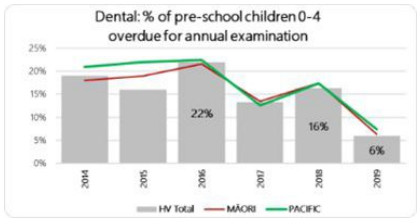


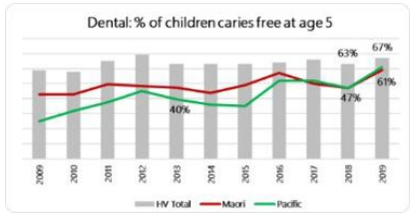
Receive all their Wellchild checks





Have healthy teeth





Healthy start: From birth to starting school, children's health is protected and supported to give them a healthy start to life - 10,160 children aged 0-4: 29% Maori, 18% Asian, 10% Pacific

How are we performing?

- 98% of estimated population is enrolled with a PHO; 91% of Maori, 97% of Pacific; 7% enrolled with PHO outside of Hutt DHB
- **Immunisation – protection:** Babies at 8 months – Pacific & Other just below target at 94% 19/20 Q4; Maori at 85% throughout 19/20
- **WCTO checks – healthy development, screening for potential problems**:
- Had all 5 core checks in first year of life: Maori 58% Pacific 68% Other 85%
- Had B4SC at four years old: Maori 71%; Pacific 81%; Other 86%. All less than National target of ≥90%
- Increase in % of Maori and Pacific children caries free at 5 to 61% is positive

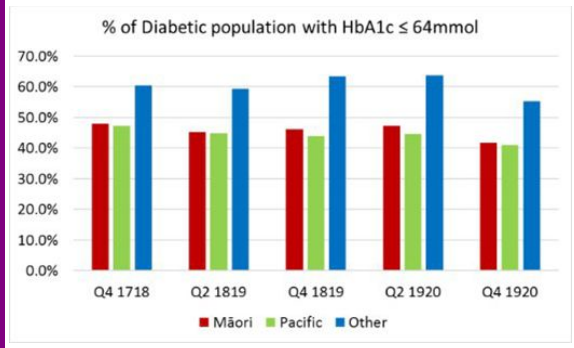
What is driving performance?

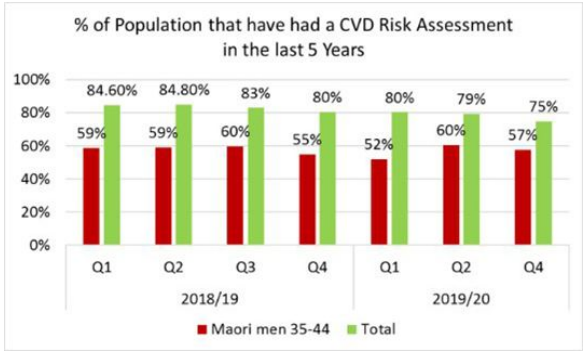
- Immunisation: Accessibility (cost, transport, childcare), media campaigns supporting immunisation, anti-vaccination lobbyists
- Well Child and B4 School Checks: Accessibility (issues include, difficulty paying for transport, or with child care responsibilities may find it difficult to attend checks).
- Child Oral Health: affordability of tooth brushes and tooth paste, and availability of cheaper unhealthy food;

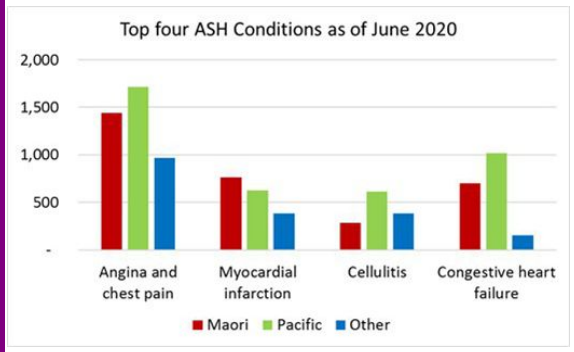
What are we doing?

- Immunisation: RPH, general practices and outreach immunisation providers improving accessibility,
- Well Child and B4 School Checks: working with providers to ensure more accessible and appropriate – and proactive follow-up on missed checks.
- Child Oral Health: oral health promotion and interventions e.g. fluoride varnish applications and adoption of healthy food and drink policies in ECE and schools.

Primary Care: Long Term Conditions







Primary Care: General practices provide first level care for Acute care and diagnosis and management of long term conditions.

How are we performing

Managing diabetes

- The population with well-managed diabetes i.e. HbA1c ≤ 64 mmol has been decreasing over the last three years. However the population with less well-managed diabetes i.e. HbA1c ≥ 64 has been increasing.
- The number of people with no HbA1c result has been increasing, currently there are 1,262 diabetics without a result.

CVD risk assessment

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

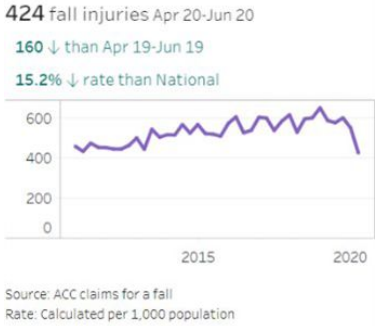
Avoidable hospitalisations (ASH)

- Angina and Chest Pain has decreased for Pacific and Other. It is constant for Maori, but is still the highest condition for the overall population.
- Congestive heart failure cases fell in the latest period but are still a major issue particularly for Pacifica.

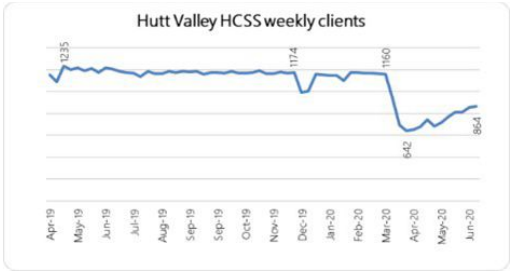
What we are doing

- We are working with our PHO regarding the decline in performance in the Diabetes services.
- TeAHN to move to practices to pro-active planning, working at an individual patient level rather than practice population level.
- Specialist support to primary care is underway, with areas for expansion being considered
- A neighbourhood approach to integration is being trialled in a population with high priority population to support specialist support to primary care, and integration with community health services

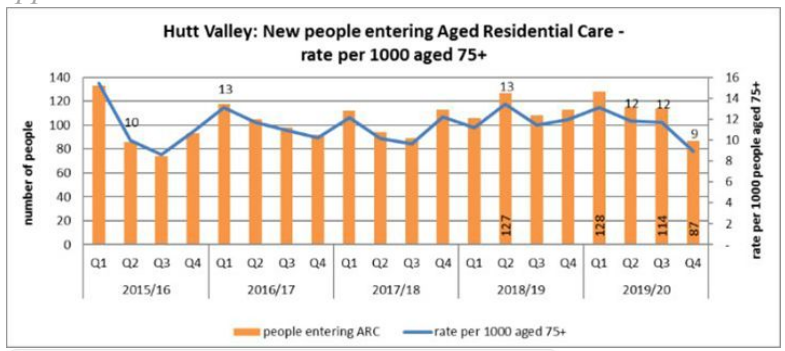
Health of Older & Frail People – community services

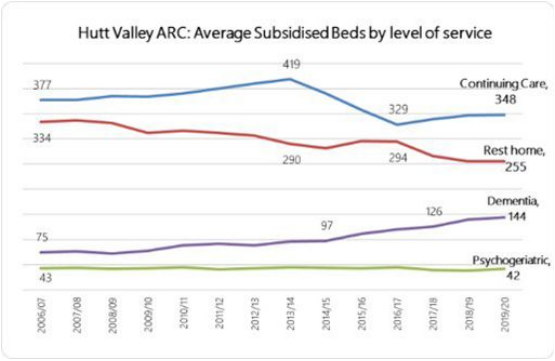


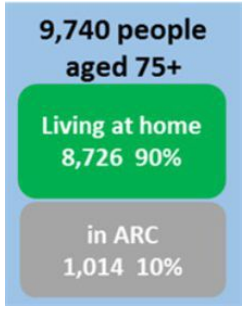
Supported to stay at home safely



Supported in residential care







Healthy Ageing: Older people are supported to maintain their independence at home, staying healthier for longer with a better quality of life and delaying entry to residential care. *Outcome measure: % older people living in own home*

How are we performing?

- 8,745 People aged 75+ years live at home - 90% (population estimate)
- 10% (995 clients) in Aged Residential Care facilities as at July 2020
- **Entering ARC:** The number of people entering ARC remained steady in 2018/19 and 2019/20 until COVID-19 lockdown in Apr-Jun 2020. On average 116 Hutt people entered ARC each quarter or 12 per 1000 people aged 75+ in 2018/19 – 2019/20 Q3. In April 2020 during COVID-19 lockdown, only 13 people entered ARC but returned to usual in May-Jun.
- **Balancing measure**: ACC claims by people aged 75+ for Falls injuries dropped during Apr-Jun 20 due to COVID-19 lockdown
- **HCSS at home:** Prior to lockdown, average 1156 Hutt people had weekly Home support Jan-Mar 2020. This dropped during COVID-19 lockdown as the service prioritised essential services to the most frail. HCSS providers delivered on average 6327 rostered home visits per week during April –May COVID-19 level 4 lockdown
- **Carer support:** 456 people caring for their frail older family member received support through day programmes, carer support and overnight respite.
- **ARC:** DHB subsidised 1,137 ARC clients in 2019/20 using 789 beds
- Rest home level – beddays for subsidised clients have been dropping over the last few years as people stay at home for longer and enter ARC at higher levels of care
- Dementia level – increasing subsidised beds as more beds have become available in new facilities
- Continuing care – highest level of care – dropped significantly in 2016/17 and increasing slightly since then to 348.

Other Commentary

People are staying at home longer and with more complex conditions with support: HCSS, Carer support, Primary Care services, DHB services

Other initiatives: Falls prevention to reduce falls and subsequent hospitalisation helping people to remain healthy at home.

Section 3

Hospital Performance

Executive Summary – Hospital Performance

- In September both surgical and medical discharges were higher than last year and high than plan (9% and 16% respectively) translating to higher Operating Room throughput and higher occupancy in the hospital with days of 100% bed occupancy. This adds to a busy month which is reflected in the operational result.
- The number of patients waiting more than 120 days for treatment has marginally decreased from last month, likewise we have made inroads into the number of people waiting more than 120 days for assessment.
- We continue to work on strategies to address the Hospital provider arm performance include improved access to assessment beds to free up ED and provide a more positive patient journey, expand the capacity of the Early Supported Discharge team to improve efficiency of discharge planning and "pull" patients home from ED and wards, and addressing delays in the Care coordination pathway.
- The 2DHB Care Coordination pathway and guidelines are developed for imminent release. Joint work with CareCo has identified joint process issues for improvement activities, and integrating NASC processes into discharge planning processes in a more timely way. This is to respond to the needs of a small number of clients / patients whose presenting needs are complex often requiring high levels of expert and unique support beyond individual service capacity and capability to deliver that incur high one on one care whilst in hospital .
- The Hospital provider arm remains unfavourable to budget. This is driven by personnel costs in excess of both Nursing, Allied Health and Support staff and treatment related. The trend for patient activity and acuity and the impact of increasingly older, frailer and more complex patients/increasing one to one care, treatment related costs particularly treatment disposables and implants are high this month taking us well ahead of plan in line with the increased surgery. Increasing accrued annual leave has been highlighted as a variance; leave management plans are in place with a proactive approach being taken by managers and leaders.
- Supporting the impact of more complex patients/increasing one to one care is that again patient acuity hours were remain very high compared to previous years. Staff vacancies, gaps with staff on special leave, a higher rate of unplanned leave, and less than optimal skill mix to meet the acuity leads to roster gaps which have to be filled with overtime, casual and allocation resource. Unplanned leave was higher as a result of winter illnesses with staff (seen across the whole hospital). Nursing Mitigations in place include active recruitment for the required FTE to reduce overtime, casual/allocation use, completion of the CCDM roll put and continual review use of minders/cohort watches to keep the level to a reasonable safe level.

Hospital Throughput

Month					Hutt Valley DHB Hospital Throughput YTD Sep-20	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							
1,193	1,098	(95)	1,041	(152)	Surgical	3,638	3,337	(301)	3,140	(498)	12,950	12,797
1,996	1,714	(282)	1,805	(191)	Medical	5,825	5,202	(623)	5,718	(107)	20,240	19,506
506	407	(99)	487	(19)	Other	1,473	1,240	(233)	1,444	(29)	4,871	5,474
3,695	**3,218**	**(477)**	**3,333**	**(362)**	**Total**	**10,936**	**9,779**	**(1,157)**	**10,302**	**(634)**	**38,061**	**37,777**
					CWD							
1,257	1,210	(47)	1,227	(30)	Surgical	3,802	3,596	(206)	3,619	(183)	13,889	12,852
1,009	1,072	63	1,120	111	Medical	2,964	3,279	315	3,340	375	12,225	11,991
537	378	(159)	428	(109)	Other	1,695	1,113	(582)	1,278	(416)	4,305	4,698
2,803	**2,660**	**(143)**	**2,775**	**(28)**	**Total**	**8,461**	**7,988**	**(473)**	**8,237**	**(224)**	**30,419**	**29,540**
					Other							
3,997	4,008	11	4,166	169	Total ED Attendances	12,317	12,315	(2)	12,764	447	48,696	47,491
972	969	(3)	975	3	ED Admissions	3,058	3,049	(9)	3,040	(18)	11,386	11,847
803	798	(5)	744	(59)	Theatre Visits	2,463	2,403	(60)	2,266	(197)	9,370	9,271
140	128	(12)	119	(21)	Non- theatre Proc	441	388	(53)	390	(51)	1,500	1,891
7,461	7,107	(354)	7,487	26	Bed Days	22,926	21,606	(1,320)	22,989	63	82,873	85,515
4.42	4.50	0.08	4.33	(0.10)	ALOS Inpatient	4.49	4.50	0.02	4.39	(0.10)	4.50	4.29
1.97	2.18	0.21	2.08	0.11	ALOS Total	2.03	2.18	0.15	2.16	0.13	2.18	2.20
8.13%	8.02%	-0.11%	8.33%	0.20%	Acute Readmission	7.57%	8.02%	0.44%	8.13%	0.56%	7.31%	7.36%

For the month of September, Medical discharges were 16% over budget and higher than the same time last year. But caseweights for Medical are lower than budget for the month and year to date. For the month Surgical discharges were 9% higher than budget. Year to date, Surgical caseweights are higher than the same time last year. Other services have had higher discharges than budget so far this year and 52% more caseweights than budget.

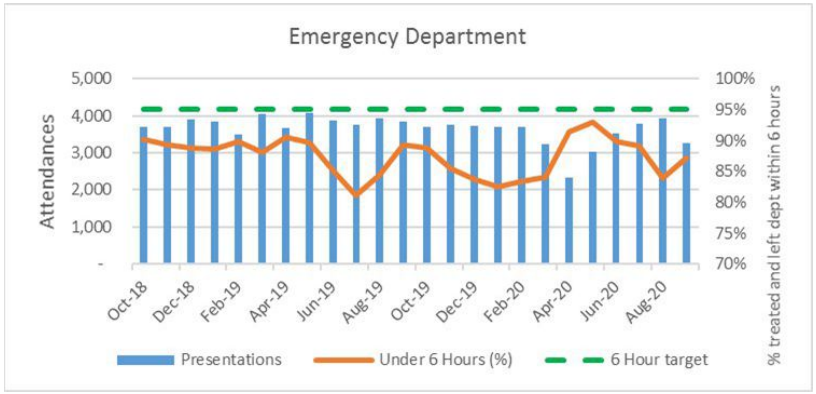
ED volumes for the month were close to budget but lower than the same time last year. The number of patients who were admitted from ED is close to budget. Theatre visits in September were close to budget for the month, but year to date, they are 9% higher than the same time last year as services implement recovery plans after COVID restrictions. Non-theatre procedures are also higher than budget for the month and year to date. Bed days were higher than budget in September but similar to the same time last year. Inpatient ALOS in September was lower than budget and the same time last year. The acute readmission rate is lower than budget.

Operational Performance Scorecard – 13 mths

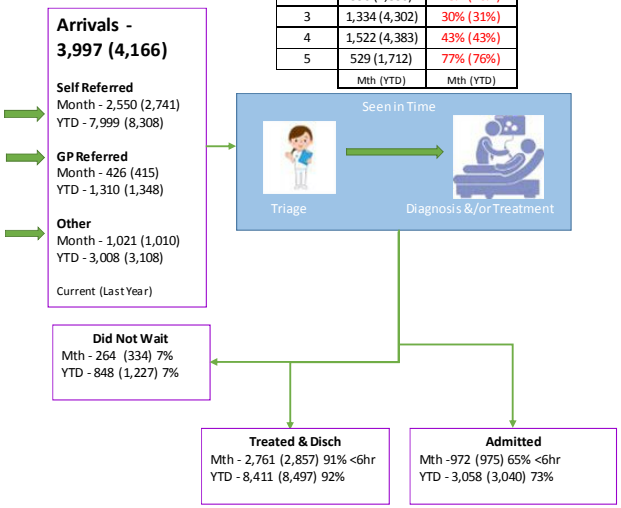
			13 Months Performance Trend													Last Four Weeks			
Domain	Indicator (MoH KPIs highlighted yellow)	2019/20 Target	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	7/09/20	14/09/20	21/09/20	28/09/20
Safe	Serious Safety Events[1]	Zero SSEs	1	6	3	0	1	4	1	2	2	2	3	3	1				
	SABSI Cases [2]	Zero	0	0	0	0	2	2	1	0	0	0	1	0	1				
	C. difficile infected diarrhoea cases	Zero	1	2	2	1	2	2	4	0	2	0	3	4	1				
	Hand Hygiene compliance (quarterly)	≥ 80%	86%	84%			83%			87%			TBC						
	Seclusion Hours- average per event (MH Inpatient ward TWA)[3]		14.5	81.0	126.8	36.4	21.8	14.0	31.1	39.1	16.3	13.8	27.7	*CCHBD					
Patient and Family Centred	Complaints Resolved within 35 calendar days[4]	≥90%																	
	Patient reported experience measure[5] (quarterly)	≥80%	85.3%	N/a			N/a			N/a									
Timely	Emergency Presentations	49,056	4,166	4,054	4,239	4,133	4,053	4,028	3,558	2,405	3,104	3,721	4,039	4,281	3,997	915	946	990	984
	Shorter Stays in ED (SSiED) % within 6hrs	≥95%	89.3%	88.7%	84.6%	83.7%	82.6%	83.5%	83.9%	91.4%	93.0%	89.9%	89.2%	84.0%	87.2%	88.1%	84.5%	85.6%	84.5%
	SSiED % within 6hrs - non admitted	≥95%	94.1%	92.7%	90.1%	90.9%	89.5%	90.1%	90.1%	95.7%	97.0%	94.7%	93.3%	90.7%	91.5%	92.2%	89.8%	90.0%	89.9%
	SSiED % within 6hrs - admitted	≥95%	75.2%	77.7%	71.0%	64.5%	63.1%	64.4%	66.6%	81.1%	82.4%	76.1%	78.6%	64.5%	75.1%	76.1%	69.4%	71.8%	70.3%
	Total Elective Surgery Long Waits -ESPI 5	Zero Long Waits	304	435	535	625	726	719	821	1,012	1,077	1,130	1,082	913	915	852	844	898	895
	No. Theater surgeries cancelled (OP 1-8)		162	169	137	116	134	98	194	50	72	98	140	148	154	41	38	37	14
	Total Elective & Acute Operations in MainTheatres 1-8[6]		744	788	769	664	784	743	704	389	673	733	868	792	803	185	177	166	126
	Specialist Outpatient Long Waits- ESPI 2	Zero Long Waits	564	587	631	891	1,130	1,194	1,265	1,396	1,384	1,240	1,096	798	674	733	710	689	699
	Outpatient Failure to Attend %	≤6.3%	6.6%	6.8%	6.9%	7.6%	7.1%	7.6%	6.9%	6.1%	7.4%	8.3%	6.8%	6.3%	5.2%	4.8%	5.3%	5.3%	7.1%
	Full Year Forecast surplus / (deficit) $m - Provider (1) (2)	($2.03)	($4.48)	($6.90)	($5.21)	($5.21)	($6.57)	($8.19)	($10.37)	($13.04)	($13.59)	($14.20)	($10.61)	($10.61)	TBC				
	Full Year Forecast surplus / (deficit) $m - DHB (1) (2)	($8.14)	($8.97)	($8.14)	($8.58)	($8.58)	($8.76)	($10.39)	($13.04)	($14.64)	($15.64)	($21.45)	($10.65)	($10.65)	TBC				
	% Theatre utilisation (Elective Sessions only)[7]	≤90%	87.9%	87.1%	86.5%	85.5%	87.9%	89.6%	86.4%	74.5%	85.2%	87.6%	85.7%	87.9%	90.4%	92.1%	89.7%	92.0%	86.6%
	Overnight Patients - Average Length of Stay (days)	≤4.3	4.36	4.82	4.52	4.37	4.34	4.35	5.31	4.90	4.26	4.44	4.39	4.76	4.51	4.92	4.34	3.78	4.70
	Long Stay Patients Not Yet Discharged (>14 days)	≤5	21	13	10	23	15	16	7	12	15	14	16	21	18	21	20	25	18
	Overnight Beds (General Occupancy) - Average Occupied	≤130	140	135	138	137	131	136	129	105	118	136	141	151	144	143	149	146	131
	Overnight Beds (General Occupancy) - % Funded Beds Occupied	≤85%	86.2%	87.9%	89.5%	89.0%	87.2%	88.2%	79.5%	65.1%	73.1%	84.2%	86.8%	93.1%	88.8%	88.1%	91.9%	89.9%	80.8%
	All Beds - ave. beds occupied[8]	≤250	250	242	244	232	231	244	223	179	207	241	244	254	249	243	257	248	231
	% sick Leave v standard	≤3.5%	3.7%	3.5%	2.9%	2.7%	2.0%	2.5%	3.6%	7.5%	6.9%	3.1%	4.3%	4.2%	4.0%				
	% Nursing agency v employee	≤1.49%	3.8%	2.6%	2.3%	1.7%	3.9%	3.0%	2.6%	2.3%	3.3%	2.0%	1.6%	1.2%	TBC				
	% overtime v standard (medical)	≤9.22%	7.4%	8.7%	11.2%	5.9%	11.6%	9.3%	7.6%	9.2%	9.7%	9.2%	6.7%	7.8%	TBC				
	% overtime v standard (nursing)	≤5.47%	12.8%	12.4%	13.8%	11.5%	17.9%	14.1%	10.6%	13.2%	12.6%	12.3%	10.8%	13.6%	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	16 (64)	100% (100%)
2	596 (1,856)	48% (46%)
3	1,334 (4,302)	30% (31%)
4	1,522 (4,383)	43% (43%)
5	529 (1,712)	77% (76%)
	Mth (YTD)	Mth (YTD)



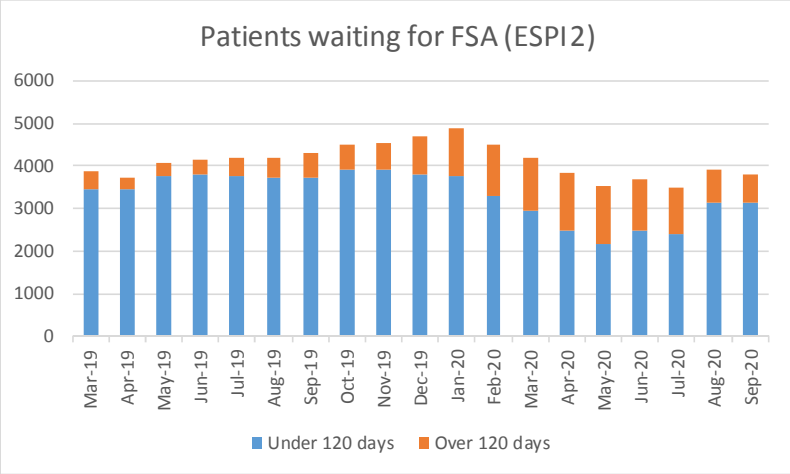
- **What is this Measure**
  - The percentage of patients admitted, discharged and transferred from an Emergency Department within 6 hours.
- **Why is it important**
  - This indicator measures flow through the whole system it is impacted by the number of people arriving at ED, how fast ED treats them, availability of beds in the hospital and community service availability.
- **How are we performing**
  - Performance of the target improved during April with lower numbers through the ED however the performance has fallen since to 87% in September.
- **What is driving Performance**
  - We continue to have increased presentations to ED and high occupancy last month impacting hospital flow which in turn affects length of stay in ED.

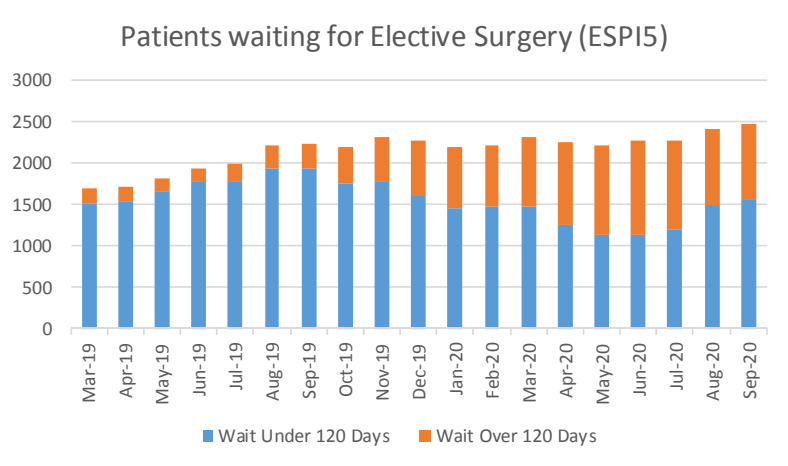
- **Management Comment**

The following work streams are being rolled out:

- CCDHB hospital flow issues have meant transfer of cardiac patients for interventions has been delayed, adversely affecting HVDHB flow.
- MAPU is working well to include General Surgical and Gynaecology patients, however hospital flow issues have increased length of stay in this area.
- The 2DHB Care Coordination pathway and guidelines are developed for imminent release. Joint work with CareCo has identified joint process issues for improvement activities, and integrating NASC processes into discharge planning processes in a more timely way

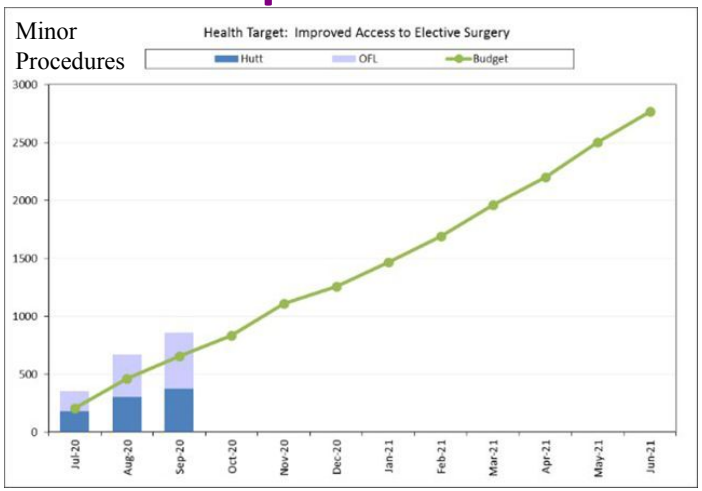
Waiting times - Planned Care

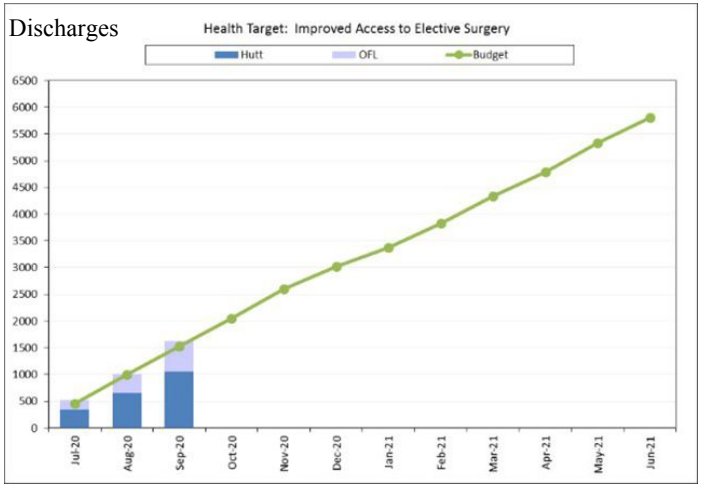




- **What is this measure?**
  - The delivery of Specialist assessments or Treatment within 120 days
- **Why is it important?**
  - It is important to ensure patients receive care at the most appropriate time to support improved health.
- **How are we performing?**
  - The total waiting for an FSA decreased by 3% this month and the number waiting over 120 days by 16% (124)
  - The number waiting for elective surgery increased by 72 to 2,478 and the number waiting over 120 days by 2 to 915
- **What is driving performance?**
  - Long waiting lists continue to be a challenge, late winter bed demand has impacted on bed capacity and this combined with RN staffing in PACU and ICU has seen OT delays and cancellations.
- **Management Comment**
  - Addressing ESPI 2 and 5 waiting lists remains a significant challenge and risk for HVDHB.
  - Developing an outsourcing contract has been slower than planned.
  - We have been unable to commence outsourcing plan in Q1. We are in negotiation with Boulcott to commence outsourcing in Q2 (mid-October).
  - A system improvement project around all aspects of managing elective flows is underway.

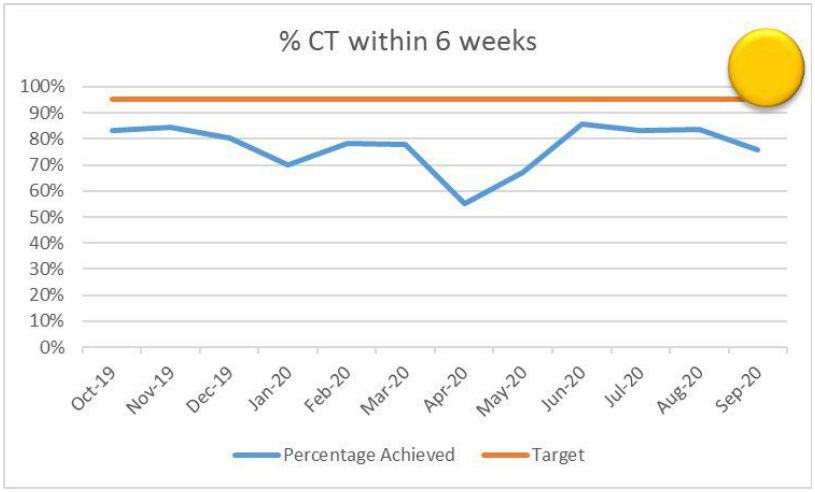
Planned Care – Inpatient discharges and Minor procedures

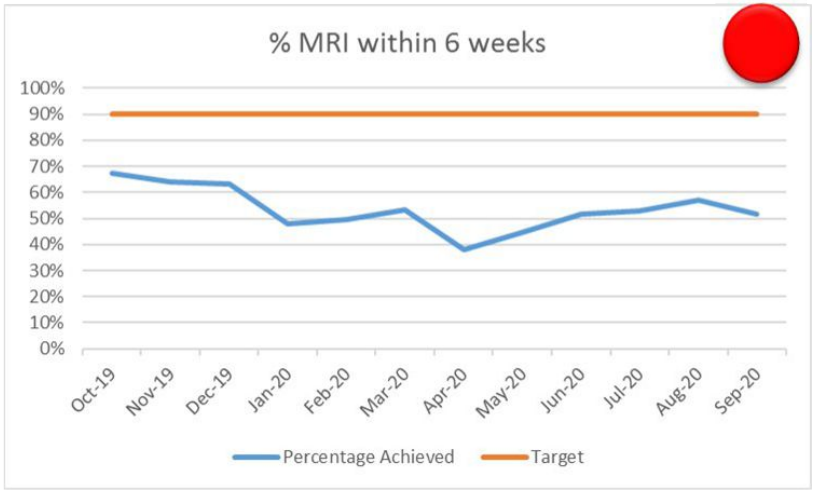




- **What is this measure?**
  - The delivery of an agreed number of inpatient surgical discharges and minor procedures to the Hutt Valley Population
- **Why is it important?**
  - It is important to ensure patients are receiving the planned care procedures required.
- **How are we performing?**
  - Phasing of budgets has been confirmed with the Ministry of Health
  - Both discharges and Minor procedures exceeded target
- **What is driving performance?**
  - A number of staffing issues and the close down during the COVID-19 lock down have resulted in an increase in patients waiting
  - There continued to be a number of minor procedures completed during the lockdown both in the hospital and community
- **Management Comment**
  - The total September planned care target was met.
  - We continue working with our SMO's to schedule surgery and utilising private providers to reduce our surgical waiting list. Based on those with greatest clinical urgency and risk of deterioration.
  - Submissions to MoH for additional funding to increase Planned Care activity,
    - an orthopaedic initiative to reduce ESPI 2 and
    - capital investment of around 3 million to establish a procedure suite.
    - We expect to know the outcome of these funding submissions on mid October 2020.

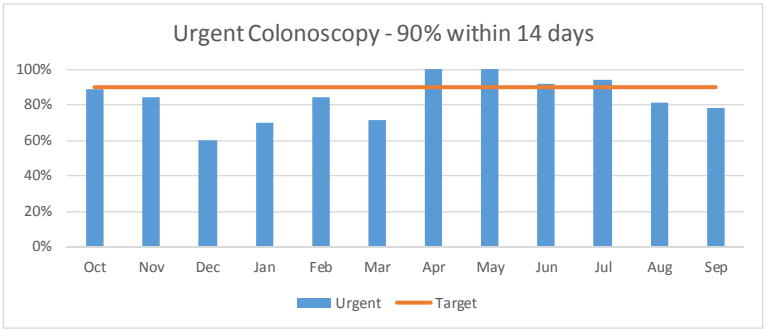
CT & MRI wait times



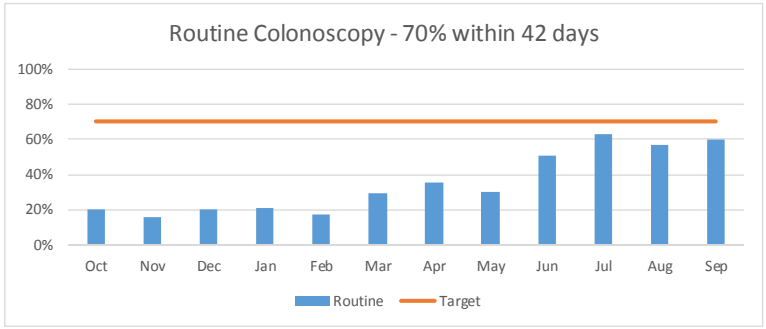


- **What is this measure?**
  - The delivery of computerised tomography (CT) scans and Magnetic Resonance Imaging (MRI) scans in a timely fashion to non-acute patients (within 42 days of referral).
- **Why is it important?**
  - Delayed diagnostic results can negatively affect health outcomes.
- **How are we performing?**
  - The % of patients receiving their MRI within 6 weeks fell a little this month.
  - CT wait times remain close to target although performance fell this month.
- **What is driving performance?**
  - There is insufficient radiologist capacity to meet reporting demand; resulting in outsourcing and delays. This will be partly addressed in the coming months with the successful appointment to two vacancies.
- **Management comment**
  - We are currently scanning all Hutt Valley domicile patients seen by CCDHB, putting further demand on the service.
  - Actions currently underway:
    - Managed daily outsourcing of reporting to Pacific Radiology to support in-house Radiologists.
    - Reviewing of intervention lists,
    - Reviewing Wairarapa radiology contract, as rates have not increased for several years
    - Reviewing current workflow within Radiology to maximise flexibility of bookings and acute imaging response.
    - Consultation underway for extended hours in the weekend for MRI appointments
    - Weekend CT list commenced to manage waitlist
    - Production plan for additional funding to support a two year plan to reduce waitlist has been submitted to MOH.

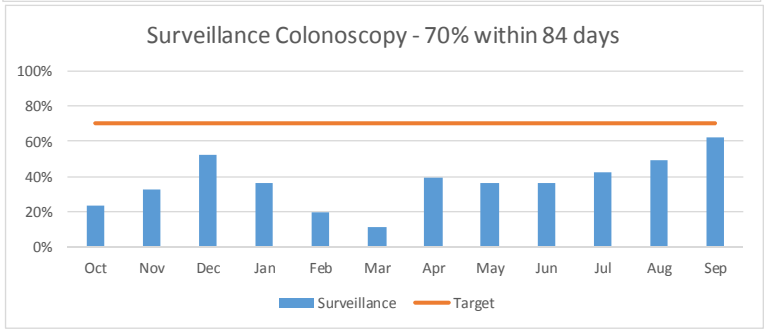
Colonoscopy Wait Times



Urgent
89% YTD



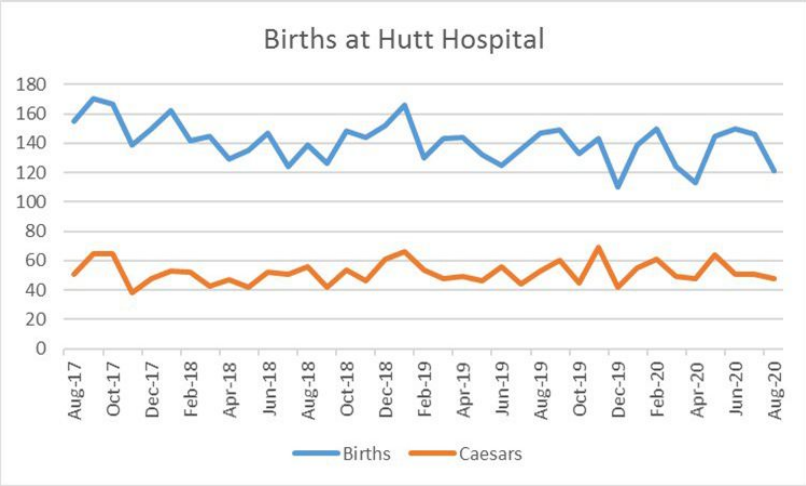
Routine
60% YTD

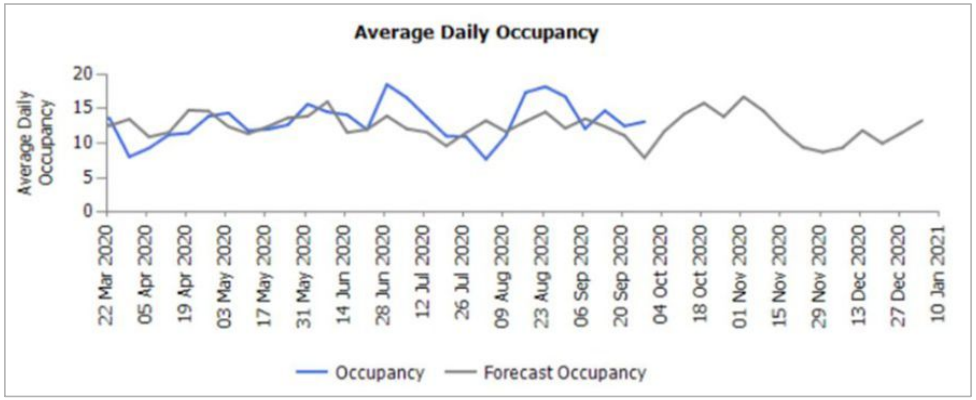


Surveil
46% YTD

- **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 are close to meeting the urgent colonoscopy target however we continue to struggle with both routine and surveillance
- **What is driving performance?**
  - We now have sufficient staffing capacity to meet demand. We continue to monitor this as we will have reduced capacity early next year.
- **Management comment**
  - Whilst we had fewer referrals during COVID-19 lockdown, we have seen a large increase in our referrals for June and July, resulting in a decreased ability to meet this timeframe, however, we are tracking at 98% for Routine patients at the 100% timeframe of 90 days
  - We are awaiting sign-off by the CEO to enable recruitment of a Nurse Endoscopist.
  - We continue to increase in our efforts to meet the 100% timeframes and are tracking in line with our Recovery and Production Plans.
  - There were 672 patients waiting more than the maximum waiting times; 0% were Maori or Pacific. .

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?**
  - We are receiving an increase in positive feedback from women using our maternity service
  - The number of births at Hutt hospital remained relatively stable
  - The Caesarian rate for the 12 months to August 2020 was an average of 39.6% which is an increase on the previous 12 months average of 36.6%. During alert level 4 and 3 less caesarean sections were done and this change in practice reduced high risk surgical intervention during the pandemic.
  - Bed Occupancy rose in remained steady for most of August & September
- **Management comment**
  - The Single Stage Business Case for approval to invest $9.47 million capital funding to upgrade the Maternity Assessment Unit, Maternity Ward and Special Care Baby Unit (SCBU) has progressed through the Capital Investment Committee. We are waiting for official confirmation of final Ministerial approval on this investment.
  - The Ministry of Health and Associate Minister of Health have received regular progress updates on our achievements in meeting recommendations from the independent review of our maternity service.

Section 4

Financial Performance & Sustainability

Summary the Financial Performance for September 2020

Month					Hutt Valley DHB Operating Report for the month of September 2020	Year to date					Annual	Annual			
Actual	Budget	Variance	Last Year	Variance	$000s	Actual	Budget	Variance	Last Year	Variance	Forecast	Budget	Variance	Last Year	Variance
					Revenue										
40,740	40,313	427	38,545	2,194	Devolved MoH Revenue	122,027	120,938	1,090	113,777	8,250	484,840	483,750	1,090	454,822	30,018
2,116	1,760	356	1,747	369	Non Devolved MoH Revenue	5,903	5,045	859	4,892	1,012	20,908	20,049	859	19,272	1,636
581	625	(44)	644	(63)	ACC Revenue	1,821	1,842	(21)	1,964	(143)	7,198	7,219	(21)	6,457	741
510	547	(36)	(402)	912	Other Revenue	1,618	1,598	20	1,550	67	6,329	6,309	20	6,074	255
10,049	9,229	821	8,506	1,543	IDF Inflow	28,514	27,686	828	25,603	2,910	111,570	110,742	828	102,288	9,282
977	303	673	421	556	Inter DHB Provider Revenue	2,227	910	1,317	857	1,370	24,978	3,637	21,341	4,507	20,471
54,973	**52,776**	**2,198**	**49,462**	**5,512**	**Total Revenue**	**162,110**	**158,017**	**4,093**	**148,644**	**13,466**	**655,823**	**631,707**	**24,116**	**593,420**	**62,403**
					Expenditure										
					Employee Expenses										
5,072	5,260	187	4,652	(420)	Medical Employees	15,914	15,776	(137)	14,686	(1,228)	60,174	63,310	3,135	60,010	(165)
5,854	6,472	618	5,773	(81)	Nursing Employees	18,911	19,409	498	17,987	(925)	70,532	76,767	6,235	75,339	4,807
2,320	2,896	576	2,497	177	Allied Health Employees	7,843	8,640	797	7,798	(45)	29,172	34,601	5,429	32,175	3,003
816	699	(117)	664	(151)	Support Employees	2,344	2,094	(250)	2,140	(204)	8,645	8,394	(250)	8,676	32
1,904	2,597	693	2,382	478	Management and Admin Employees	6,898	7,786	888	7,502	605	27,152	30,812	3,661	28,166	1,015
15,966	**17,923**	**1,957**	**15,968**	**2**	**Total Employee Expenses**	**51,909**	**53,705**	**1,795**	**50,112**	**(1,797)**	**195,674**	**213,884**	**18,209**	**204,366**	**8,692**
					Outsourced Personnel Expenses										
310	247	(63)	335	25	Medical Personnel	941	742	(199)	700	(241)	6,437	2,965	(3,472)	3,763	(2,674)
115	91	(24)	220	105	Nursing Personnel	294	273	(21)	483	190	6,850	1,093	(5,758)	2,002	(4,848)
47	87	40	67	20	Allied Health Personnel	125	262	137	130	5	5,545	1,049	(4,495)	583	(4,962)
53	20	(33)	28	(25)	Support Personnel	162	61	(101)	141	(21)	345	244	(101)	522	177
726	119	(606)	147	(579)	Management and Admin Personnel	1,222	327	(895)	328	(894)	5,432	1,765	(3,668)	1,671	(3,761)
1,252	**565**	**(687)**	**798**	**(454)**	**Total Outsourced Personnel Expenses**	**2,745**	**1,666**	**(1,079)**	**1,783**	**(961)**	**24,609**	**7,116**	**(17,493)**	**8,541**	**(16,068)**
3,002	697	(2,305)	1,050	(1,952)	Outsourced Other Expenses	4,474	2,090	(2,384)	2,277	(2,197)	30,770	8,363	(22,407)	9,845	(20,925)
2,346	2,388	42	2,205	(141)	Treatment Related Costs	7,679	7,107	(573)	7,392	(287)	29,575	28,666	(910)	27,169	(2,406)
2,112	1,477	(636)	1,619	(493)	Non Treatment Related Costs	5,950	4,636	(1,314)	4,988	(961)	21,825	18,467	(3,358)	37,215	15,390
9,798	9,151	(648)	7,778	(2,020)	IDF Outflow	27,542	27,452	(90)	24,415	(3,126)	109,897	109,807	(90)	101,298	(8,598)
18,749	18,820	71	18,185	(564)	Other External Provider Costs	57,045	56,927	(118)	54,018	(3,027)	227,652	227,534	(118)	218,583	(9,069)
2,227	2,377	150	2,395	168	Interest, Depreciation & Capital Charge	6,757	7,131	374	6,916	159	29,193	28,517	(676)	25,186	(4,007)
55,454	**53,397**	**(2,057)**	**49,998**	**(5,456)**	**Total Expenditure**	**164,101**	**160,714**	**(3,387)**	**151,902**	**(12,199)**	**669,195**	**642,352**	**(26,842)**	**632,203**	**(36,991)**
(481)	**(621)**	**141**	**(537)**	**56**	**Net Result**	**(1,991)**	**(2,697)**	**705**	**(3,259)**	**1,267**	**(13,372)**	**(10,645)**	**(2,726)**	**(38,784)**	**25,412**
					Result by Output Class										
692	161	531	(274)	967	Funder	1,960	6	1,953	(274)	2,234	1,944	(9)	1,953	(7,889)	9,834
69	(3)	71	58	11	Governance	98	11	87	118	(20)	62	(25)	87	634	(572)
(1,241)	(780)	(462)	(320)	(921)	Provider	(4,049)	(2,714)	(1,335)	(3,103)	(946)	(15,378)	(10,611)	(4,767)	(31,528)	16,150
(480)	**(621)**	**141**	**(537)**	**56**	**Net Result**	**(1,991)**	**(2,697)**	**705**	**(3,259)**	**1,268**	**(13,372)**	**(10,645)**	**(2,726)**	**(38,784)**	**25,412**

There may be rounding differences in this report

Executive Summary – Financial Position

Financial performance year to date

- Total Revenue favourable $4,093k
- Personnel and outsourced Personnel unfavourable $716k
  - Medical unfavourable ($337k); Nursing favourable $477k; Allied Health favourable $934k, Support Staff unfavourable ($351k); Management and Admin unfavourable ($7k); Annual leave Liability cost has increased by $1,379k since September 2019
- Outsourced other expenses unfavourable ($2,384k), includes MHAIDs changes
- Treatment related Costs unfavourable ($573k)
- Non Treatment Related Costs unfavourable ($1,314k), includes Holiday Act provision.
- IDF Outflow unfavourable ($90k)
- Other External Provider Costs unfavourable ($118k)
- Interest depreciation and capital charge favourable $374k

Analysis of Operating Position – Revenue

- **Revenue:** Total revenue favourable $2,198k for the month
  - Devolved MOH revenue $427k favourable, driven by COVID-19.
  - Non Devolved revenue $356k favourable driven largely by the recognition of Regional Public Health contract Revenue, originally deferred due to COVID-19.
  - ACC Revenue ($44k) favourable.
  - Other revenue ($36k) unfavourable for the month reflecting lower than expected co-patient revenue.
  - IDF inflows favourable $821k for the month.
  - Inter DHB Revenue favourable $673k, 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 - September 2020	Funder [1]	Provider (excl. Regional Public Health)	Provider - Regional Public Health (RPH)	Total
$000s	Actual	Actual	Actual	Actual
Revenue				
MoH Revenue Recognised - COVID19 [2]	1,087	214	368	1,669
Expenditure				
Employee Expenses				
Medical Employees		(5)	258	253
Nursing Employees		1	201	202
Allied Health Employees		14	479	492
Support Employees		40	32	72
Management and Admin Employees		20	83	103
Total Employee Expenses	**0**	**70**	**1,052**	**1,122**
Expenses				
Outsoruced - Provider	0	20	85	105
External Providers - Funder	1,193			1,193
Clinical Expenses - Provider	0	2	26	29
Non-clinical Expenses- Provider	0	200	2	202
Total Non Employee Expenses	**1,193**	**222**	**114**	**1,529**
Total Expenditure	**1,193**	**292**	**1,166**	**2,651**
Net Impact	**(105)**	**(78)**	**(798)**	**(982)**

(1) Net of RPH & Provider tagged funding

(2) Includes funding via Whanganui DHB

- The September year to date financial position includes $2.7m additional costs in relation to COVID-19.
- Revenue of $1.1m has been received to fund additional costs for community providers and Regional Public Health.
- The net impact year to date is $1.0m additional costs currently unfunded.

Analysis of Operating Position – Personnel

- **Total Personne**l including outsourced favourable $1,270k for the month
  - Medical personnel incl. outsourced favourable $124k. Outsourced costs are ($63k) unfavourable, Medical Staff Internal are $187k favourable driven by the move to the new MHAIDS structure $365k, partly offset by RMO and HO overspends ($184k).
  - Nursing incl. outsourced $593k favourable. Employee costs are $618k favourable, driven by moving to the new MHAIDS structure $596k. Excluding MHAIDS, the favourable movements were Senior Nurses $48k, Registered Nurses $35k and Registered Midwives $135k, partly offset by Internal Bureau Nurses and Health Care Assistants ($232k). This reflects the partial implementation of the Care Capacity Demand Management (CCDM) process and Maternity Review recommendations.
  - Allied Health incl. outsourced $616k favourable, with outsourced favourable $40k, internal employees favourable $576k. Employee costs were driven by MHAIDS restructure $534k, with the balance in Regional Public Health.
  - Support incl. outsourced unfavourable ($149k), with Outsourced ($33k) unfavourable, and employee costs ($117k) unfavourable, driven by Orderlies ($63k), Cleaners ($13k), Sterile Supply Assistants ($23k) and Facilities ($26k).
  - Management & Admin incl. outsourced favourable $86k; internal staff favourable $693k, Outsourced unfavourable ($606k). This reflects the transition of ICT and MHAIDS Staff to the new structures.
  - Sick leave for September was 4.0%, which is higher than the same time last year, which was 3.7%.

FTE Analysis

Month					FTE Report	Year To Date					Annual	
Actual	Budget	Variance	Last Year	Variance	Sep-20	Actual	Budget	Variance	Last Year	Variance	Budget	Last Year
					FTE							
276	285	8	284	7	Medical	282	285	3	287	4	287	294
772	830	58	805	33	Nursing	806	831	25	796	(10)	829	818
344	416	72	406	62	Allied Health	379	416	37	398	19	417	402
148	137	(11)	140	(8)	Support	145	137	(8)	138	(6)	137	143
320	388	67	367	47	Management & Administration	338	388	50	372	34	388	365
1,861	**2,057**	**196**	**2,002**	**141**	**Total FTE**	**1,950**	**2,057**	**107**	**1,992**	**42**	**2,058**	**2,023**
					$ per FTE							
18,346	18,463	117	16,406	(1,940)	Medical	56,358	55,381	(977)	51,247	(5,111)	209,528	215,094
7,585	7,795	209	7,175	(411)	Nursing	23,464	23,361	(103)	22,592	(872)	85,069	93,878
6,744	6,956	213	6,145	(598)	Allied Health	20,693	20,755	62	19,577	(1,116)	69,948	86,026
5,514	5,094	(420)	4,742	(772)	Support	16,199	15,262	(937)	15,464	(735)	63,013	58,552
5,941	6,695	754	6,489	548	Management & Administration	20,390	20,076	(313)	20,142	(247)	70,009	84,348
8,581	**8,715**	**134**	**7,977**	**(603)**	**Average Cost per FTE all Staff**	**26,615**	**26,109**	**(507)**	**25,158**	**(1,457)**	**95,063**	**105,729**

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 5FTE, MOSS under budget by 0.3 FTE, offset by RMO's & House Officers combined.

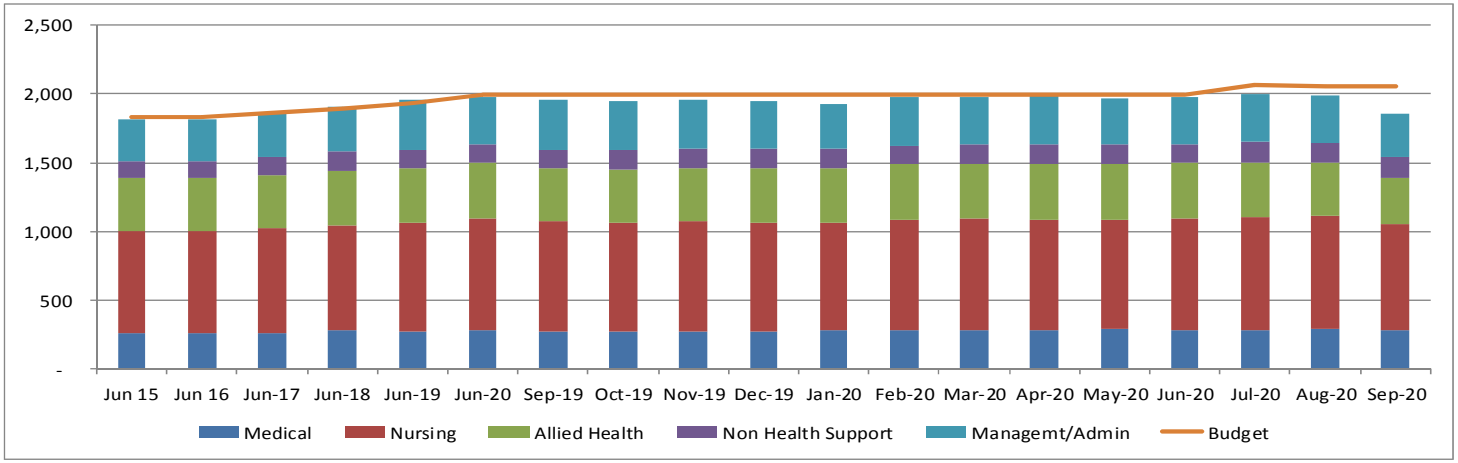
Nursing under by 58 FTE for the month, driven by MHAIDS restructure 53 FTE:
Excluding MHAIDS the contribution to movements were; Internal Bureau Nurses and HCA's are over budget (23) FTE mostly driven by General Medical (9) FTE, ED (6) FTE and other variances. This is offset by Registered Nurses and Health Care Assistants under budget 10 FTE and Registered Midwives 16 FTE. This reflects the transition of changes made under both CCDM recommendations and the Maternity Review.

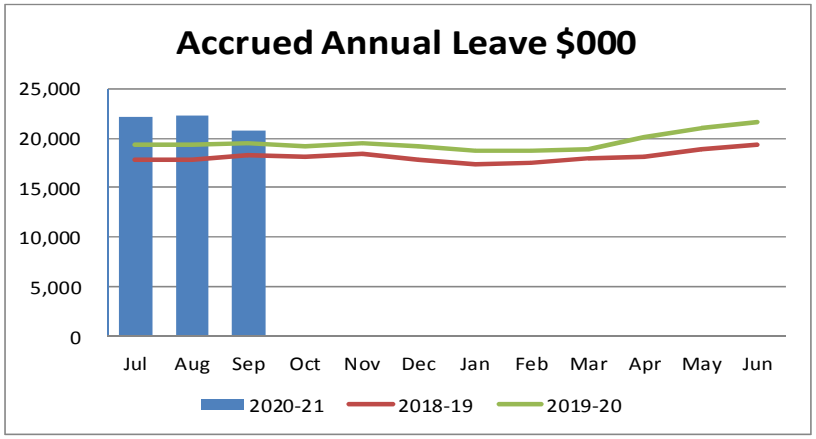
Allied FTEs are under by 72 FTEs for the month, driven by the MAHIDS restructure 61:
Excluding MHAIDS the contribution to movements were; Favourable variances in Health promotion 5 FTE, Other Allied Health 2 FTE, Pharmacists 1 FTE.

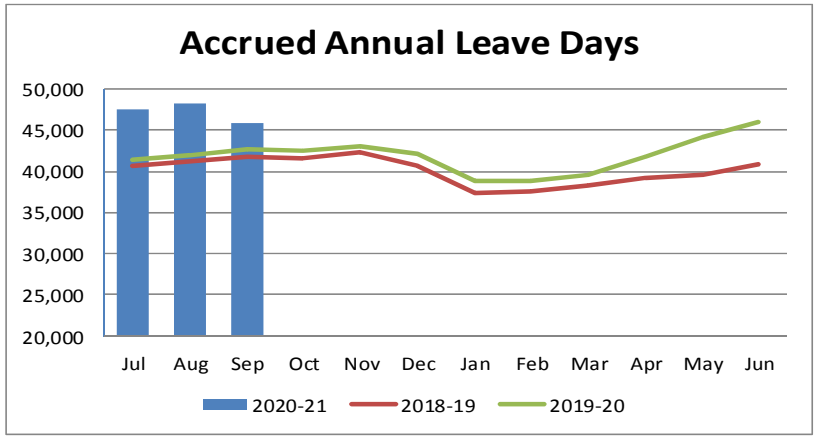
Support FTEs are (11) FTEs over budget driven by Food services (2) FTE, Cleaning (1) FTE and Orderlies (8) FTE.

Management & Admin are under budget by 67 FTEs driven by the MHAIDS & ITS Restructures 49FTE.
Excluding MHAIDS and ITS changes favourable variance of 18FTE, other variances include; Project Management 2FTE, SPO 3FTE, Quality 2 FTE, Surgical Women's & Children's 4FTE, Regional Public Health 3FTE and Breast Screening Programme 5 FTE.

FTE Analysis







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

Analysis of Operating Position – Other Expenses

- **Other Operating Costs**
  - Outsourced other unfavourable ($2,305k) for the month, driven by 3DHB MHAIDS Charges offset by saving against personnel budgets.
  - Treatment related costs $42k favourable. Hospital Medicines rebates $316k, offset by Treatment Disposables ($172k), Patient Appliances ($21k) and Instruments and Equipment ($100k) and other minor variances.
  - Non Treatment Related costs unfavourable ($636k) including the provision for Holidays Act Settlement ($227k) which is not budgeted as advised by MoH, Rent ($16k) related mainly to COVID-19, Security ($47k) related mainly to COVID-19 and Outsourced Maintenance ($61k).
  - IDF Outflows ($648k) unfavourable for the month, reflecting current year wash-up payments.
  - Other External Provider costs favourable $71k, driven by Public Health ($540k) predominantly related to COVID-19, offset by Disability Support Providers $835k, Laboratory ($224k) and other minor variances.
  - Interest, Depreciation & Capital Charge favourable $150k, driven by depreciation $146k.

Section 5

Additional Financial Information & Updates

Financial Position as at 30 September 2020

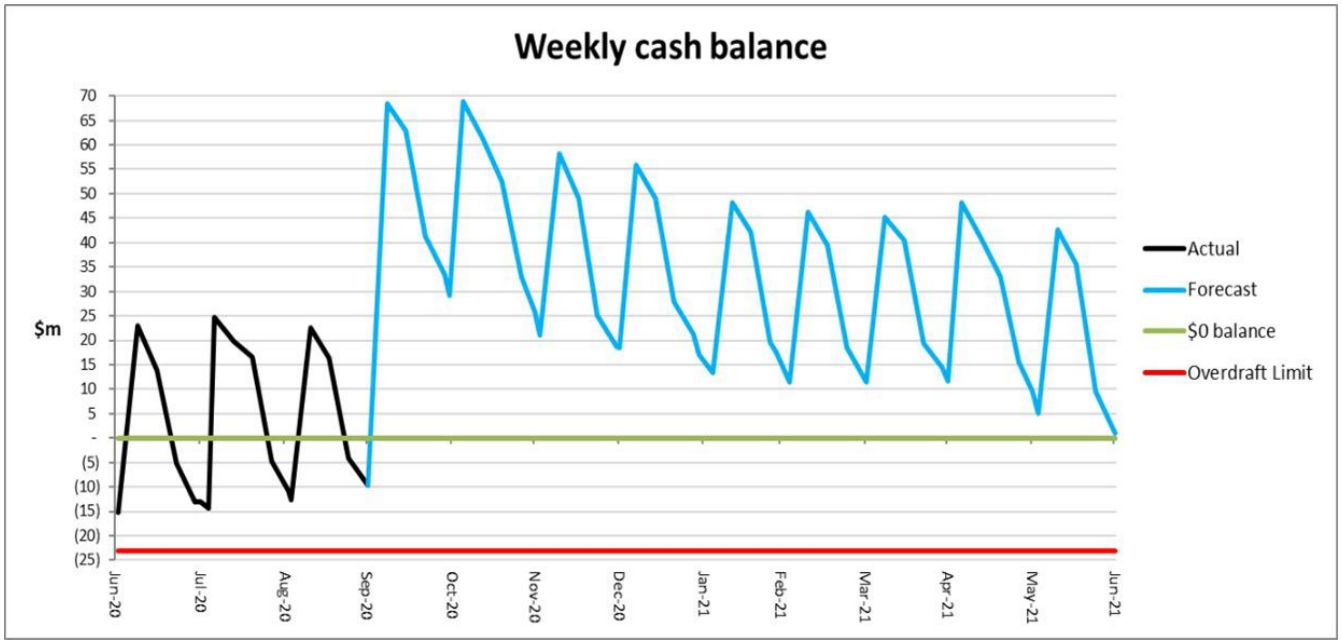
$000s	Actual	Budget	Variance	Jun 20	Variance	Explanation of Variances Between Actual and Budget
Assets						
Current Assets						
Bank - Non DHB Funds *	1,838	4,927	(3,089)	4,927	(3,089)	Payments from NHMG to DHB's paid earlier than budgeted
Accounts Receivable & Accrued Revenue	29,543	27,577	1,966	27,577	1,966	
Stock	2,264	2,200	65	2,199	66	
Prepayments	1,328	815	512	815	512	
Total Current Assets	**34,973**	**35,519**	**(546)**	**35,518**	**(545)**	
Fixed Assets						
Fixed Assets	227,469	235,101	(7,632)	229,790	(2,321)	
Work in Progress	15,956	14,001	1,955	14,001	1,955	
Total Fixed Assets	**243,425**	**249,102**	**(5,677)**	**243,791**	**(366)**	
Investments						
Investments in Associates	1,150	1,150	0	1,150	0	Allied Laundry
Trust Funds Invested	1,178	1,347	(169)	1,347	(169)	Restricted Trusts
Total Investments	**2,328**	**2,497**	**(169)**	**2,497**	**(169)**	
Total Assets	**280,726**	**287,118**	**(6,392)**	**281,806**	**(1,080)**	
Liabilities						
Current Liabilities						
Bank	9,673	22,976	13,304	10,986	1,314	Average bank balance in Sep-20 was $9.2m
Accounts Payable and Accruals	72,914	65,924	(6,990)	73,615	701	Includes Holidays Act Provision of $28.2m
Crown Loans and Other Loans	31	42	10	42	10	
Capital Charge Payable	3,106	0	(3,106)	0	(3,106)	
Current Employee Provisions	27,926	26,018	(1,909)	26,518	(1,409)	
Total Current Liabilities	**113,650**	**114,960**	**1,310**	**111,161**	**(2,490)**	
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	1,838	4,927	3,089	4,927	3,089	Payments from NHMG to DHB's paid earlier than budgeted
Trust Funds	1,219	1,347	128	1,347	128	
Total Non Current Liabilities	**12,207**	**15,426**	**3,218**	**15,424**	**3,216**	
Total Liabilities	**125,858**	**130,385**	**4,528**	**126,584**	**727**	
Net Assets	**154,869**	**156,732**	**(1,864)**	**155,222**	**(353)**	
Equity						
Crown Equity	123,916	128,123	(4,207)	123,916	0	
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)	(353)	(2,697)	2,343	(38,784)	38,430	
Total Equity	**154,869**	**156,732**	**(1,864)**	**155,222**	**(353)**	

* NHMG - National Haemophilia Management Group

Statement of Cash Flows to 30 September 2020

$000s	Jul Actual	Aug Actual	Sep Actual	Oct Forecast	Nov Forecast	Dec Forecast	Jan Forecast	Feb Forecast	Mar Forecast	Apr Forecast	May Forecast	Jun Forecast
Operating Activities												
Government & Crown Agency Revenue	41,434	42,012	44,384	41,955	41,966	41,981	41,882	41,900	42,091	41,991	41,998	42,054
Receipts from Other DHBs (Including IDF)	9,112	10,490	8,932	10,160	10,160	10,158	10,160	10,160	10,160	10,160	10,160	10,160
Receipts from Other Government Sources	721	778	753	753	834	710	683	750	638	677	638	750
Other Revenue	1,833	1,581	(2,392)	383	380	380	388	380	380	383	380	380
Total Receipts	**53,100**	**54,861**	**51,678**	**53,250**	**53,340**	**53,228**	**53,112**	**53,189**	**53,268**	**53,212**	**53,175**	**53,343**
Payments for Personnel	(21,092)	(16,745)	(18,276)	(17,008)	(16,279)	(17,764)	(16,285)	(15,586)	(17,815)	(17,084)	(16,348)	(17,089)
Payments for Supplies (Excluding Capital Expenditure)	(4,686)	(5,368)	(4,330)	(5,209)	(4,754)	(2,786)	(13,766)	(6,936)	(8,635)	(4,927)	(4,897)	(4,916)
Capital Charge Paid	0	0	0	(0)	(0)	(6,210)	(0)	(0)	(0)	(0)	(0)	(7,260)
GST Movement	(710)	75	230	350	350	350	350	(2,000)	(2,000)	(1,000)	(2,500)	3,350
Payments to Other DHBs (Including IDF)	(9,106)	(8,637)	(8,548)	(9,151)	(9,151)	(9,151)	(9,151)	(9,151)	(9,151)	(9,151)	(9,151)	(9,151)
Payments to Providers	(18,833)	(19,317)	(19,860)	(19,026)	(18,978)	(19,148)	(18,907)	(18,092)	(18,814)	(19,187)	(19,366)	(19,088)
Total Payments	**(54,427)**	**(49,991)**	**(50,784)**	**(50,045)**	**(48,812)**	**(54,709)**	**(57,760)**	**(51,765)**	**(56,415)**	**(51,349)**	**(52,262)**	**(54,154)**
Net Cashflow from Operating Activities	**(1,327)**	**4,871**	**894**	**3,206**	**4,528**	**(1,481)**	**(4,647)**	**1,423**	**(3,146)**	**1,862**	**913**	**(811)**
Investing Activities												
Interest Receipts	0	0	0	21	21	21	21	21	21	21	21	21
Dividends	0	0	0	4	4	4	4	4	4	4	4	4
Total Receipts	**0**	**0**	**0**	**25**	**25**	**25**	**25**	**25**	**25**	**25**	**25**	**25**
Capital Expenditure	(913)	(1,399)	(964)	(272)	(8,772)	(1,772)	(272)	(1,772)	(5,772)	(14,772)	(1,472)	(8,773)
Increase in Investments and Restricted & Trust Funds Assets	99	57	13	0	0	0	0	0	0	0	0	0
Total Payments	**(814)**	**(1,343)**	**(951)**	**(272)**	**(8,772)**	**(1,772)**	**(272)**	**(1,772)**	**(5,772)**	**(14,772)**	**(1,472)**	**(8,773)**
Net Cashflow from Investing Activities	**(814)**	**(1,343)**	**(951)**	**(247)**	**(8,747)**	**(1,747)**	**(247)**	**(1,747)**	**(5,747)**	**(14,747)**	**(1,447)**	**(8,748)**
Financing Activities												
Equity Injections - Capital	0	0	0	1,000	0	0	0	0	4,000	13,000	0	0
Equity Injections - Deficit Support	0	0	0	35,000	0	0	0	0	0	0	0	0
Total Receipts	**0**	**0**	**0**	**36,000**	**0**	**0**	**0**	**0**	**4,000**	**13,000**	**0**	**0**
Interest Paid on Finance Leases	(9)	(5)	(3)	(6)	(6)	(6)	(6)	(6)	(6)	(5)	(5)	(5)
Total Payments	**(9)**	**(5)**	**(3)**	**(6)**	**(6)**	**(6)**	**(6)**	**(6)**	**(6)**	**(5)**	**(5)**	**(5)**
Net Cashflow from Financing Activities	**(9)**	**(5)**	**(3)**	**35,994**	**(6)**	**(6)**	**(6)**	**(6)**	**3,994**	**12,995**	**(5)**	**(5)**
Total Cash In	53,100	54,861	51,678	89,275	53,365	53,253	53,137	53,214	57,293	66,237	53,200	53,368
Total Cash Out	(55,250)	(51,338)	(51,738)	(50,323)	(57,590)	(56,487)	(58,037)	(53,543)	(62,192)	(66,127)	(53,739)	(62,933)
Net Cashflow												
Opening Cash	(10,986)	(13,136)	(9,613)	(9,673)	29,280	25,055	21,821	16,921	16,592	11,693	11,803	11,264
Net Cash Movements	(2,150)	3,523	(60)	38,953	(4,225)	(3,234)	(4,900)	(329)	(4,899)	110	(539)	(9,564)
Closing Cash	**(13,136)**	**(9,613)**	**(9,673)**	**29,280**	**25,055**	**21,821**	**16,921**	**16,592**	**11,693**	**11,803**	**11,264**	**1,699**

Weekly Cash Flow – Actual to 31 July 2020



Note

- the overdraft facility shown in red is set at $23 million as at September 2020
- the lowest bank balance for the month of August was $12.7m overdrawn
- the cash forecast assumes an equity injection of $35m in the forecast for October.

Summary of Leases – as at 30 September 2020

		Original Cost	Monthly Amount	Annual Amount	Total Lease Cost	Start Date	End Date	Lease type
Rental Property Leases	**Occupants**							
Wainuiomata Health Centre	District Nurses		1,149	13,787		1/11/2017	31/10/2020	Operating
Public Trust House Lower Hutt	Community Mental Health		21,887	262,643		1/09/2017	1/09/2023	Operating
CREDS - Johnsonville	Eating Disorders		5,370	64,435		1/01/2015	Rolling lease	Operating
RPH - Porirua Public Health	RPH School Health - Promotional Health		9,088	109,055		15/03/2015	14/03/2021	Operating
Criterion Lane Upper Hutt	Lagans Pharmacy - Physiotherapy		2,363	28,359		5/01/2019	31/12/2020	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
			50,685	**608,214**				
Car Park Leases								
CBD Towers Upper Hutt			542	6,500		8/06/2015	7/06/2021	Operating
Public Trust House Lower Hutt			1,603	19,240		1/09/2017	1/09/2023	Operating
			2,145	**25,740**				
Motor Vehicle Leases								
Motor Vehicle Lease plus Management Fees (115 Vehicles)			33,754	405,051		Ongoing	Ongoing	Operating
			33,754	**405,051**				
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		7,303	87,641	438,205	28/06/2017	28/06/2022	Operating
1 x Ultrasound (Equigroup)	Philips NZ Commercial Ltd		1,758	21,099	105,495	28/08/2017	28/07/2022	Operating
CT Scanner (Equigroup)	Toshiba Medical Systems		25,187	302,244	1,511,220	28/05/2017	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
		293,188	**96,394**	**1,156,764**	**5,916,636**			
Total Leases			**182,978**	**2,195,769**				

Treasury as at 30 September 2020

1) Short term funds / investment ($000)

NZHP banking activities for the month	Current month ($000)	Last month ($000)
Average balance for the month	$9,180	$8,420
Lowest balance for the month	($12,740)	($14,346)
Average interest rate	(0.42%)	(0.55%)
Net interest earned/(charged) for the month	($3)	($4)

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	5	
Total value of transactions	$25,610	NZD
Largest transaction	$17,283	NZD

	No. of transactions	Equivalent NZD
AUD	4	$8,327
GBP		
SGD		
USD	1	$17,283
Total	**5**	$25,610

4) Debtors ($000)

Top 10 Debtors	Outstanding	Current	1-30 Days	31-60 Days	61-90 Days	91-120 Days	121-180 Days	181+ Days
Ministry of Health	$4,641	$4,060	$103	$135	$101	$0	$0	$242
Capital & Coast District Health Board	$2,924	$292	$210	$42	$150	$24	$110	$2,095
Accident Compensation Corporation	$828	$516	$7	$12	$84	($64)	$64	$209
Wairarapa District Health Board	$716	$90	$40	$77	$38	$226	$0	$245
Health Workforce NZ Limited	$154	$154	$0	$0	$0	$0	$0	$0
Wellington Southern Community Laboratories	$78	$2	$2	$3	$2	$2	$65	$0
Auckland District Health Board	$77	$0	$3	$67	$0	$0	$5	$2
Non Resident	$55	$0	$0	$3	$0	$0	$0	$53
ESR Limited	$54	$51	$0	$2	$0	$0	$0	$0
Oranga Tamariki - Ministry for Children	$42	$0	$0	$0	$0	$0	$0	$42
Total Top 10 Debtors	**$9,568**	**$5,167**	**$365**	**$341**	**$376**	**$189**	**$244**	**$2,887**

Board Information

December 2020

Capital & Coast DHB September 2020 Financial and Operational Performance Report	
Action Required **The Capital & Coast DHB Board note:** (a) The release of this report into the public domain. (b) The DHB had a ($4.3m) deficit for the month of September 2020, being $2.4m unfavourable to budget before excluding COVID-19 and Holidays Act [2003] (c) The DHB year to date had a deficit of ($12.3m), being ($4.1m) unfavourable to budget before COVID-19 and Holidays Act [2003] (d) In the two months we have incurred $7.8m additional net expenditure for COVID-19 and $2.0m against provision for Holidays Act [2003] (e) This means that the DHB has an overall YTD deficit of ($2.4m) from normal operations (excluding COVID-19 and Holidays Act) being $5.7m 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 requirement for COVID response in the 20/21 fiscal year. Uncertainty remains around the extent to which the DHB COVID response costs will be funded in 20/21. The Ministry have asked DHBs' to separately report unfunded net COVID impacts for 20/21. These are 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.

For the three months to 30 September 2020 the overall DHB year to date result, including COVID and Holidays Act costs is $12.3m deficit.

Excluding the $7.8m COVID-19 net expenses and the Holidays Act [2003] provision the DHB result for the three month's to 30 September 2020 is $2.4m deficit, versus a budget deficit of $8.1m.

Additional net COVID related expenditure year to date is $7.8m.

The monthly provision for increasing Holidays Act liability is $756k and year to date the impact on the result is $2.04m

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

Capital Expenditure was $13.2 million year to date. While below plan, the capital spend rate is increasing.

We had a negative cash Balance at month-end of $19.2 million offset by positive "Special Funds" of $12.8 million (net $6.4 million overdraft). It should be noted that there is a significant amount of the COVID response that has not been funded by the crown at this time and this has a negative cash impact on the DHB.

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

The Emergency Department has experienced a 7.0% decrease (380) in the number of presentations compared to September 2019, this equates to an approximate reduction of 12.2 presentations per day. Strikingly the number of presentations for patients aged under 16 show a reduction of 34.8% reduction year on year for September. At the same time ED wait time performance has declined due to the on-going processes in place related to COVID-19 screening, maintaining a COVID readiness and restrictions on the use of spaces previously used to support our bed capacity. This has all greatly exacerbated flow given the mismatch between inpatient activity and the existing bed base.

Utilisation of available of adult beds in core wards in September 2020 is 94.4%, this is higher than recorded in September 2019 and must be viewed in the context of a reduced number of available bed spaces due to COVID readiness, need for distancing, and less beds temporarily opened at Kenepuru due to developing increased of day ward access. Overall a challenging month for patient flow. Medical activity work is down partially attributable to the frailty pilot underway.

Planned care surgical work increased for the month of September 2020 by 7.5% when compared to September 2019. There were 617 Elective theatre case discharges in September, 90 ahead of the planned 527, mainly driven by SMOs taking minimal leave during this period. Outsourced volumes were limited due to contractual constraints with one of our private providers, therefore only achieving 80 of the planned 169 procedures in September, 89 behind for the month.

A number of work streams taking an all of system approach continue to be rolled out within the Acute Demand and Bed Capacity Programme. Notable highlights are the expansion of the Advancing Wellness at Home Initiative (AWHI) project to a wider catchment and other inpatient wards, increasing the opening hours of the Children's Assessment Unit which has been relocated to the "Pink Zone" in ED, establishment of a Project group to review patients who have been in hospital more than 10 days, to identify barriers to patients being discharged and a working group established to identify space to create additional acute assessment beds.

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 26 FTE below our annual budget (however note lead DHB).

Financial	The YTD result for the DHB was ($2.4m) deficit from normal operations, against our DHB budget of ($8.2m). An additional ($7.8m) was spend on unfunded COVID-19 costs split between the provider and funder arm, and ($2.0m) 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

3.1.1 Capital & Coast DHB September 2020 Financial and Operational Performance Report

Capital & Coast District Health Board

Monthly Financial and Operational Performance Report

For the period ending 30 September 2020

Presented in October 2020

Capital & Coast District Health Board

Contents

Section 1

Financial and Performance Overview and Executive Summary

Executive Summary

- There is ongoing significant cost due to the COVID response into the 20/21 fiscal year. Uncertainty remains around how much of the DHB COVID response costs will be funded in 20/21. The Ministry have asked DHBs is to separately report unfunded net COVID impacts for 20/21, these being considered outside our responsible deficit and budgets. They have also advised that ongoing provisions for the liability due to Holidays Act remediation are to be reported separately to the base budget.
- Excluding the COVID-19 net expenses and Holidays Act [2003] provision the DHB's result for the three month's to 30 September 2020 is $2.4m deficit, versus a budget deficit of $8.1m.
- Additional net COVID related expenditure year to date is $7.8m.
- The monthly provision for increasing Holidays Act liability is $756k and year to date the impact on the result is $2.04m
- For the three months to 30 September 2020 the overall DHB year to date result, including COVID and Holidays Act costs is $12.3m 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 $13.2 million year to date, while below plan, the capital spend rate is increasing.
- We had a negative cash Balance at month-end of $19.2 million offset by positive "Special Funds" of $12.8 million (net $6.4 million overdraft). It should be noted that there is a significant amount of the COVID response that has not been funded by the crown at this time and this has a negative cash impact on the DHB.
- The DHB continues to have a target to pay commercial creditors within 10 days of the invoice being received in the payments office.

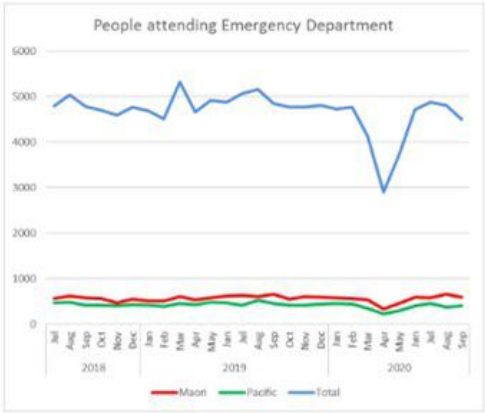
Executive Summary continued

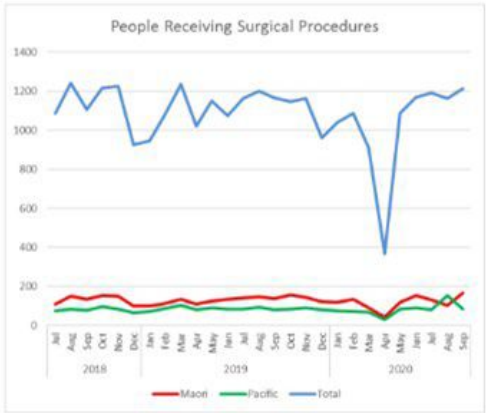
- The emergency department has experienced a 7.0% decrease (380) in the number of presentations compared to September 2019, this equates to an approximate reduction of 12.2 presentations per day. Strikingly the number of presentations for patients aged under 16 show a reduction of 34.8% reduction year on year for September. This requires further understanding from an DHB wide perspective. Planned care surgical work increased for the month of September 2020 by 7.5% when compared to September 2018; medical activity work is down partially attributable to the frailty pilot underway.
- Utilisation of available of adult beds in core wards in September 2020 is 94.4%, this is higher than recorded in September 2019 and must be viewed in the context of a reduced number of available bed spaces due to COVID readiness, need for distancing, and less beds temporarily opened at Kenepuru due to developing increased of day ward access. Overall a challenging month for patient flow. The Elective theatre cases in September were positive, achieving 617 discharges, 90 ahead of the planned 527, mainly driven by SMOs taking minimal leave during this period. Outsourcing volume was limited due to contractual constraints with one of our private providers, therefore only achieving 80 of the planned 169 procedures in September, 89 behind for the month.
- The continued decline in ED wait times is related to the on-going processes in place related to COVID-19 screening, maintaining a COVID readiness and restrictions on the use of spaces previously used to support our bed capacity. This has all greatly exacerbated flow given the mismatch between inpatient activity and the existing bed base.
- The number of work streams taking an all of system approach continue to be rolled out within the Acute Demand and Bed Capacity Programme. Notable highlights are the expansion of the Advancing Wellness at Home Initiative (AWHI) project to a wider catchment and other inpatient wards, increasing the opening hours of the Children's Assessment Unit which has been relocated to the "Pink Zone" in ED, establishment of a Project group to review patients who have been in hospital more than 10 days, to identify barriers to patients being discharged and a working group established to identify space to create additional acute assessment beds.
- Outside two extraordinary items (additional costs during COVID-19 and Holidays Act Provisions) not included within the budget the Hospital provider arm continues with its cautious start to the new financial year; targeted efficiency measures are in place however the pressure of clinical service demands and FTE management especially around annual leave is going to be a major challenge. Leave hours taken as a percentage of FTE was less than the same time last year but annual leave balances are increasing –leave management plans are in place with a proactive approach being taken by managers and leaders.

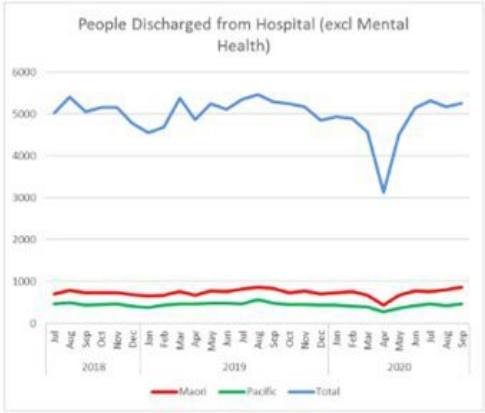
Performance Overview: Activity Context (People Served)

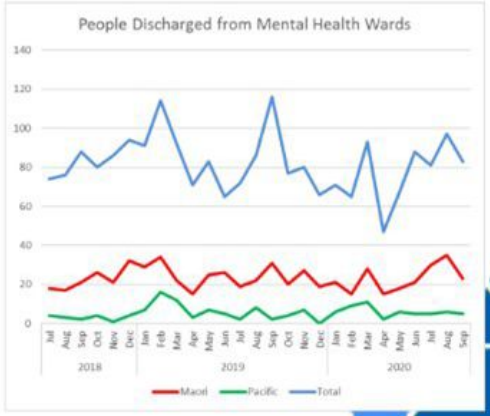
CCDHB funds services that touch thousands of people in our community every month. Unless otherwise indicated, the numbers below count individuals once and are based on CCDHB being the DHB of Service. Our services have returned to delivering services to our population without the restrictions due to COVID-19.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

People attending ED	**4,503**	594 Maori, 406 Pacific
People receiving Surgical Procedures (in main theatres)	**1,215**	166 Maori, 86 Pacific
People discharged from Kenepuru Community Hospital or Wellington Regional Hospital (excl Mental Health)	**5,254**	857 Maori, 463 Pacific
People discharged from Mental Health Wards	**83**	23 Maori, 5 Pacific



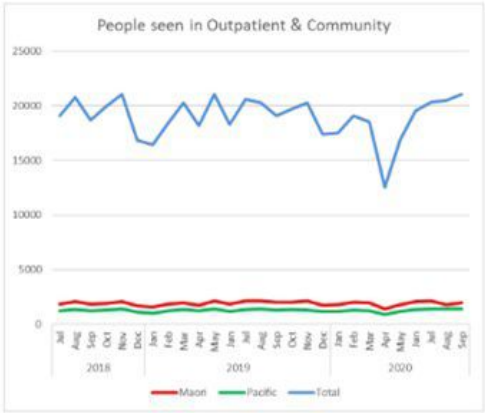


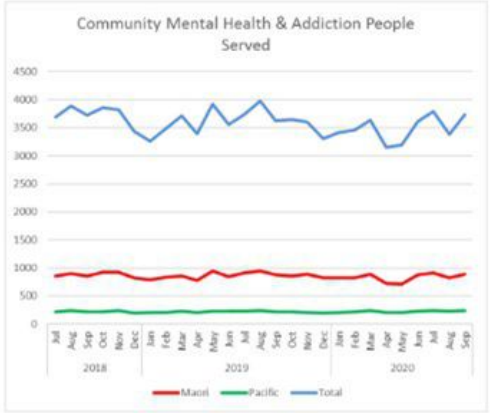


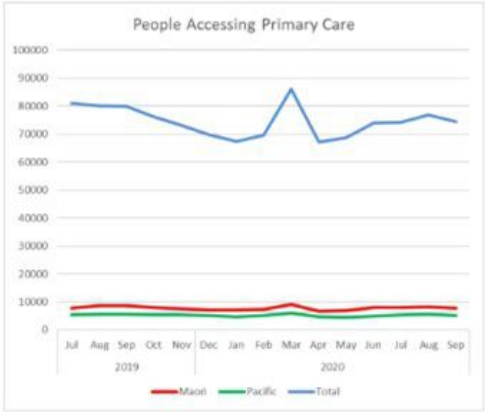


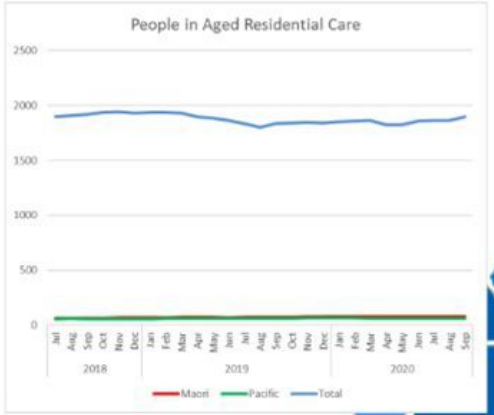
Performance Overview: Activity Context (People Served)

People seen in Outpatient & Community	**21,065**	1,940 Maori, 1,403 Pacific
Community Mental Health & Addiction People Served	**3,738**	887 Maori, 241 Pacific
People accessing primary care	**74,488**	7,889 Maori, 5,193 Pacific
People in Aged Residential Care	**1,898**	78 Maori, 63 Pacific









Financial Overview – September 2020

YTD Operating Position	YTD Provider Position	YTD Funder Position	YTD Capital Exp
$12.3m deficit Incl. $7.8m COVID-19 costs Incl. $2.0m Holidays Act	$6.2m deficit Incl. $5.3m COVID-19 costs Incl. $2.0m Holidays Act	$6.2m deficit Incl. $2.5m COVID-19 costs	$13.2m spend Incl. $2.8m strategic capex
Against a budgeted YTD deficit of $8.1m. Month result was ($2.4m) unfavourable. YTD $5.7m favourable BAU variance.	Against a budgeted deficit of $3.9m. Month result was ($952k) unfavourable result. YTD $5m favourable BAU variance.	Against a budgeted deficit of $4.2m. Month result was ($2m) unfavourable result. YTD $0.5m favourable BAU variance.	Against a KPI of a budgeted baseline spend of $16.5m. This includes funded projects – Children's Hospital

YTD Activity vs Plan (CWDs)	YTD Paid FTE	Annual Leave Taken
2.94% behind[1]	5,423[3]	($17.8m) annualised[4]
540 CWDs below PVS plan (164 IDF CWDs behind, of which 43 Hutt). Month result -280 CWDs excluding work in progress.	YTD 26 below annual budget of 5,449 FTE excluding outsourced roles/lead DHB. This is 555 FTE vacancies at end September inclusive of lead DHB transfers.	Underlying YTD annual leave taken is under by 7.8 days per FTE and Lieu leave taken for public holidays is short by 2.3 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 667 cwd outsourced (331 events) ~$3.7m 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 54 FTE worse than budgeted growth, Outsourced staff are also not counted in this metric which is currently $1.8m adverse to budget.

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

Hospital Performance Overview – September 2020

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

ED (SSIED) 6 Hour rule	ESPI 5 Long Waits	Specialist Outpatient Long Waits	Serious Safety Events[2]
65.6%	124	Data not yet available	7
29.4% below the ED target of 95% Monthly -2.9%	Against a target of zero long waits a monthly improved movement of -1	Against a target of zero long waits	An expectation is for nil SSEs at any point.

YTD Activity vs Plan (CWDs)	YTD Paid FTE	YTD Cost per WEIS
2.94% behind[1]	3,608[3]	$5,935*
540 CWDs below PVS plan (164 IDF CWDs behind, of which 43 Hutt). Month result -280 CWDs excluding work in progress.	YTD 56 below annual budget of 3,664 FTE. 263 FTE vacancies at month end.	Against a national case-weight price per WEIS of $5,216 (13.8% above). YTD Dec was $5,758 (In Jan pre-COVID-19). *to May 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 667 cwd outsourced (331 events) ~$3.7m 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 15 FTE worse than budgeted, Outsourced staff are also not counted in this metric which is currently $234k 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 negative variance of $210k, when adjusted for the current loss on COVID costs in our community. Revenue was $2,529k ahead of budget entirely due to COVID 19 revenue, but there is a risk in the loss of inter-district flow revenue.
- Achievement of volumes by the hospital provider arm, and under delivery of acute inter-district flows account for the most significant variations being a $1,686k variance which offsets the revenue and the cost to the funder.
- Funding for community services are $200k favourable with age residential care reflecting 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.
- CCDHB has additional COVID revenue of $3,172k and the costs are $4,959k. This is the subject of negotiations with MoH seeking a full cost recovery. The ongoing demand for managed isolation facilities, and community surveillance will continue throughout Alert Level 1.
- External provider costs are negative by $841k. This reflects variance in the costs of community pharmaceuticals. This is being closely monitored and reviewed as the costs of pharmaceuticals remain volatile in this post-COVID environment and risks to supply.
- 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 continue to support older people to live in their own homes, with a growing number requiring DHB funded support. This is positive for older people and improves health and social outcomes. There was no increase in reported stress during COVID for older people receiving services.
  - A significant increase in rheumatic fever is of significant concern. There is further work underway to identify how we can improve support in our Pacific communities particularly.
  - Removing cost barriers to long acting contraception and the Emergency Contraceptive Pill (ECP) has increased access and continues to increase to a long run reduction in termination rates. Increasing access for Maori and Pacific woman is a priority to reduce the termination rate.

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	Sep 2020	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year
72,885	72,885	68,138	0	4,747	Base Funding	218,655	218,655	204,414	0	14,241
5,995	4,665	5,019	1,330	977	Other MOH Revenue - Funder	14,161	13,995	15,474	167	(1,312)
0	0	0	0	0	COVID Revenue from MOH	3,172	0	0	3,172	3,172
211	45	49	166	161	Other Revenue	639	136	277	503	362
2,953	2,936	2,743	17	210	IDF Inflows PHOs	9,180	8,808	8,200	373	981
18,395	18,517	16,837	(121)	1,558	IDF Inflows 19/20 Wash-up Prov	53,863	55,550	52,480	(1,686)	1,384
100,439	**99,048**	**92,786**	**1,392**	**7,653**	**Total Revenue**	**299,672**	**297,143**	**280,844**	**2,529**	**18,827**
					Internal Provider Payments					
824	824	817	0	(7)	DHB Governance & Administration	2,471	2,471	2,874	0	403
53,094	53,222	48,322	129	(4,771)	DHB Provider Arm Internal Costs - HHS	161,805	163,498	151,011	1,694	(10,794)
7,799	7,752	7,477	(48)	(322)	DHB Provider Arm Internal Costs - MH	23,302	23,255	22,469	(48)	(833)
2,355	1,983	6,173	(372)	3,818	DHB Provider Arm Internal costs - Corp	6,236	5,864	7,594	(372)	1,358
64,072	**63,781**	**62,789**	**(291)**	**(1,282)**	**Total Internal Provider**	**193,814**	**195,088**	**183,948**	**1,274**	**(9,866)**
					External Provider Payments:					
6,593	5,703	5,779	(891)	(815)	- Pharmaceuticals	18,159	17,108	17,225	(1,050)	(934)
6,715	6,645	6,368	(69)	(346)	- Capitation	20,174	19,936	19,078	(239)	(1,096)
7,460	7,354	6,943	(105)	(516)	- Aged Care and Health of Older Persons	21,527	22,063	21,144	536	(383)
2,827	2,862	2,284	35	(543)	- Mental Health	8,592	8,586	7,155	(6)	(1,438)
786	807	664	21	(122)	- Child, Youth, Families	2,361	2,421	1,978	60	(383)
551	619	496	68	(55)	- Demand driven Primary Services	1,830	2,194	1,887	364	58
2,473	2,356	2,387	(116)	(86)	- Other services	7,244	7,069	7,020	(175)	(224)
3,725	3,725	3,645	0	(80)	- IDF Outflows Patients to other DHBs	11,176	11,176	10,966	0	(210)
5,250	5,240	4,944	(10)	(306)	- IDF Outflows Other	16,050	15,720	14,824	(330)	(1,226)
36,380	**35,312**	**33,509**	**(1,067)**	**(2,870)**	**Total External Providers**	**107,114**	**106,274**	**101,277**	**(841)**	**(5,837)**
1,479	**0**	**0**	(1,479)	(1,479)	- COVID in Community PHO, Pharms, ARC	**4,959**	**0**	**0**	(4,959)	(4,959)
101,930	**99,093**	**96,298**	**(2,837)**	**(4,153)**	**Total Expenditure**	**305,887**	**301,362**	**285,226**	**(4,526)**	**(20,662)**
(1,491)	**(45)**	**(3,512)**	**(1,445)**	**2,021**	**Net Result**	**(6,216)**	**(4,219)**	**(4,382)**	**(1,997)**	**(1,834)**

Funder Financials – Variance Explanations

Revenue

- Revenue has a positive variance YTD Sep of $2.5m.
- COVID-19 community funding of $3.2m received from Ministry. This is for PHO GP Assessments and CBACS plus Aged Care and Maori COVID-19 response funding. There are cost offsets. The funding does not offset all the costs. The Ministry paid a further $1.4m to the DHB in October 2020. There is still a shortfall of $500k.
- PHO funding wash-ups and volume funding of $670k. There are outflow costs of ($239k) offsetting this revenue.

SIP Funder Revenue Variances	Month $000's	YTD $000's
COVID-19 community funding	1,120	3,172
PHOs wash-up & add funding	376	670
Other revenue (with equivalent costs)	17	373
CWD IDF 2020/21 washup funding	(121)	(1,686)
Year to Date Revenue Variances	**1,392**	**2,529**

Internal Provider Payments:

- An amount of $1.7m was not paid to the Provider Arm due to under achievement of the IDF targets at YTD Sep 2020.

External Provider Payments:

- Pharmaceutical expenses are $1,050k unfavourable. This is being closely monitored in this post-COVID environment with risks to supply and future costs.
- PHO Capitation expenses are $239k unfavourable. Additional costs due to volumes are offset by additional revenue. Effect is expected to be neutral at year end.
- Aged Residential Care and Health of Older People costs are $641k favourable. Volumes are being maintained.
- Demand driven and other services are favourable $249k. Lower costs due to the effect of COVID-19 lockdown on activity such as vaccination and other services.
- IDF Outflows additional costs ($330k) relates to washup in the HCSS contract managed by Hutt DHB.
- COVID-19 funds ($5m) mainly due to ongoing GP assessment and CBAC claims in support of the COVID-19 response as directed by the Ministry. The DHB has received some extra funding for CBACS until September 2020, however this does not fully cover the GP assessments as well. Some additional funds received in Oct 2020.

Inter District Flows (IDF)

DHB of Domicile	YTD September estimated inpatient inflow wash-up
Taranaki DHB	-$493,333
Hawke's Bay DHB	-$293,452
Hutt Valley DHB	-$238,681
Other under-delivered (9 DHBs)	-$490,040
Other over-delivered (4 DHBs)	$97,471
Waikato DHB	$140,959
Wairarapa DHB	$173,192
Whanganui DHB	$192,198
Total undelivered inpatient IDF CWD (negative is CCDHB not delivering services to other DHBs therefore unfavourable from both a patient treatment and P&L perspective)	-$911,687

DHB of Service	YTD August estimated inpatient outflow wash-up
Total unserviced inpatient IDF CWD (negative is our population being over-serviced by other DHBs therefore unfavourable from a P&L perspective but favourable from a patient treatment perspective)	$297,160

Changed Recognition:

- The DHB is back to standard recognition of IDFs from the start of the financial year rather than the COVID-19 approach taken last year.
- We have recognised non-delivery of IDF inflows with an unfavourable result of $1.3m.

IDF Inflow (revenue):

- Overall IDF inflows are unfavourable by ($1.3m) which is driven by lower acute IDF flows.
- The majority of the lower IDF inflows (actuals) are caused by acute inpatient lower volumes:
  - Acute: ($1.6m): Cardiology ($624k), followed by Neurosurgery and Gen Med. Offset by Cardiothoracic $938k (with significant outsource)
  - Elective: $729k; Vascular $598k offset by Ortho ($204k)

IDF Outflow (expense):

- Overall IDF outflows are overall unfavourable by ($330k) and this will be reviewed as the IDFs for complex patients are revisited next month.
- August YTD largely relates to higher numbers of CCDHB patients treated at other DHBs as indicated on the table to the left.
  - Acute: $252k, arranged $31k, elective $14k
  - Auckland represents $104k
- This information is analysed and collated to provide the breakdown by DHB of Service to enable the services to understand service delivery change.

Older people supported to live at home

What is this measure?

DHB targets:

- 90% of people over 75 years old supported to live at home
- 60% of people 65+ receiving DHB-funded support to live in their own home

As outlined in the Healthy Ageing Strategy, the focus areas for 2019-2022 include:

- Maintain and enhance older people's capacity through supportive environments, disease minimisation and prevention
- Prevention of unnecessary acute hospitalisations and emergency department attendances
- Improve support for informal carers

How are we performing?

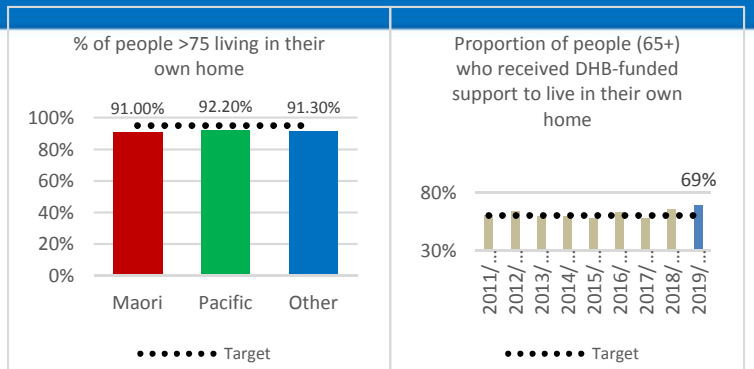
- For all ethnic groups in CCDHB, the proportion of people 75+ living at home is slightly below the target of 95%. Importantly, there is little difference between these groups. This means that only a small proportion of our older people live in long-term care facilities and the proportion of people who live at home with DHB support is increasing overall, and is above the target of 60%
- The COVID-19 lockdown period saw a significant reduction in people receiving care. Despite this, the proportion of informal carers who expressed feelings of stress remained relatively stable, suggesting older people's care needs are being managed by their informal carers. Importantly, ED presentations for older people reduced for this group during lockdown. Since returning to level 1, ED presentations have remained at a level similar to before the outbreak.

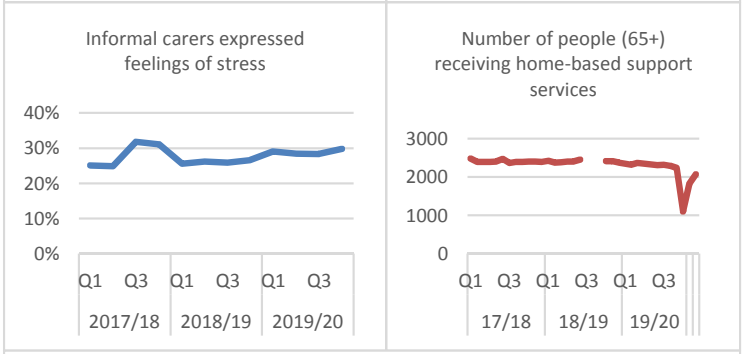
What is driving performance?

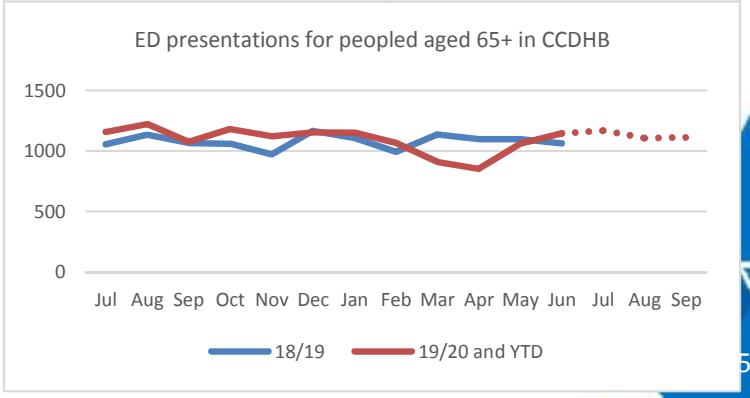
- The COVID-19 lockdown period impacted on the delivery of services, but does not seem to have not dramatically increased acute hospital presentations for older people.

Management comment

- We are making good progress in our system development/ Ongoing implementation of our frailty approach across our health system is a significant priority.







Rheumatic fever update

What is this measure?

The Rheumatic Fever Prevention Programme (RFP) has three main strategies to reduce rates in NZ:

- Increase awareness of rheumatic fever, what causes it, and how to prevent it
- Reduce household crowding and therefore reduce household transmission of strep throat bacteria within households
- Improve access to timely and effective treatment for strep throat infections

Why is this important?

- Rheumatic fever is a serious autoimmune condition where the risk increases significantly for people living in crowded housing conditions and areas of socioeconomic deprivation; and for people who have repeated untreated strep throat infections.

How are we performing?

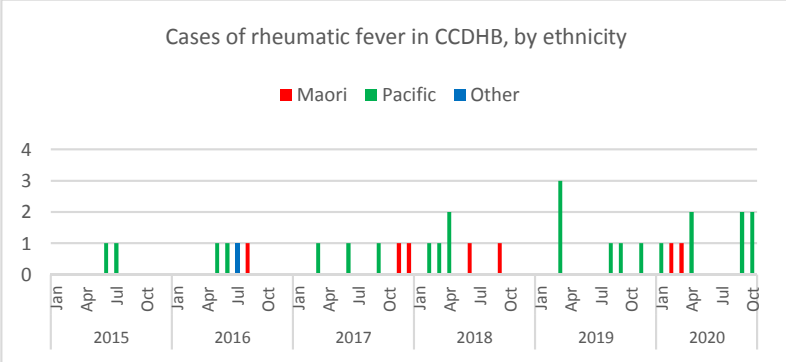
- In 2020 to date, there have been 9 new cases of rheumatic fever in CCDHB, with the majority being in Pacific children. Nationally, rates have increased by 25% compared to last year.
- Incidence of rheumatic fever is pervasive for Pacific children, with only one non-Māori, non-Pacific case since 2015. The cases are largely concentrated to highly deprived areas.

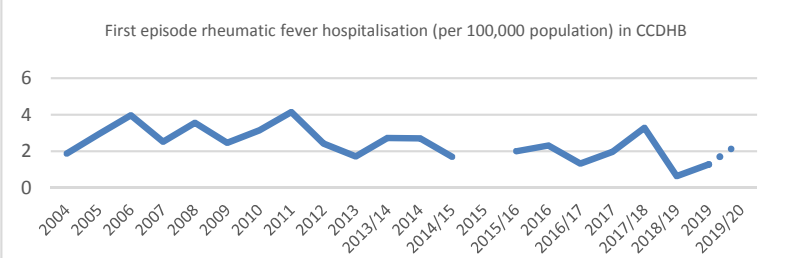
What is driving performance?

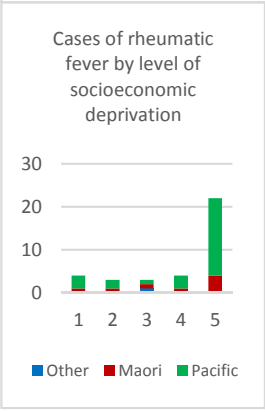
- The impact of COVID-19 lockdowns cannot be underestimated. General practitioners have expressed concern that reduced access to primary care during the COVD-19 lockdown period could have made it difficult for people to get assessed and treated. Research through public health has identified that care was accessed for sore throats. Crowding due to lockdowns may also have contributed.

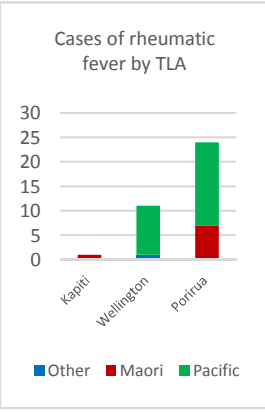
Management comment

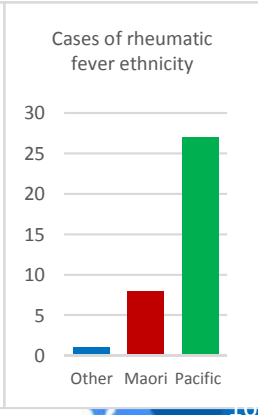
- This is a serious issue for our DHBs. An integrated Pacific focused plan is being developed to address this significant health problem.











Data for CCDHB, since 2015

Sexual and reproductive health update

What is this measure?

- Increased access to contraception and contraception information; reduced rates of unintended pregnancy; and reduced rates of abortion are important indicators of improved sexual and reproductive health.

Why is this important?

- Both New Zealand and international evidence has highlighted that cost is a major factor in contraceptive access. Timely and safe access to effective contraception gives autonomy and choice around the timing of pregnancies.

How are we performing?

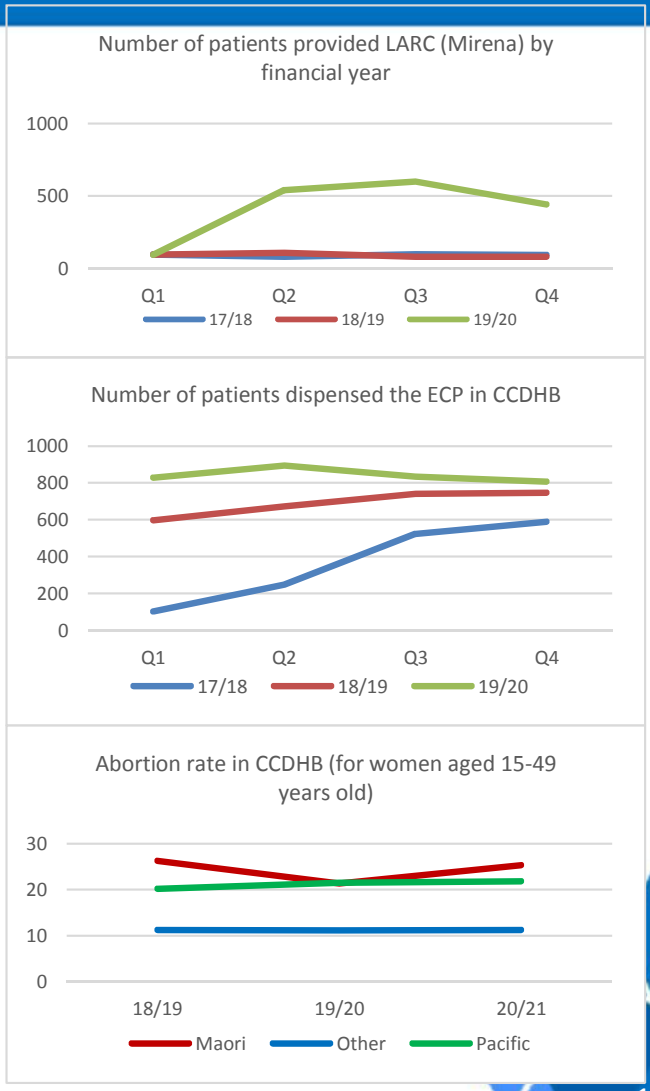
- Long acting contraception is important. Since the introduction of the IUD subsidy (and widened community access), Mirena insertions provided to CCDHB women has increased significantly. The average number of patients who had a Mirena inserted in 2019/20 was approximately 4.5 times higher than in the previous two financial years (or an increase of 358%).
- The total abortion rate in New Zealand is the lowest since 1990, and is decreasing in teenagers. However, the rate of abortion in CCDHB is much higher for Māori and Pacific women, and this has not changed significantly. Data from StatsNZ indicates that this pattern exists nationally.

What is driving performance?

- Māori and Pacific women experience additional barriers in accessing timely and effective contraception, and reproductive healthcare. CCDHB has targeted access to Maori and Pacific women with significant increases in access compared t previous years. This has included reductions in cost barriers.
- This builds on the ability to access the ECP at a subsidised cost without a prescription from pharmacies. Previously, funded ECP was only available through GPs and Family Planning clinics. Again, the removal of cost and other access barriers is evident.

Management comment

- Further improving access for Maori and Pacific woman in a priority moving forward to achieve the next level of improvement.



Section 2.2

Hospital Performance

Executive Summary – Hospital Performance

- The emergency department has experienced a 7.0% decrease (380) in the number of presentations compared to September 2019, this equates to an approximate reduction of 12.2 presentations per day. Strikingly the number of presentations for patients aged under 16 show a reduction of 34.8% reduction year on year for September. This requires further understanding from an DHB wide perspective. Planned care surgical work increased for the month of September 2020 by 7.5% when compared to September 2018; acute medical charges are down in part attributable to the frailty pilot underway.

- Utilisation of available of adult beds in core wards in September 2020 is 94.4%, this is higher than recorded in September 2019 though it must be viewed in the context of a reduced number of available bed spaces due to COVID readiness, need for distancing, and less beds temporarily opened at Kenepuru due to developing increased of day ward access. Overall a challenging month for patient flow. The Elective theatre cases in September were positive, achieving 617 discharges, 90 ahead of the planned 527, mainly driven by SMOs taking minimal leave during this period. Outsourcing volume was limited due to contractual constraints with one of our private providers, therefore only achieving 80 of the planned 169 procedures in September, 89 behind for the month.

- The continued decline in ED wait times is related to the on-going processes in place related to COVID-19 screening, maintaining a COVID readiness and restrictions on the use of spaces previously used to support our bed capacity. This has all greatly exacerbated flow given the mismatch between inpatient activity and the existing bed base.

- A number of work streams taking an all of system approach continue to be rolled out within the Acute Demand and Bed Capacity Programme. Notable highlights are the expansion of the Advancing Wellness at Home Initiative (AWHI) project to a wider catchment and other inpatient wards, increasing the opening hours of the Children's Assessment Unit which has been relocated to the "Pink Zone" in ED, establishment of a Project group to review patients who have been in hospital more than 10 days, to identify barriers to patients being discharged and a working group established to identify space to create additional acute assessment beds.

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

CCDHB Activity Performance

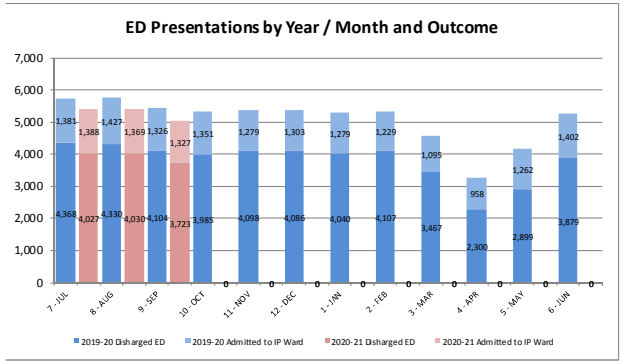
Capital and Coast DHB: September 2020

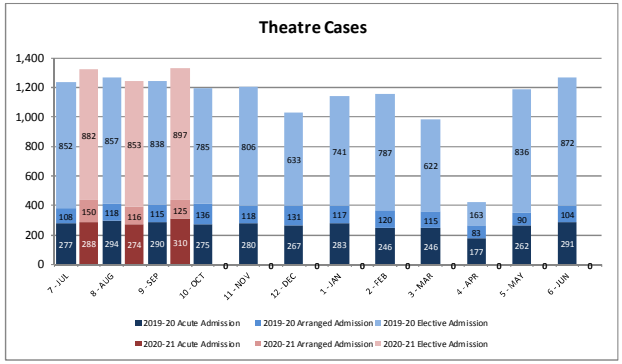
ED Presentations

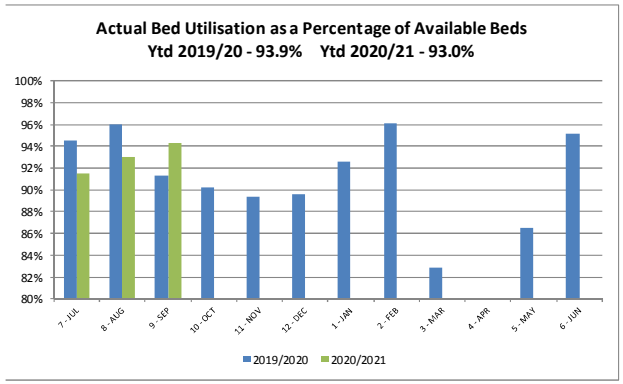
	2019/20	2020/21
YTD Totals	16,936	15,864
Change		-1,072
% Change		-6%

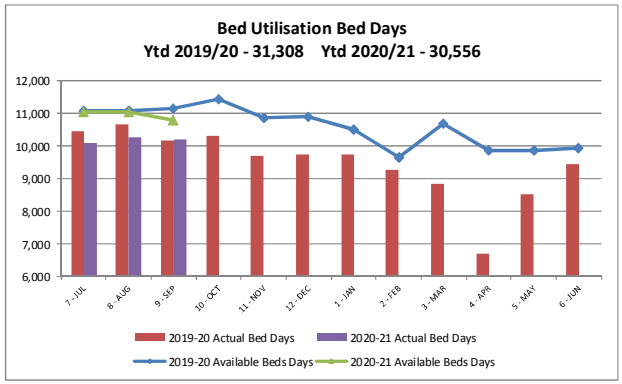
Theatre Cases

	2019/20	2020/21
YTD Totals	3,749	3,895
Change		146
% Change		4%









- The number of ED presentations in September 2020 is lower than the number recorded in the same month in the previous financial year. The emergency department September 2020 has experienced a 7.0% decrease (380) in the number of presentations compared to September 2019, this equates to an approximate reduction of 12.2 presentations per day.
- Significantly the number of presentations for patients aged under 16 in September 2020 was 570 compared to a total of 874 in September 2019, a reduction of 304 (34.8% reduction). When you compare Under 16 presentation year to date (July to Sept) the number has decreased by 948 (33%).
- The utilisation of available of adult beds in core wards in September 2020 is 94.4% which is higher than the 94.3% rate recorded in September 2019. The number of available beds in September 2020 is lower than in September 2019 with bed spaces now transferred to ED from MAPU, COVID readiness, need for distancing, and less beds temporarily opened at Kenepuru in September 2020.
- The Elective theatre cases have increased for the month of September 2020 by 7.5% (65 cases) when compared to September 2018 (which had 1 less week day). The increases are spread across a number of specialties in particular Ophthalmology (31), Cardiothoracic (20) Gynaecology (20) but countered by a decrease in Urology (-31).
- A recovery plan is in development which will need continued support from the private sector however DHBs consider at least a year will be required to address the backlog.

CCDHB Activity Performance

Capital and Coast DHB: September 2020

HSS Inpatient Caseweight Activity

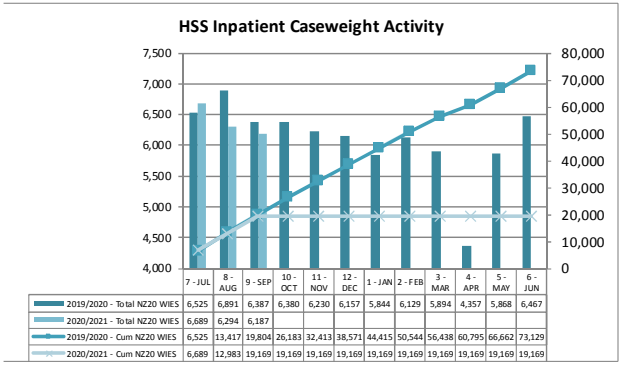
	2019/20	2020/21
YTD Totals	19,804	19,169
Change		-635
% Change		-3.2%

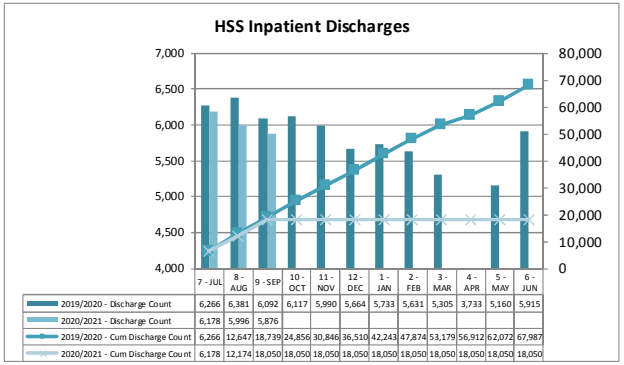
** This includes all Hospital Acitivty including ACC, Non Resident, Non-Casemix but excludes Mental Health*

HSS Inpatient Discharges

	2019/20	2020/21
YTD Totals	18,739	18,050
Change		-689
% Change		-3.7%

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



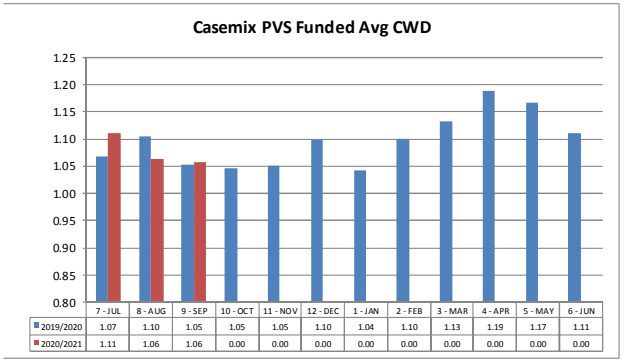


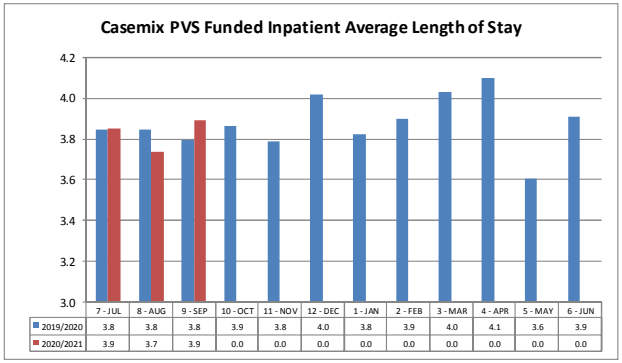
Casemix PVS Funded Avg CWD

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

Casemix PVS Funded Inpatient Average Length of Stay

	2019/20	2020/21
YTD Totals	3.87	3.83
Change		-0.04
% Change		-1.1%





Comparisons with same period last year:

- Local acute CWDs are lower than previous financial year (-619 CWDs) with a decrease in discharges; a lower ALOS and a similar average CWD. Both the discharge decrease and CWD decrease is driven primarily by General Medicine, Paediatric Medicine, Respiratory Medicine Oncology and Neonatal.
- Local Elective CWDs are higher than the previous financial year (27 CWDs) with a small increase in discharges; a lower ALOS and similar average CWD. The discharge increase is driven primarily by General Surgery and Vascular Surgery. The CWD increase is driven primarily by Cardiothoracic and Cardiology.
- IDF acute CWDs are lower (-418 CWDs) than the previous financial year also with a decrease in discharges a higher ALOS and a similar average CWD. The discharge decrease is driven primarily by Cardiology and Respiratory Medicine. The CWD decrease is driven primarily by Cardiology, Neonatal, Cardiothoracic and General Surgery.
- IDF Elective CWDs are higher than the previous financial year (340 CWDs) with more discharges an increase in ALOS and a higher average CWD. The discharge increase is driven primarily by Vascular Surgery, Gynaecology and Neurosurgery. The CWD increase is driven primarily by Cardiothoracic, Vascular Surgery, Neurosurgery and Gynaecology.
- In combination these four admission groups equate to a decrease of 860 CWDs compared to the previous year. The services that most significantly impact this shift are Neonatal (168 CWDs 20% of the total, which will fall as un-coded events are coded) and the four of the specialties most likely to be impacted by the reduction in the number of presentations to the Emergency department; General Medicine (318 CWDs, 37% of the total variance which is also significantly impacted by the change in counting in the AHOP ward), Paediatric Medical (221 CWDs 26% of the total variance), Respiratory Medicine (122 CWDs, 14% of the total variance), Acute Cardiology (108 CWDs 13% of the total variance).

Discharges:

- Publicly funded casemix discharges for the month of September 2020 have decreased by 225 (-4.0%) in comparison to the number of discharges recorded in September 2019. The decrease in discharges will be linked partly to the reduction in the number of presentations to ED but at a specialty level were spread across a number of specialties the with the decreases most evident in Paediatric Medicine (86 Acute), General Medicine (74 Acute), Emergency Medicine (72 Acute) Respiratory Medicine (43 Acute) but were countered by increases in General Surgery (29 Acute, 20 Elective) and Ophthalmology (46 Elective).
- The decrease in the number of the casemix discharge for General Medicine can also be attributed to the work being carried out by the Geriatricians in the AHOP ward which commenced July 2020. These patient one transferred to the Geriatricians are funded based on bed days (HOP214) in previous year the same patients would have been treated under General Medicine and likely recorded as being casemix this equates to approx. 52 acute discharges in September 2020 and 167 discharges 2020-21 financial year to date.
- The number of outsourced discharges in private facilities decreased from 112 in September 2019 to 99 in September 2020 a decrease of 13 discharge (12% decrease).
- The September Ytd average CWD 2020/21 is lower (-0.01) than the previous year.
- The September Ytd inpatient average Length of Stay for 2020/21 (3.83) is lower (-0.04) than the previous year.

HHS Operational Performance Scorecard – period Sep 19 to Sep 20

Domain	Indicator	2020/21 Target	2019-Sep	2019-Oct	2019-Nov	2019-Dec	2020-Jan	2020-Feb	2020-Mar	2020-Apr	2020-May	2020-Jun	2020-Jul	2020-Aug	2020-Sep
Care	Serious Safety Events	Zero SSEs	5	6	8	8	5	10	8	8	10	6	14	7	7
	Total Reportable Events	TBD	1,095	1,153	1,058	1,004	880	1,108	1,207	722	904	1,081	1,165	1,261	1,348
Patient and Family Centred	Complaints Resolved within 35 calendar days	TBD	97.7%	93.4%	91.9%	87.5%	94.2%	87.7%	92.4%	100.0%	93.5%	91.8%	87.2%	94.0%	97.8%
	% Discharges with an Electronic Discharge summary	TBD													
Access	Emergency Presentations		5,430	5,336	5,377	5,389	5,319	5,336	4,562	3,258	4,161	5,281	5,415	5,399	5,050
	Emergency Presentations Per Day		181	172	179	174	172	184	147	109	134	176	175	174	168
	Emergency Length of Stay (ELOS) % within 6hrs	≥95%	74.4%	77.2%	75.5%	77.4%	80.0%	75.5%	78.7%	84.7%	82.8%	74.6%	72.6%	68.5%	65.6%
	ELOS % within 6hrs - non admitted	TBD	80.3%	83.7%	81.1%	83.2%	85.8%	81.2%	84.6%	90.7%	90.4%	82.6%	79.8%	76.8%	75.2%
	ELOS % within 6hrs - admitted	TBD	58.4%	60.0%	59.6%	61.1%	63.0%	58.6%	61.8%	70.5%	66.3%	54.6%	53.5%	46.8%	41.3%
	Total Elective Surgery Long Waits	Zero Long Waits	64	94	107	135	166	146	178	402	435	357	263	124	124
	Additions to Elective Surgery Wait List		1,400	1,312	1,399	1,120	1,129	1,411	1,271	554	1,097	1,499	1,515	1,356	1,391
	% Elective Surgery treated in time	TBD	92.7%	92.7%	92.1%	92.2%	85.8%	86.0%	89.0%	92.7%	76.3%	71.3%	72.9%	84.2%	90.3%
	No. surgeries rescheduled due to specialty bed availability	TBD	10	5	18	4	1	8	1	1	1	12	5	9	13
	Total Elective and Emergency Operations in Main Theatres	TBD	1,201	1,179	1,199	997	1,067	1,101	927	378	1,103	1,202	1,237	1,192	1,254
	Faster Cancer Treatment 31 Day - Decision to Treat to Treat	85%	93.0%	92.0%	85.0%	97.0%	89.0%	84.0%	88.0%	91.0%	92.0%	91.0%	92.0%	84.0%	85.0%
	Faster Cancer Treatment 62 Day - Referral to Treatment	90%	94.0%	97.0%	86.0%	97.0%	76.0%	89.0%	97.0%	92.0%	77.0%	85.0%	94.0%	82.0%	93.0%
	Specialist Outpatient Long Waits	Zero Long Waits	13	43	91	165	238	324	488	1,079	1,286	1,450	1,076	571	Tbc
	% Specialist Outpatients seen in time	Zero Long Waits	91.0%	92.8%	91.9%	94.4%	80.4%	83.9%	82.0%	87.1%	81.0%	74.3%	74.4%	85.1%	90.1%
	Outpatient Failure to Attend %	TBD	7.3%	7.1%	7.0%	7.6%	6.9%	7.4%	7.7%	4.4%	7.1%	6.6%	7.1%	6.7%	6.9%
	Maori Outpatient Failure to Attend %	TBD	14.7%	15.7%	14.5%	16.2%	15.0%	15.1%	16.1%	8.8%	14.5%	13.9%	15.6%	15.0%	15.8%
	Pacific Outpatient Failure to Attend %	TBD	17.3%	17.0%	14.8%	16.3%	16.4%	15.7%	16.1%	8.1%	17.4%	17.0%	17.4%	14.4%	14.3%
Financial Efficiency	Forecast full year surplus (deficit) ($million)		($20.9m)	($20.9m)	($26m)	($29.5m)	($29.5m)	($29.5m)	($29.5m)	($47.5m)	($47.5m)	($44.2m)	($39.8m)	($39.8m)	($62m)
	Contracted FTE (Internal labour)		4,851	4,864	4,855	4,834	4,835	4,837	4,847	4,893	4,930	4,973	4,977	5,037	5,240
	Paid FTE (Internal labour)		5,187	5,163	5,209	5,264	5,192	5,195	5,197	5,188	5,198	5,309	5,316	5,367	5,602
	% Main Theatre utilisation (Elective Sessions only)	85.0%	79.2%	78.1%	79.0%	83.0%	82.0%	81.0%	80.0%	78.1%	82.0%	81.0%	83.0%	82.0%	82.0%
Discharge and Occupancy	% Patients Discharged Before 11AM	TBD	25.8%	25.6%	22.4%	24.0%	23.9%	24.3%	22.7%	19.3%	20.4%	21.9%	24.4%	23.1%	25.4%
	Adult Long Stay Patients Not Yet Discharged (>14 days) WLG	TBD	22	27	32	29	26	39	29	19	24	29	30	35	51
	Adult Overnight Beds - Average Occupied WLG	TBD	314	308	305	289	294	295	275	225	264	294	298	299	317
	Adult Long Stay Patients Not Yet Discharged (>14 days) KEN	TBD	27	19	27	23	23	18	10	17	16	17	19	19	19
	Adult Overnight Beds - Average Occupied KEN	TBD	83	76	71	66	72	69	62	46	55	63	71	72	74
	Child Overnight Beds - Average Occupied	TBD	29	24	24	21	19	21	18	15	18	23	24	23	22
	NICU Beds - ave. beds occupied	36	36	37	36	33	32	28	34	38	30	29	28	31	38
ALOS	Overnight Patients - Average Length of Stay (days)	TBD	3.79	3.86	3.79	4.02	3.82	3.90	4.03	4.10	3.61	3.91	3.85	3.74	3.85
Care	Rate of Presentations to ED within 48 hours of discharge	TBD	3.7%	3.7%	4.2%	3.6%	3.7%	4.2%	3.7%	4.1%	3.3%	3.8%	3.7%	3.7%	4.3%
	Presentations to ED within 48 hours of discharge	TBD	200	196	226	193	196	225	168	133	139	203	199	201	215
Staff Experience	Staff Reportable Events	TBD	125	138	127	102	111	138	137	89	108	161	140	152	130
	% sick Leave v standard	TBD	3.5%	3.2%	3.0%	2.4%	2.1%	2.6%	3.5%	2.6%	2.5%	3.6%	4.0%	4.0%	3.6%
	Nursing vacancy	TBD	212.2	208.9	213.9	228.1	219.1	211.6	206.6	192.1	170.0	157.6	248.5	269.6	256.7
	% overtime v standard (in total)	TBD	1.7%	1.9%	1.7%	1.6%	1.6%	1.6%	1.9%	1.4%	1.4%	1.6%	1.7%	1.8%	2.0%

Hyperlink for more details on CCDHB performance. Highlighted where an identified target.

Shorter Stays in ED (SSIED)

What is this measure?

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

Why is this important?

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

How are we performing?

- CCDHB SSIED performance for September 2020 was 65.6%. This result is a decrease on the 68.5% recorded last month (August 2020) and the 74.6% recorded in September 2019. The performance of patients who were seen, treated and discharged by ED for September 2020 was 77%. The performance of patients who were seen and admitted to hospital for September 2020 was 46%.
- A factor that affects our SSiED performance is the occupancy/bed utilisation in our wards. The average occupancy for September 2020 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 September 2020 was 352.

What is driving performance?

- Our performance being less than target was due to the increase of elective and acute surgical work that was delayed during our COVID response. For September 2020, the average bed days utilised by acute admissions increased by 11 beds per day compared to August 2020. We also have in place ongoing processes related to COVID-19 screening and precautions. During the month of September 2020, there was one presentation where the patient was suspected of having COVID-19.
- We continue to operate parallel processes in our in-patient wards to manage COVID case definition vs. non-COVID patients. Up to of 30 bed spaces have been taken out of the system as we implement these dual processes and observance distancing guidelines.
- 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.

Performance	JUL	AUG	SEP
2019-20	78%	75%	75%
2020-21	73%	68%	66%

Breaches	JUL	AUG	SEP
2019-20	1149	1315	1254
2020-21	1358	1576	1615

ED Volumes	JUL	AUG	SEP
2019-20	5,285	5,284	4,940
2020-21	5,024	4,997	4,689

Management Comment

- The following work streams continue to be progressed and rolled out including:
  - To free up ED, we continue to use Ward 6 East as our "query COVID" ward for patients who have been swabbed as part of their admission process. Once the results come back negative the patients are transferred to the ward where they will be treated for their presenting concern.
  - The Acute Health of the Older Person (A-HOP) / Frailty Unit pilot in Ward 3 continues until November. The initial review presented in September indicates that the pilot is having the expected outcomes of shorter length of stay with early geriatric assessment and interventions.
  - 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.
  - Children's Health with Emergency Services continue to work on a project to increase the opening hours and resourcing of the Children's Assessment Unit. The assessment unit was relocated to the "Pink Zone" in ED as a result of COVID-19 response planning. It has been agreed that this initiative should continue in ED as it provides better response to children requiring emergency treatment.
  - 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.

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?

- The Ministry of Health are yet to confirm our planned care volumes for 20/21 financial year, however we can report our internal results.
- Our in-house results for September were positive, achieving 617 discharges, 90 ahead of the planned 527, mainly driven by SMOs taking minimal leave during this period. Outsourcing volume was limited due to contractual constraints with one of our private providers, therefore only achieving 80 of the planned 169 in September, 89 behind for the month.
- IDF outflow results are positive for September reporting 13 ahead of our planned 86.
- Minor procedures in-house are exceeding September month's plan, reporting 167 ahead of the planned 333 volume. This is driven by the concentrated efforts to provide additional outpatient clinics to ophthalmology patients.

What is driving performance?

The improvement in discharges supports our recovery post COVID-19 efforts.

Management Comment

We continue to work on scheduling surgery, both in Wellington and Kenepuru. Currently refurbishment of the advanced procedure room is being undertaken in Kenepuru theatres with completion due at the end of November. Where Careful planning to ensure surgery continues is managed with the use of Theatre 13 in Wellington during construction. Outsource contracts are still being negotiated and although there has been agreement on some procedures we are still unable to get the volume out we need to support meeting our outsourced planned care target for 20/21.

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?

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

Why is this important?

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

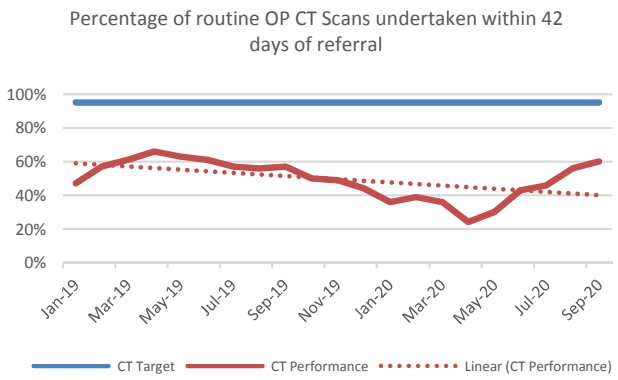
How are we performing?

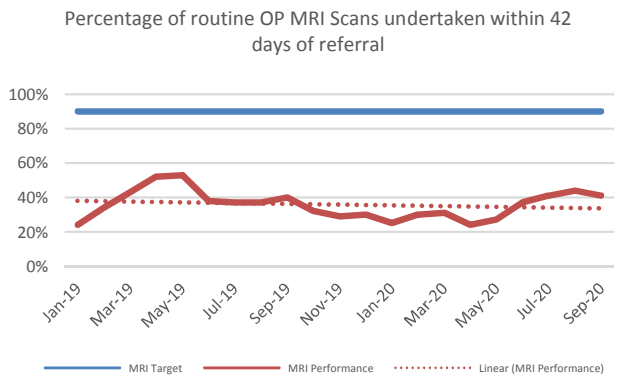
Waiting times for CT and MRI remain high as a result of historical insufficient capacity to meet demand and the pandemic response. Subsequently, the percentage measure is low.

However, due to increased outsourcing and additional ad hoc weekend lists, progress continues to be made as demonstrated in the graphs below.

What is driving performance?

Long term growth in demand for Radiology services has not been matched with Radiology capacity.





Management Comment

With current waiting times, there is still a critical risk of patient harm including disease progression. However, the significant improvement in CT in the last 4 months has reduced this. The service continues to prioritise based on clinical urgency and performs Inpatient and ED patients within expected timeframes to maximise inpatient flow.

Actions currently underway to address waiting times:

- Increased outsourcing in line with MoH request and additional unbudgeted revenue completed for June and July.
- Upcoming planned care funding packet for CCDHB from MoH due towards the end of the year. Investment in Radiology high on the priority list. If successful, will bring sustainable improvements in waiting times. Awaiting confirmation before action can be taken.
- Ad hoc elective lists booked on weekends staffed with volunteer MIT/SMO where sufficient staffing allows.
- Working with the region to increase RMO training positions (long term solution to mitigate national SMO shortages).
- Successful recruitment to 3 new SMO positions.

It is difficult to predict with certainty the production and demand in the next 3 – 6 months due to a variety of factors (e.g. recruitment and retention, COVID response, MoH waiting list initiatives) however, with a lot of clinical staff taking leave over October we hope to maintain waiting times through October/November rather than reduce significantly. There will be another push through November to reduce waiting times and then we expect another slow down through the Christmas period.

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 remains above target (96.1%).

What is driving performance?

- A combination of reduced demand since April due to the impacts of COVID, and a change to the SMO roster allowing additional sessions to be created improving capacity.

What is driving performance?

- The SMO roster change seems to be working well, and is being regularly monitored by the clinical leader, Service Manager, and Administration staff to iron out any issues. Two consultants going on parental leave over the next 6 months will add to the challenge however cover arrangements are being organised.

Acute Coronary Syndrome

Key clinical quality improvement indicators

What is this measure?

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

Why is this important?

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

How are we performing?

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

   National Performance 75.0%, Central Region-76.0% (357/470), CCDHB 86.2% (81/94), Hawkes Bay 54.7% (35/64), Hutt Valley 69.6% (32/46), Mid Central 75.5% (74/98)

   b. Maori Door to Cath. <= 3 days Quarter 1 results (Target is 70%)

   Central Region Total- 72.2% (39/54) , CCDHB 88.9% (8/9), Hawkes Bay 56.3% (9/16), Hutt Valley 50% (1/2), Mid Central 86.7% (13/15)

   c. Pacific Door to Cath. <= 3 days Quarter 1 results (Target is 70%):

   Central Region Total- 78.6% (11/14), CCDHB 100% (7/7), Hawkes Bay 66.7% (2/3), Hutt Valley 0% (0/1), Mid Central 100% (1/1)
2. The second measure relates to data quality, integrity - the target is that over 95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS-QI ACS and Cath/PCI registry data collection within 30 days.
   – CCDHB result for August was 100%. As a region the target was not achieve for August - 91.4%.

What is driving performance?

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

Management Comment

- Increased lab capacity resulting from the new SMO Roster and redistribution of interventional lab sessions, has allowed better lab utilisation. The underlying issue remains access to beds, increased by Cardiology reducing its IRW IP footprint from 8 IRW inpatient beds to 4 inpatient beds. This has resulted in less flexibility and impacts on the service ability to transfer regional patients in a timely manner when busy. Work is currently being done to utilise the transfer lounge in the future for pre and post procedure management, aiming to free up bed space in IRW and help mitigate this issue.

Faster Cancer Treatment

What is this measure?

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

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

Why is this important?

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

How are we performing?

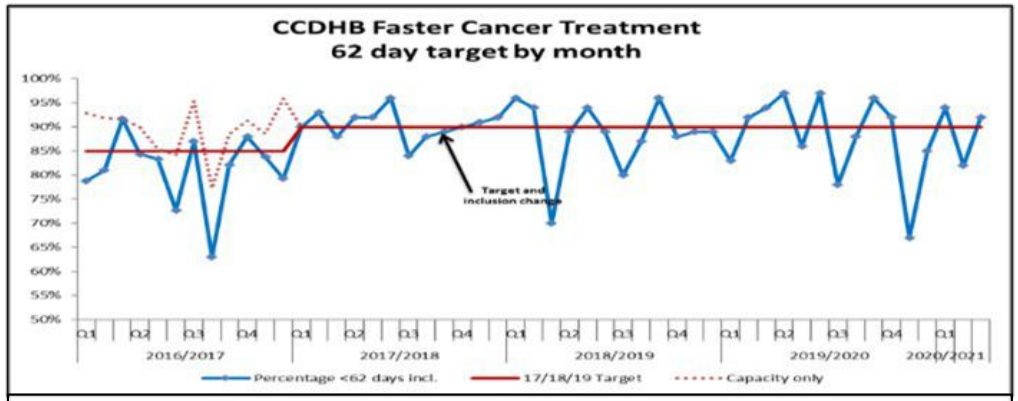
- CCDHB is compliant with the 62 day target for September 92% vs the aim of 90% of patients receiving their first cancer treatment within 62 days of being referred with a high suspicion of cancer.
- CCDHB is non-compliant with the 31 day indicator for September at 84% vs the aim of 85% of patients commencing treatment within 31 days from decision to treat. This is the first month since February 2020 where CCDHB has not been compliant, but note that a number of cases are pending histology confirmation and numbers may alter in the coming week, as they did last month.

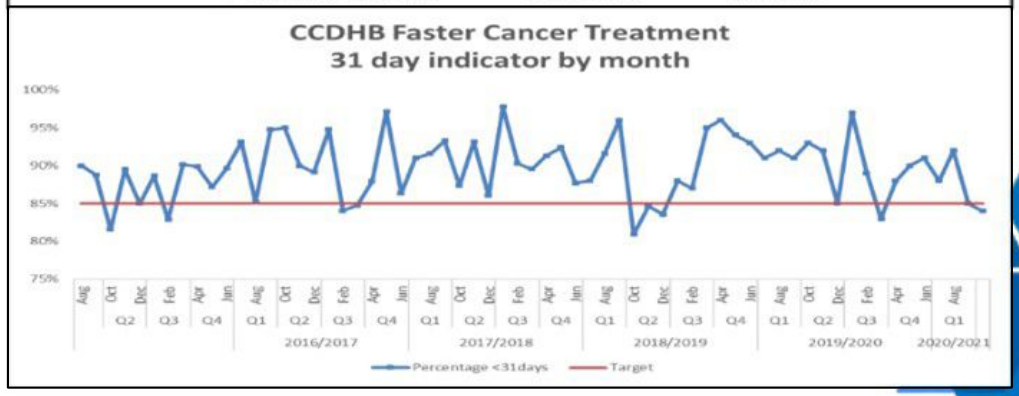
What is driving performance?

- Challenges for reaching the 62 day target, such as access to FSA and diagnostic procedures contributed to delays in the front end of the patient pathway.
- All 31 day breach patients (21) had surgery as first treatment. Capacity constraints related to urology, H&N, breast and skin tumour streams in order of frequency with surgery being the first treatment. Lack of ICU bed and substitution for an urgent case occurred one occasion.

Management Comment

- COVID 19 planning and beyond proved challenging for services that assess, treat and manage patients with cancer. As a consequence we have begun to see a recovery in the number of patients presenting which has challenged access to FSA appointments in some services and surgical scheduling. Imaging was less frequently stated, while histology delay was more frequently stated this month.





Colonoscopy

What is this measure?

Diagnostic colonoscopy

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

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

Surveillance colonoscopy

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

Why is this important?

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

How are we performing?

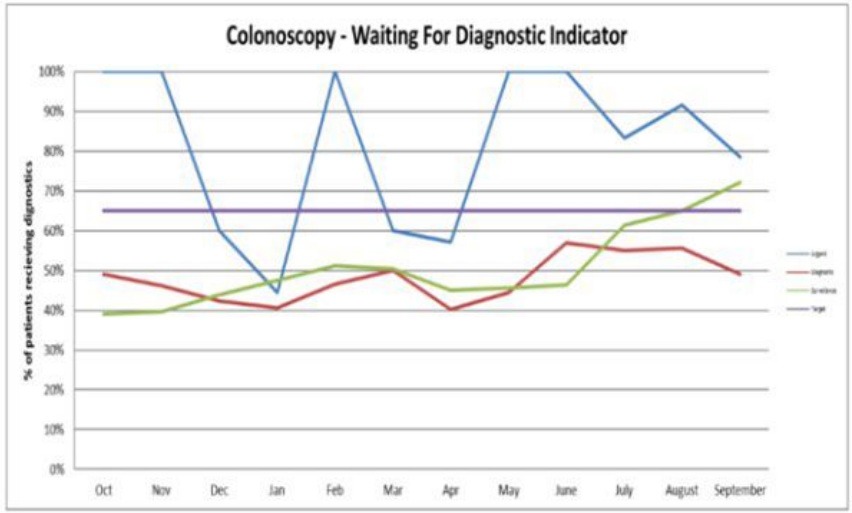
- CCDHB did not meet the Ministry of Health target for non-urgent and surveillance colonoscopies achieving 49% and 72% respectively against a targets of 70%. We did not meet the Ministry of Health target for Urgent achieving 79%.

What is driving performance?

- At the end of September there were 227 patients who had either a diagnostic or surveillance colonoscopy compared to 219 the previous month. At the end of September there was 308 patients waiting for either a diagnostic or surveillance colonoscopy compared to 496 the previous month

Management Comment

- We have completed outsourcing to reduce the waiting list which has shown to have an impact, work is on-going in-house to improve the number of patients per list.



Section 2.3

Mental Health Addiction & Intellectual Disability

Executive Summary – Mental Health Performance

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

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

Indicator	2020/21 Target	13 Months Performance Report												
		2019-Sep	2019-Oct	2019-Nov	2019-Dec	2020-Jan	2020-Feb	2020-Mar	2020-Apr	2020-May	2020-Jun	2020-Jul	2020-Aug	2020-Sep
Access Rate	3%	3.8%	3.8%			3.6%			3.8%					
Shorter waits for non-urgent Mental Health services <= 3 weeks (Younger Persons Community & Addictions Sector)	80%	44.8%	44.7%	42.6%	38.8%	51.8%	51.9%	33.5%	30.4%	44.0%	49.2%	50.4%		
Shorter waits for non-urgent Mental Health services <= 3 weeks (Adult Community & Addictions Sector)	80%	58.9%	59.1%	64.9%	55.6%	61.0%	63.9%	58.1%	47.6%	64.5%	57.7%	57.8%		
Shorter waits for non-urgent Mental Health services <= 8 weeks (Younger Persons Community & Addictions Sector)	95%	79.4%	90.0%	81.6%	90.9%	93.8%	77.3%	49.7%	75.5%	88.7%	86.1%	88.4%		
Shorter waits for non-urgent Mental Health services <= 8 weeks (Adult Community & Addictions Sector)	95%	86.7%	89.0%	87.1%	87.6%	90.3%	87.4%	72.9%	78.1%	94.8%	93.1%	94.5%		
Community service users seen in person in last 90 days	95%	79.3%	77.5%	79.1%	76.6%	77.9%	76.4%	68.8%	54.8%	56.1%	62.9%	76.7%	82.9%	83.8%
Community DNA rate	<=5%	7.6%	8.0%	8.6%	7.4%	7.4%	7.8%	7.0%	4.0%	5.1%	6.6%	6.9%	6.6%	7.4%
Maori under Section 29 CTO (Rate per 100,000 population) 2019/20 Target: 10% reduction of rate of previous year (405)		409	396			404			395					
Wellness Plans	95%	42.2%	41.2%			43.1%			47.3%					
Wellness Plans - Acceptable Quality	95%	71.1%	68.8%			78.9%			79.1%					
Community Services Transition (Service Exit) Plans	95%	53.3%	48.7%			47.6%			53.4%					
Community Services Transition (Service Exit) Plans - Acceptable Quality	95%	67.4%	66.1%			61.9%			71.6%					

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

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

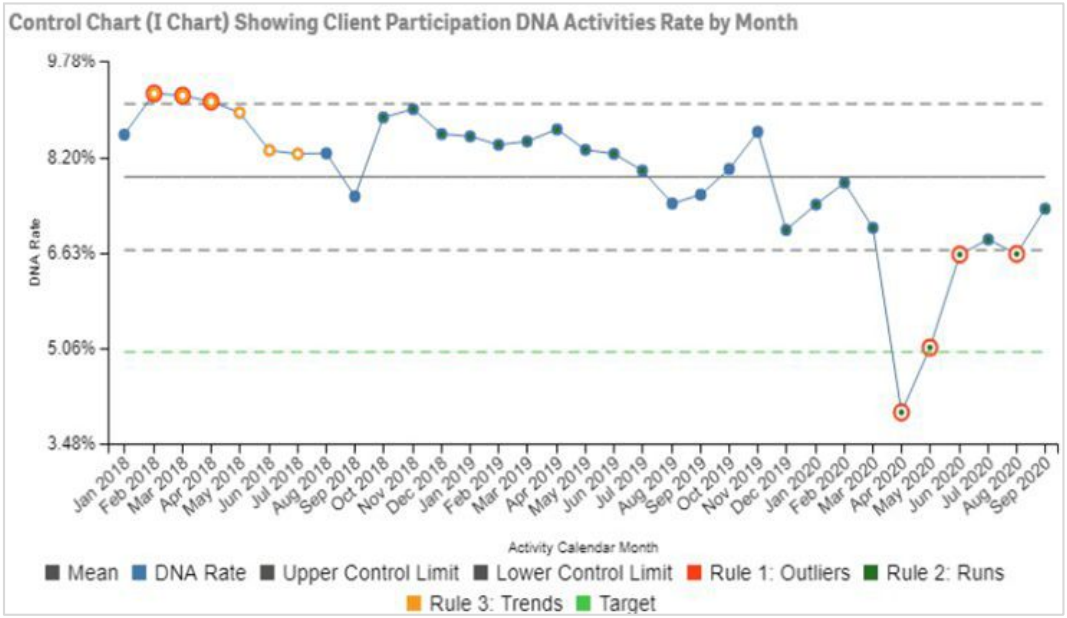
Indicator	2020/21 Target	2019-Sep	2019-Oct	2019-Nov	2019-Dec	2020-Jan	2020-Feb	2020-Mar	2020-Apr	2020-May	2020-Jun	2020-Jul	2020-Aug	2020-Sep
Pre-Admission Community Care	75%	61.8%	76.8%	64.4%	71.7%	60.7%	70.7%	74.0%	71.7%	68.5%	75.5%	84.5%	67.2%	74.5%
Post-Discharge Community Care	90%	66.4%	72.8%	76.5%	85.7%	73.1%	87.5%	77.5%	75.0%	87.0%	90.5%	84.0%	69.1%	74.6%
Acute Inpatient Readmission Rate (28 Day)	<=10%	3.7%	10.6%	3.3%	2.9%	7.6%	7.9%	3.1%	11.9%	8.5%	5.1%	5.0%	4.7%	6.4%
Inpatient Services Transition Plan	95%	65.5%	71.1%			70.5%			72.4%					
Inpatient Services Transition Plan - Acceptable Quality	95%	73.3%	87.5%			82.7%			74.4%					
Clinically Safe Acute Inpatient Occupancy Rate Te Whare Ahuru		101.7%	103.8%	90.6%	100.1%	100.9%	102.4%	98.1%	78.1%	77.8%	99.7%	94.6%	97.7%	98.8%
Clinically Safe Acute Inpatient Occupancy Rate Te Whare O Matairangi		0.0%		104.8%	110.9%	102.9%	105.1%	101.1%	100.0%	93.2%	106.2%	108.2%	109.3%	105.1%
Seclusion Hours	Aspirational goal of zero seclusion by 31 December 2020	711	679	668	404	458	622	995	733	632	965	590	878	272
Seclusion Hours - Māori		190	261	439	113	265	254	682	317	282	620	133	294	85
Seclusion Hours - Pacific Peoples		8	134	162	157	3	289	74	136	116	195	91	72	10
Seclusion Events		18	17	14	11	16	21	32	29	28	27	20	37	25
Seclusion Events - Māori		7	7	8	6	8	13	15	13	14	12	7	12	7
Seclusion Events - Pacific Peoples		1	4	2	2	1	4	4	3	4	9	3	3	1

Adverse Performance requiring immediate corrective Action

Performance is below target, corrective action may be required

Performance on or better than Target / Plan

KPI Spotlight – MHAIDS Did Not Attend Rate



What is this measure?

Did Not Attend (DNA) Rate is calculated as the total number of DNA activities recorded divided by the total number of face-to-face and DNA activities recorded.

Why is it important?

DNAs are important as when people do not attend it impacts negatively on treatment outcomes and efficient use of clinical time.

How are we performing?

There has been an overall reduction in the DNA rate since the first half of 2019. Recent results for April and May are not comparable as there were significantly less face-to-face appointments being offered during the COVID-19 lockdown period. The September result of 7.4% is the highest since February (mean since Jan-2018: 7.9%, target: 5%).

What is driving performance?

Reducing DNA rates has been a focus for both the Younger Persons sector (as part of a national KPI focus in addressing barriers to engagement) and the Adult Community & Addictions sector. Initiatives have included surveying people that do not attend scheduled appointments to address their reasons, offering more flexibility around appointment times and venues, automated reminder texts and emails.

MHAIDS have recently engaged with tāngata whaiora and their whānau to survey the effectiveness of telehealth during the COVID-19 pandemic. Further utilisation of audio-visual methods may improve service user engagement and continue to reduce the DNA rate across MHAIDS to a target 5%.

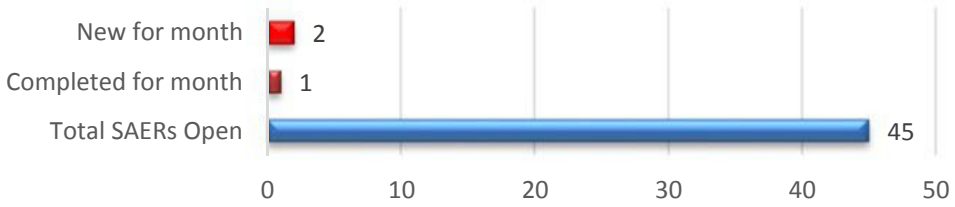
MHAIDS Quality & Safety Monthly Update

September 2020 Summary

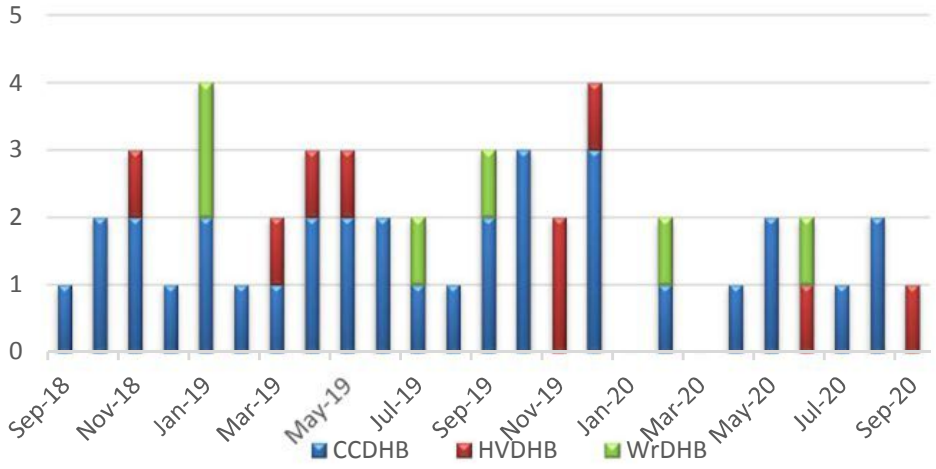
- MHAIDS High Performance, High Engagement project workshop is planned for October. The workshop is designed to help MHAIDS identify, discuss and agree on Critical Health and Safety Risks. The risks will then be analysed and used to plan H&S improvements
- MHAIDS Quality Team will work with CCDM Data Councils to develop quality improvement activities using the collected data to inform these.
- Mentoring Programme to train and support staff to review adverse events commences in October. This is in collaboration with QIPS.

EFFECTIVE SAFETY SYSTEMS TO RECOGNISE RISK AND REDUCE HARM

Open Serious Adverse Event Reviews August 2020

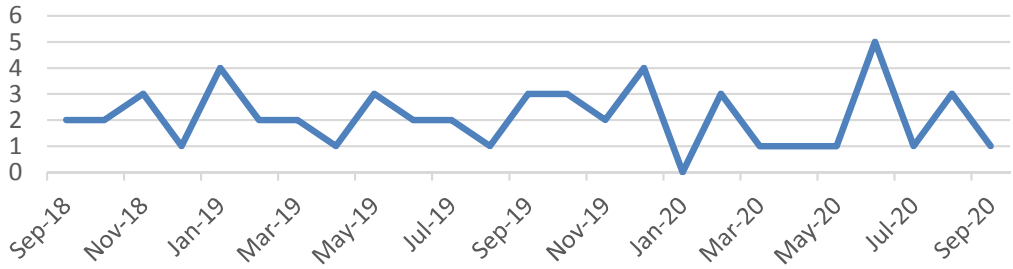


Serious Adverse Events - Suspected Suicides



Serious Adverse Events

New SAC 1 or 2 Events by Month



Key Points:

2 Events reported to HQSC:

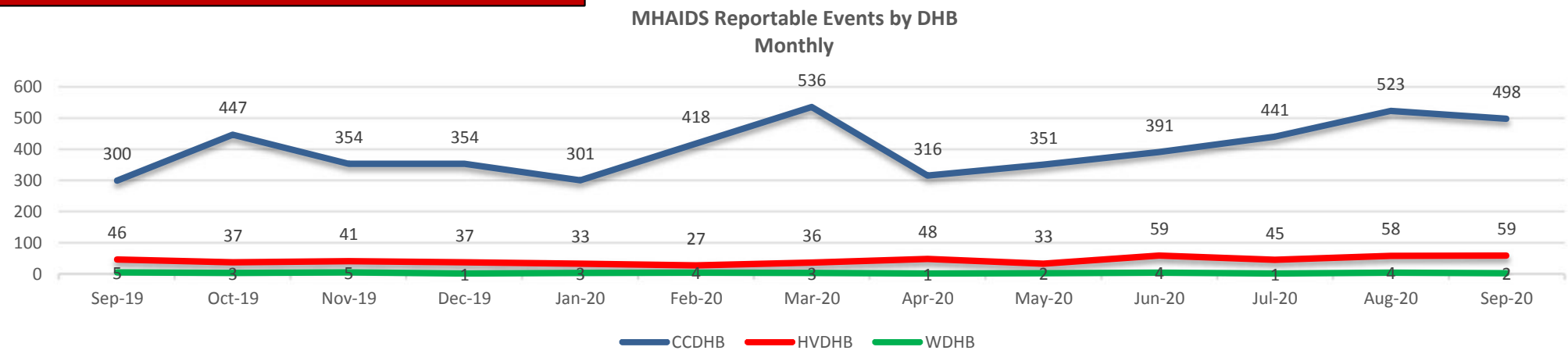
1 Suspected Suicide
1 Serious Self Harm

Note 90312 confirmed SAC 2 in October which is why graph for Sept only shows one new event.

New SER Cases – September 2020	
RE Number	SAC Rating
90312	SAC 2
90332	SAC 2
Closed SER Cases – September 2020	
71082	SAC 2

EFFECTIVE SAFETY SYSTEMS TO RECOGNISE RISK AND REDUCE HARM

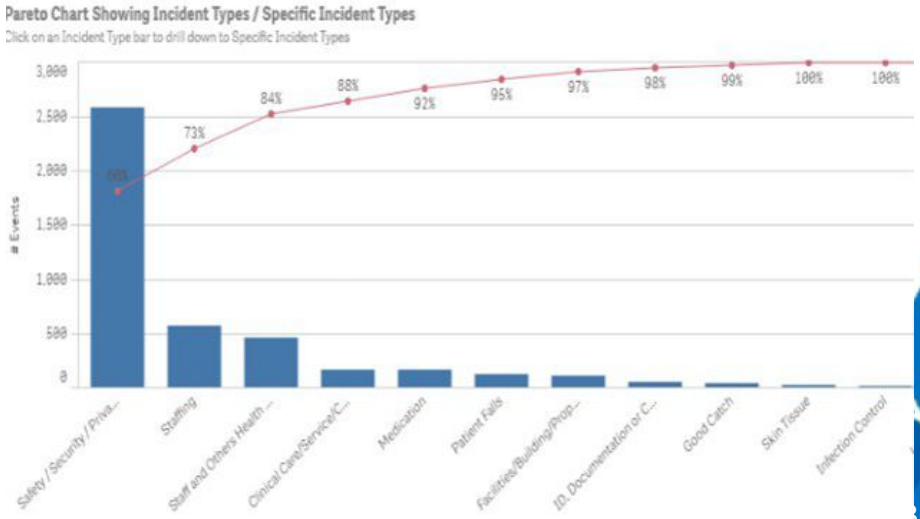
Reportable Events



Key Points:

Drop in overall number of reported events from previous month.

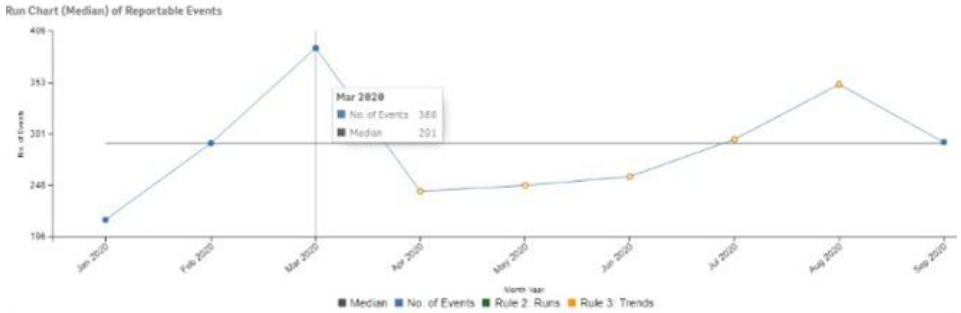
MHAIDS High Performance, High Engagement project workshop is planned for October.
The workshop is designed to help MHAIDS identify, discuss and agree on Critical Health and Safety Risks. The risks will then be analysed and used to plan H&S improvements



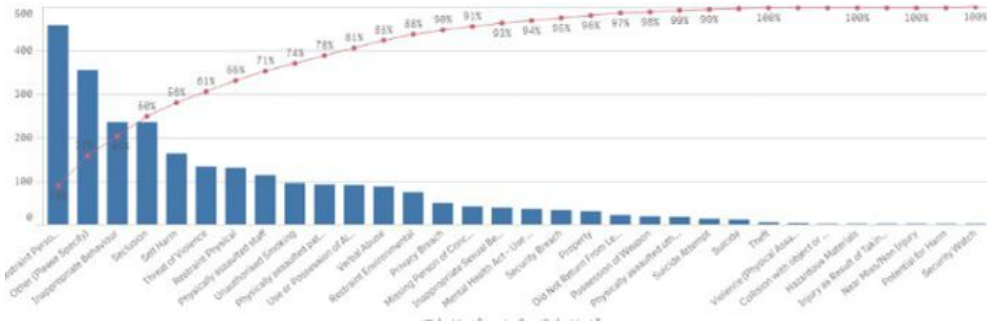
EFFECTIVE SAFETY SYSTEMS TO RECOGNISE RISK AND REDUCE HARM

Reportable Events Continued

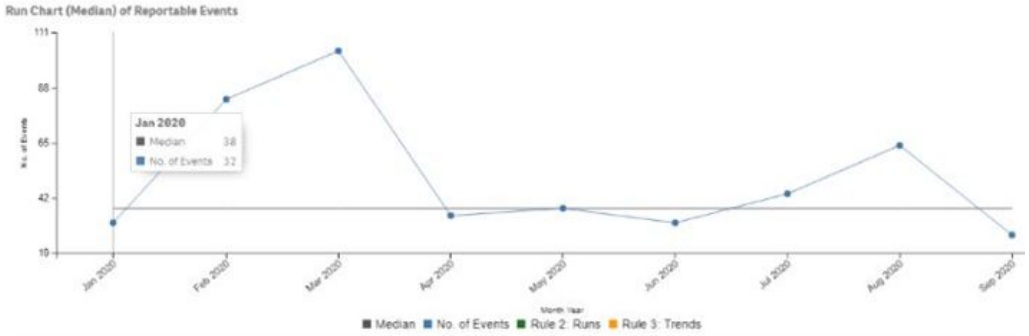
Reportable Events – Safety Security & Privacy 2020 Monthly Comparison



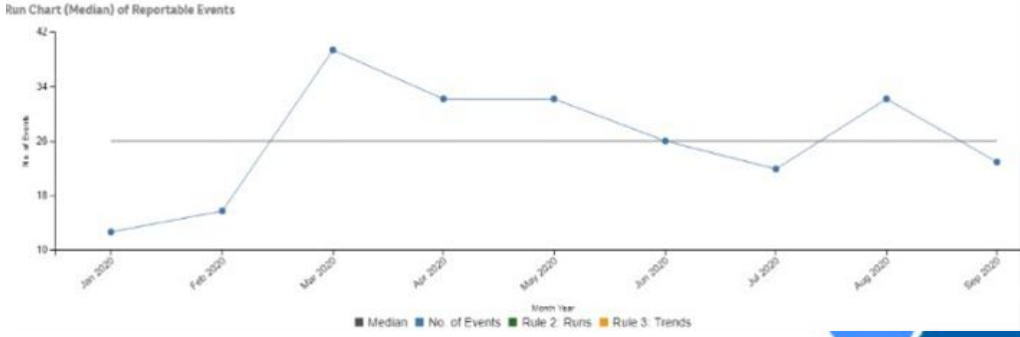
Reportable Events – Safety Security & Privacy by Type for September 2020



Personal Restraint Events 2020



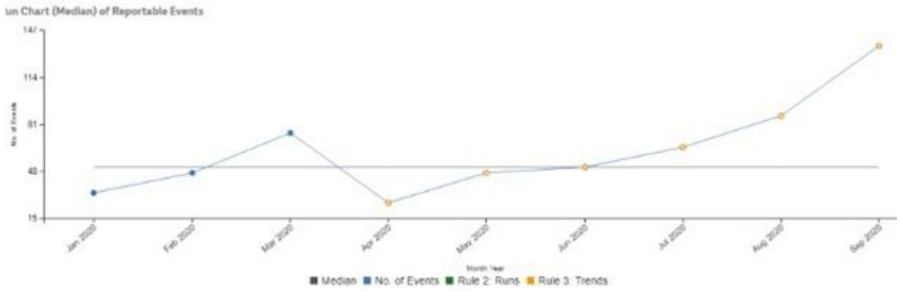
Seclusion Events 2020



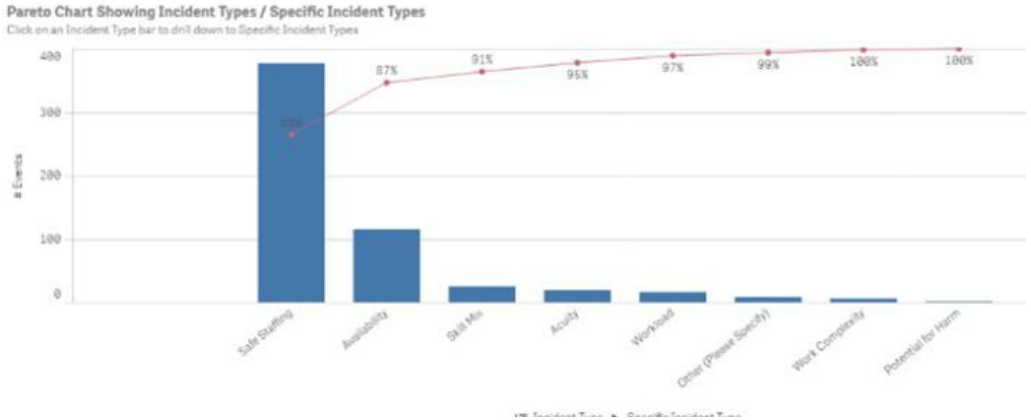
EFFECTIVE SAFETY SYSTEMS TO RECOGNISE RISK AND REDUCE HARM

Reportable Events Continued

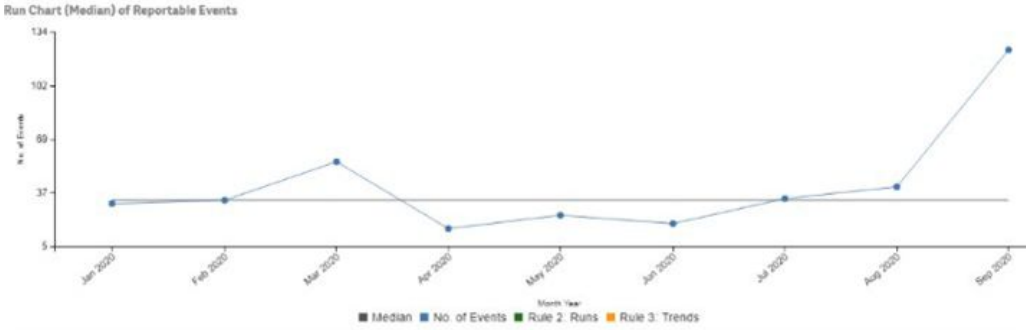
Reportable Events – Staffing 2020 Monthly Comparison



Reportable Events – Staffing by Type for September 2020



Events 2020



Key Points:

Increase in reported number of safe staffing events has continued with a jump from 41 in August to 123 in September.

Staff have an increased awareness of the importance of reporting these events.

CCDM group supported MHAIDS to set up local data councils who are very positive about seeing their data on the CCDM dashboard and the transparency this is creating to inform and guide future quality improvement activities.

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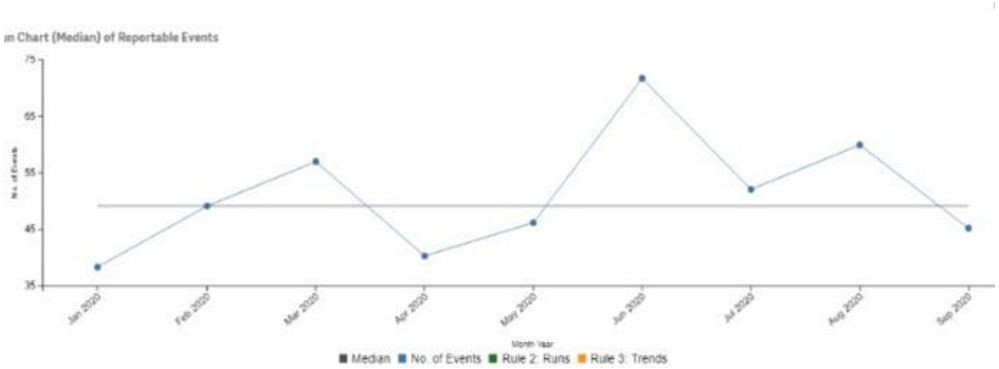
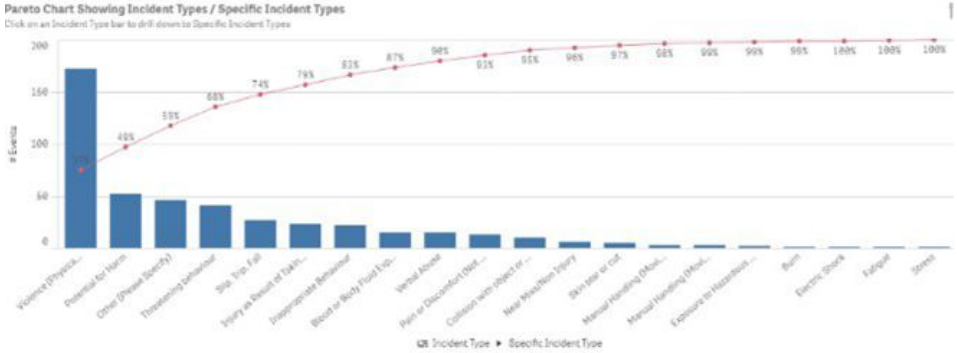
EFFECTIVE SAFETY SYSTEMS TO RECOGNISE RISK AND REDUCE HARM

Reportable Events Continued

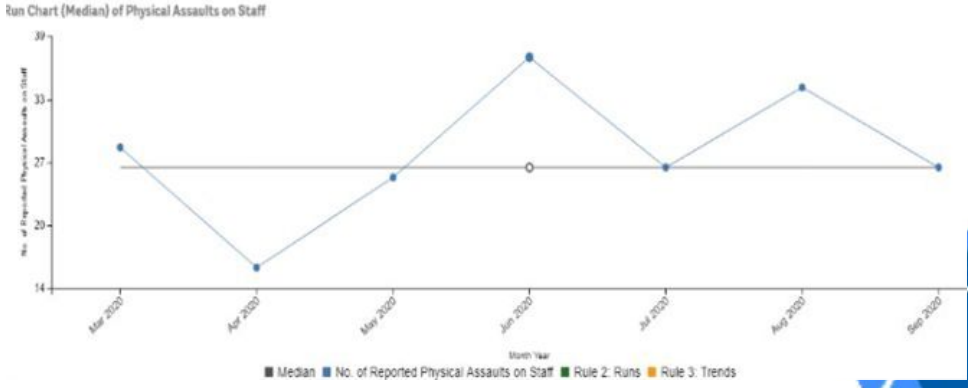
Reportable Events – Health and Safety 2020 Monthly Comparison



Reportable Events – Health and Safety by Type for September 2020



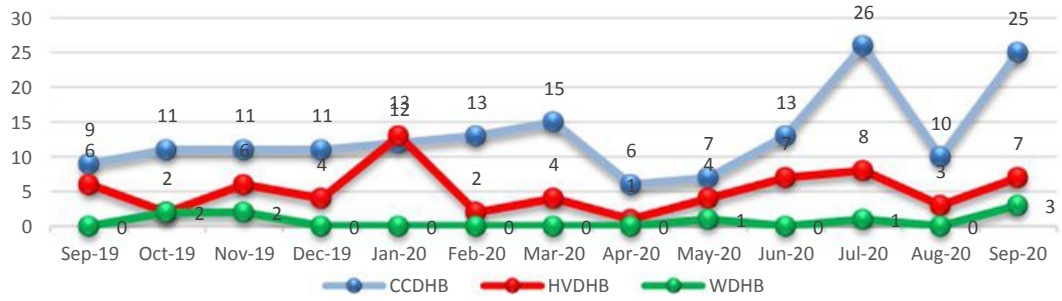
All Staff and Other Health and Safety Events: 45	
BBFE Events: 2	Slips, Trips and Falls: 3
All Manual Handling Events: 0	Manual Handling Patient: 0
Manual Handling Object: 0	Physical Assaults on Staff: 26



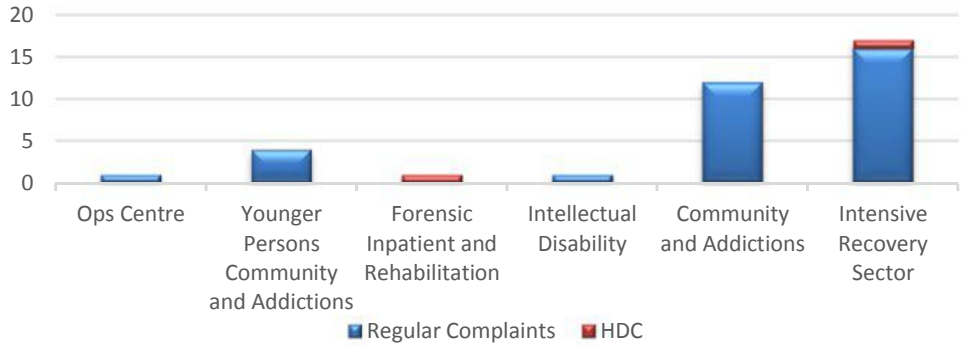
PERSON & WHĀNAU CENTRED CARE

Complaints

MHAIDS Complaints received per month

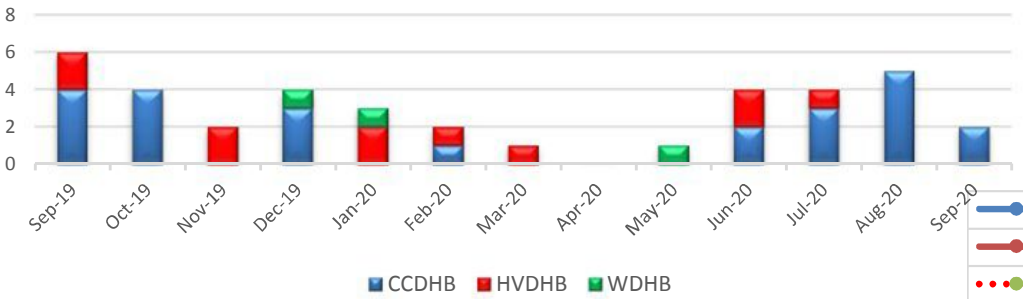


MHAIDS Complaints received per service - September 2020

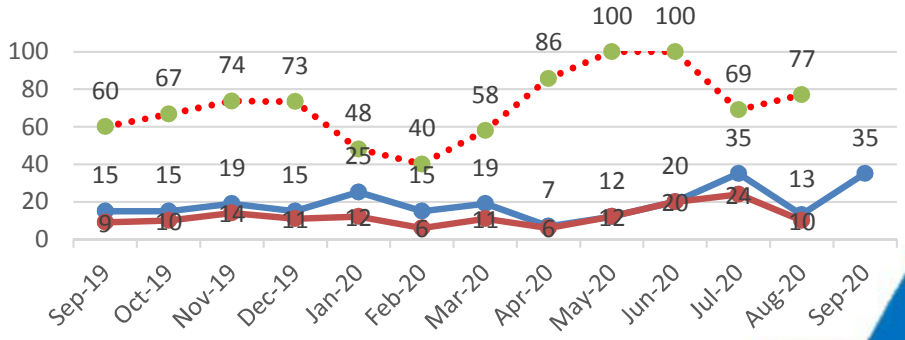


Key Points:
Increase in number of complaints received in September.
10/13 (77%) responses were sent within 20 day timeframe.

MHAIDS HDC Complaints received per month



MHAIDS Complaints Received and Closed within 20 Working Days



	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Complaints Received	15	15	19	15	25	15	19	7	12	20	35	13	35
Responded in Time	9	10	14	11	12	6	11	6	12	20	24	10	
Percentage	60	67	74	73	48	40	58	86	100	100	69	77	

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 $5.7m 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:
  - ($7.8m); COVID-19: additional costs during COVID-19
  - ($2.0m); 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, $9 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 which are largely 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 October was already ($26.2m) in overdraft, offset by $12.8m 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.
- The focus of the DHB last year turned to the planning and preparedness for COVID-19. This has resulted in groups being formed and staff dedicated to planning, 122,000 hours of planning recorded up to May 2020 (not direct patient activity) has been focused on COVID-19. We continue to monitor developments with respect to COVID-19 and will reintroduce planning hours tracking if necessary.
- 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 September 2020	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	(368)	(2,643)		(11,328)	0
			Non-Devolved MoH Revenue				0	0
2,037			Other Revenue	510			2,547	0
			IDF Inflow				0	0
			Inter DHB Provider Revenue				0	0
2,037	**(8,317)**	**0**	**Total Revenue**	**142**	**(2,643)**	**0**	**(8,781)**	**0**
			Personnel					
(1,610)		(2,049)	Medical	(1,897)		(601)	(3,507)	(24,739)
(1,620)		(9,145)	Nursing	(834)		(985)	(2,454)	(40,551)
		(1,370)	Allied Health			(164)	0	(6,750)
		32	Support			(44)	0	(1,811)
		168	Management & Administration			(186)	0	(7,654)
(3,230)	**0**	**(12,365)**	**Total Employee Cost**	**(2,731)**	**0**	**(1,979)**	**(5,961)**	**(81,505)**
			Outsourced Personnel					
(51)			Medical	(159)			(210)	0
			Nursing				0	0
			Allied Health				0	0
			Support				0	0
			Management & Administration				0	0
(51)	**0**	**0**	**Total Outsourced Personnel Cost**	**(159)**	**0**	**0**	**(210)**	**0**
2,834			Treatment related costs - Clinical Supp	(724)			2,110	0
(1,952)			Treatment related costs - Outsourced	(560)			(2,511)	0
(1,921)			Non Treatment Related Costs	(982)		(66)	(2,903)	(66)
			IDF Outflow				0	0
	(9,917)		Other External Provider Costs (SIP)		(5,177)		(15,093)	0
			Interest Depreciation & Capital Charge				0	0
(1,039)	**(9,917)**	**0**	**Total Other Expenditure**	**(2,266)**	**(5,177)**	**(66)**	**(18,398)**	**(66)**
(4,320)	**(9,917)**	**(12,365)**	**Total Expenditure**	**(5,155)**	**(5,177)**	**(2,046)**	**(24,569)**	**(81,571)**
6,357	**1,600**	**12,365**	**Net result**	**5,297**	**2,533**	**2,046**	**15,788**	**81,571**

- The year to date financial position includes $7.8m additional costs in relation to COVID-19.
- Revenue of $2.6m has been received to fund additional costs for community providers which is now exhausted.
- Additional personnel costs of $2m 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 – September 2020

Month - September 2020									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 September 2020	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	COVID-19 change from Trend	Holidays Act [2003]	Actuals exc COVID-19 / HA	Actuals exc COVID vs Budget
78,880	77,550	73,157	1,330	5,724	768		78,112	562	Devolved MoH Revenue	235,989	232,650	219,888	3,339	16,101	3,011		232,977	327
3,789	3,546	3,504	243	286			3,789	243	Non-Devolved MoH Revenue	11,509	10,730	10,410	779	1,099			11,509	779
2,913	2,852	3,257	60	(344)	(100)		3,013	160	Other Revenue	9,635	8,726	10,159	909	(524)	(510)		10,145	1,419
21,348	21,452	19,580	(104)	1,768			21,348	(104)	IDF Inflow	63,044	64,357	60,679	(1,313)	2,364			63,044	(1,313)
3,664	769	859	2,895	2,806			3,664	2,895	Inter DHB Provider Revenue	5,608	2,335	2,254	3,273	3,354			5,608	3,273
110,595	**106,170**	**100,356**	**4,425**	**10,239**	**668**	**0**	**109,927**	**3,757**	**Total Revenue**	**325,785**	**318,798**	**303,390**	**6,986**	**22,394**	**2,501**	**0**	**323,283**	**4,485**
									Personnel									
15,763	15,383	13,542	(379)	(2,221)	1,359	200	14,204	1,180	Medical	45,572	46,965	42,023	1,393	(3,549)	1,897	601	43,075	3,890
20,391	18,873	17,459	(1,518)	(2,931)	(11)	328	20,074	(1,200)	Nursing	60,315	56,983	53,523	(3,332)	(6,793)	834	985	58,497	(1,514)
6,348	5,534	4,846	(814)	(1,502)		55	6,293	(759)	Allied Health	17,872	16,988	15,310	(884)	(2,562)		164	17,708	(720)
938	872	792	(66)	(146)		15	923	(51)	Support	2,664	2,652	2,509	(12)	(155)		44	2,620	32
7,132	6,276	5,862	(856)	(1,270)		62	7,070	(794)	Management & Administration	20,062	19,009	18,391	(1,053)	(1,671)		186	19,876	(867)
50,572	**46,939**	**42,502**	**(3,633)**	**(8,070)**	**1,348**	**660**	**48,564**	**(1,625)**	**Total Employee Cost**	**146,486**	**142,597**	**131,756**	**(3,889)**	**(14,730)**	**2,731**	**1,979**	**141,776**	**821**
									Outsourced Personnel									
907	439	433	(468)	(473)	81		826	(387)	Medical	2,206	1,332	1,613	(875)	(593)	159		2,048	(716)
82	25	30	(57)	(52)			82	(57)	Nursing	180	75	60	(105)	(120)			180	(105)
89	114	109	24	20			89	24	Allied Health	330	341	373	11	43			330	11
21	22	43	1	23			21	1	Support	115	66	120	(49)	6			115	(49)
337	82	264	(255)	(73)			337	(255)	Management & Administration	1,042	245	799	(797)	(243)			1,042	(797)
1,435	**681**	**880**	**(754)**	**(555)**	**81**	**0**	**1,354**	**(673)**	**Total Outsourced Personnel Cost**	**3,874**	**2,059**	**2,965**	**(1,815)**	**(909)**	**159**	**0**	**3,715**	**(1,656)**
10,607	11,015	10,369	408	(238)	69		10,538	477	Treatment related costs - Clinical Supp	33,086	33,739	32,445	653	(641)	724		32,362	1,377
2,061	2,392	2,137	331	76	(0)		2,061	331	Treatment related costs - Outsourced	6,926	6,671	6,477	(255)	(449)	560		6,366	305
7,505	6,966	6,460	(539)	(1,045)	22	0	7,483	(517)	Non Treatment Related Costs	20,742	20,823	19,490	81	(1,253)	982	66	19,694	1,130
8,975	8,965	8,589	(10)	(386)			8,975	(10)	IDF Outflow	27,226	26,896	25,801	(330)	(1,426)			27,226	(330)
28,884	26,347	24,921	(2,537)	(3,963)	1,355		27,529	(1,182)	Other External Provider Costs (SIP)	84,847	79,378	75,487	(5,469)	(9,360)	5,177		79,670	(293)
4,857	4,799	5,102	(59)	245			4,857	(59)	Interest Depreciation & Capital Charge	14,877	14,781	15,318	(96)	441			14,877	(96)
62,889	**60,485**	**57,577**	**(2,404)**	**(5,311)**	**1,446**	**0**	**61,443**	**(958)**	**Total Other Expenditure**	**187,705**	**182,288**	**175,019**	**(5,417)**	**(12,687)**	**7,443**	**66**	**180,196**	**2,092**
114,895	**108,104**	**100,959**	**(6,791)**	**(13,936)**	**2,874**	**660**	**111,361**	**(3,257)**	**Total Expenditure**	**338,065**	**326,945**	**309,739**	**(11,120)**	**(28,325)**	**10,332**	**2,046**	**325,687**	**1,258**
(4,300)	**(1,935)**	**(603)**	**(2,365)**	**(3,697)**	**(2,206)**	**(660)**	**(1,435)**	**500**	**Net result**	**(12,280)**	**(8,146)**	**(6,349)**	**(4,133)**	**(5,931)**	**(7,831)**	**(2,046)**	**(2,404)**	**5,743**
(1,491)	(45)	(3,512)	(1,445)	2,022					Funder	(6,216)	(4,219)	(4,392)	(1,997)	(1,823)				
32	(0)	(81)	32	114					Governance	167	(0)	(55)	167	223				
(2,842)	(1,889)	2,991	(952)	(5,833)					Provider	(6,231)	(3,928)	(1,901)	(2,304)	(4,330)				
(4,300)	**(1,935)**	**(603)**	**(2,365)**	**(3,697)**					**Net result**	**(12,280)**	**(8,146)**	**(6,349)**	**(4,133)**	**(5,931)**				

Note two adjustments are made for COVID-19 and 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 ($12.28m)
- Included within this result is recognition of the adjustment to the holiday act provision ($2.0m) and an estimated impact of COVID-19 of ($7.8m).
- Excluding the two items above brings the deficit for the year into deficit of ($2.4m) being $5.7m favourable to budget.
- Revenue is favourable by $2.6m YTD. The largest variance is due to lead DHB changes, special fund/ research revenue. Inpatient IDF revenue was recognised behind target by ($1.3m), with planned care (electives) set to target whilst the year gets underway.
- Personnel costs including outsourced is ($5.8m) YTD, excluding the Holidays Act provision ($2.0m) and the COVID-19 related costs of ($2.9m) incurred the net unfavourable variance is ($834k). This $834k net unfavourable variance is driven by two different issues – underspends in staffing for a number of services totalling $1.6m, have been more than offset by the transfer of Mental Health and ICT services to CCDHB from other DHBs ($2.5m). CCDHB receives revenue to fully cover the costs of the transferred services and this is recognised in the ytd result.
- Treatment related clinical supplies $653k favourable YTD, the overspend in blood products ($375k) unfavourable were offset by favourable variances across other categories, such as; dispensed drugs, prostheses, grafts and outreach clinics.
- Outsourced clinical services is unfavourable YTD by ($245k); favourable movement in laboratory sendaway tests are offsetting increased outsourced CT scans. Surgical procedures performed in September were significantly delayed.
- Non treatment related costs $81k YTD favourable due to lower spend on asset maintenance, and new investment initiatives not yet commenced. This is offset by lead DHB overhead charges.
- The funder arm is unfavourable YTD due to additional spend requirements for our community COVID-19 response. Otherwise is generally favourable for the across community expenditure whilst programmes commence.

Analysis of the Operating Position – Revenue and Personnel

Revenue

- Revenue is favourable by $7m YTD despite recognising IDFs being behind target by $1.3m.
- The variance is due to revenue for special funds/research of $556k, MHAIDS revenue of $3.3m, largely in relation to lead DHB transfer, $2.5m funder arm revenue for COVID-19 and additional revenue for being lead DHB for ICT.

Personnel

- Medical Personnel is $647k unfavourable for the month, YTD favourable by $1.12m (excluding holidays act). The unfavourable position for the month is due to transfer of costs to CCDHB for MHAIDs services and the year to date favourable variance is driven by vacancies across other services, most notably surgery and Women's and Children's services.
- Nursing Personnel is ($1.2m) unfavourable to budget for the month, YTD ($2.45m) unfavourable (excluding Holidays Act). 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 ($734k) unfavourable to budget for the month, YTD ($709k) unfavourable to budget (excluding Holidays Act). $576k of the YTD variance results from the transfer of staff from other DHBs to CCDHB. This is offset by revenue.
- Support Personnel labour month position is unfavourable by ($50k), YTD unfavourable by ($17k) (excluding holidays act).
- Management/Admin Personnel is unfavourable in the month by ($1m), YTD unfavourable by ($1.6m) (excluding holidays act). $765k 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 – September 2020

Month : Sep 2020						Capital & Coast DHB Statement of Cashflows	Year to Date				
			Variance							Variance	
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	Notes	YTD Sep 2020	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year
						Operating Activities					
111,987	**111,708**	**113,201**	**279**	**(1,214)**		**Receipts**	**333,737**	**335,125**	**325,011**	**(1,388)**	**8,726**
						Payments					
43,542	45,974	40,416	2,432	(3,126)		Payments to employees	147,980	137,922	139,939	(10,058)	(8,041)
62,856	63,336	55,011	481	(7,845)		Payments to suppliers	187,199	190,895	182,105	3,696	(5,095)
0	0	0	0	0		Capital Charge paid	12,110	12,100	0	(10)	(12,110)
196	(137)	1,977	(333)	1,780		GST (net)	(1,553)	410	(546)	1,963	1,007
106,594	**109,174**	**97,404**	**2,579**	**(9,190)**		**Payments - total**	**345,736**	**341,327**	**321,497**	**(4,409)**	**(24,239)**
5,393	**2,535**	**15,797**	**2,858**	**(10,404)**	**6**	**Net cash flow from operating Activities**	**(11,999)**	**(6,203)**	**3,513**	**(5,797)**	**(15,512)**
						Investing Activities					
(69)	75	148	144	217		Receipts - Interest	**101**	**225**	**359**	**124**	**258**
0	0	0	0	0		Receipts - Other	0	0	0	0	0
(69)	**75**	**148**	**144**	**217**		**Receipts - total**	**101**	**225**	**359**	**124**	**258**
						Payments					
0	0	0	0	0		Investment in associates	0	0	0	0	0
2,298	5,511	3,857	3,213	1,559		Purchase of fixed assets	10,567	16,533	7,987	5,965	(2,581)
2,298	**5,511**	**3,857**	**3,213**	**1,559**		**Payments - total**	**10,567**	**16,533**	**7,987**	**5,965**	**(2,581)**
(2,367)	**(5,436)**	**(3,709)**	**3,357**	**1,776**	**7**	**Net cash flow from investing Activities**	**(10,467)**	**(16,308)**	**(7,628)**	**6,090**	**(2,322)**
						Financing Activities					
0	0	0	0	0		Equity - Capital	0	0	0	0	0
0	0	0	0	0		Other Equity Movement	674	0	0	674	674
0	0	0	0	0		Other	0	0	(55)	0	(55)
0	**0**	**0**	**0**	**0**		**Receipts - total**	**674**	**0**	**(55)**	**674**	**729**
						Payments					
0	**0**	**0**	**0**	**0**		Interest payments	**0**	**0**	**0**	**0**	**0**
0	**0**	**0**	**0**	**0**		**Payments - total**	**0**	**0**	**0**	**0**	**0**
0	**0**	**0**	**0**	**0**	**8**	**Net cash flow from financing Activities**	**674**	**0**	**(55)**	**674**	**729**
3,026	**(2,901)**	**12,088**	**6,215**	**(8,628)**		**Net inflow/[outflow] of CCDHB funds**	**(21,792)**	**(22,510)**	**(4,170)**	**967**	**(17,106)**
(6,582)	(1,373)	(8,175)	5,209	(1,593)		**Opening cash**	18,236	18,236	8,083	0	(10,153)
111,918	111,783	113,349	423	(997)		Net inflow funds	334,512	335,349	325,314	(589)	9,714
108,892	114,685	101,261	5,792	(7,631)		Net (outflow) funds	356,303	357,860	329,484	1,556	(26,819)
3,026	**(2,901)**	**12,088**	**6,215**	**(8,628)**		**Net inflow/[outflow] of CCDHB funds**	**(21,792)**	**(22,510)**	**(4,170)**	**967**	**(17,106)**
(3,556)	(4,274)	3,913	719	(7,469)		**Closing cash**	(3,556)	(4,274)	3,913	719	(7,469)

Capital and Coast DHB
RECONCILIATION OF CASH FLOW TO OPERATING BALANCE

	Notes	YTD Sep 2020 Actual $000	Budget $000	Variance $000
Net Cashflow from Operating		**(11,999)**	**(17,568)**	5,569
Non operating financial asset items		**(45)**	-	(45)
Non operating non financial asset items		**(1,033)**	**(765)**	(268)
Non cash PPE movements				
Depreciation & Impairment on PPE		(8,164)	(8,325)	161
Gain/Loss on sale of PPE		0	-	0
Total Non cash PPE movements		**(8,164)**	**(8,325)**	**161**
Interest Expense		-	-	**0**
Working Capital Movement				
Inventory		1,083	-	1,083
Receipts and Prepayments		31,933	12,100	19,833
Payables and Accruals		(24,054)	6,412	(30,466)
Total Working Capital movement		**8,962**	**18,512**	**(9,551)**
Operating balance		**(12,280)**	**(8,146)**	(4,134)

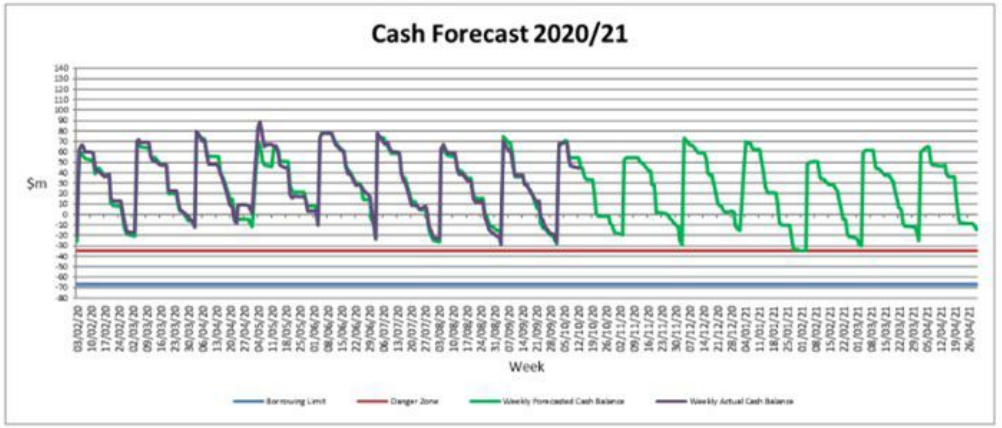
Current Ratio – This ratio determines the DHB's ability to pay back its short term liabilities.
DHB's current ratio is 0.32 (August 20: 0.31);

Debt to Equity Ratio – This ratio determines how the DHB has financed the asset base.
DHB's total liability to equity ratio is 43:57 (Aug 20: 41:59)

Debt Management / Cash Forecast – September 2020

Accounts Receivable
30-Sep-20

Aged Debtors report ($'000)	Total	Current	1-30	31 - 60	61 - 90	91+	Previous Period
Ministry of Health	10,735	4,937	2,322	1,725	19	1,732	11,842
Other DHB's	8,141	2,642	540	884	349	3,726	7,680
Kenepuru A&M	233	29	22	26	156	-	238
ACC	271	67	- 2	15	25	166	406
Misc Other	3,490	1,169	230	81	198	1,812	3,902
Total Debtors	22,870	8,844	3,112	2,731	747	7,436	24,068
less : Provision for Doubtful Debts	(1,583)						(2,132)
Net Debtors	21,287						21,936



Cash Management

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

Debt Management

- **Ministry of Health:** invoices on hold due to contracts not yet signed by MOH, reports not yet provided by CCDHB or disputed invoices.
- **Other DHB's:** Single largest debtor outstanding for more than 91 days is Hutt Valley DHB at $3.7m
- **Kenepuru A&M:** Includes significant number of low value patient transactions. Provision of the overdue debts is $135k
- **Misc Other:** Includes non-resident debt of approx. $2.18m. About 77% of the non-resident debt have payment arrangements in place. The balance will be referred to collection agencies if unpaid.

Balance Sheet / Cashflow – as at 30 September 2020

Aug-20	Month : Sep 2020							Capital & Coast DHB Balance Sheet
					Variance			
Actual	Actual	Budget	At Sep 2019	At Jun 2020	Actual vs Budget	Actual vs Sep 2019	Notes	YTD Sep 2020
31	31	31	34	31	0	(3)	1	Bank
(5)	10	(0)	0	6,523	10	10	1	Bank NZHP
12,685	12,783	11,683	11,686	11,683	1,101	1,097	1	Trust funds
55,348	62,851	49,375	53,640	49,375	13,476	9,211	2	Accounts receivable
9,826	10,078	8,995	8,832	8,995	1,083	1,247		Inventory/Stock
5,839	8,651	6,257	6,216	6,257	2,394	2,436		Prepayments
83,723	**94,405**	**76,341**	**80,407**	**82,864**	**18,064**	**13,997**		**Total current assets**
519,051	516,087	530,421	531,284	522,978	(14,333)	(15,196)		Fixed assets
14,847	14,847	14,847	9,859	11,626	0	4,988		Work in Progress - CRISP
60,459	68,067	54,096	44,105	57,317	13,971	23,962		Work in progress
594,357	**599,002**	**599,363**	**585,248**	**591,921**	**(362)**	**13,754**	3	**Total fixed assets**
0	0	0	0	0	0	0		Investments in New Zealand Health Partnership
1,150	1,150	1,150	1,150	1,150	0	0		Investment in Allied Laundry
1,150	**1,150**	**1,150**	**1,150**	**1,150**	**0**	**0**		**Total investments**
679,229	**694,556**	**676,854**	**666,805**	**675,935**	**17,702**	**27,751**		**Total Assets**
19,291	19,182	15,988	7,806	0	(3,194)	(11,376)		Bank overdraft HBL
73,611	82,386	64,504	67,474	76,604	(17,882)	(14,912)	4	Accounts payable, Accruals and provisions
0	0	0	0	0	0	0	7	Loans - Current portion
3,534	5,428	4,925	6,315	(252)	(502)	888	6	Capital Charge payable
593	593	593	593	593	0	0		Insurance liability
22,067	105,310	36,144	87,981	36,144	(69,166)	(17,329)	5	Current Employee Provisions
143,082	64,875	140,857	52,613	140,857	75,983	(12,261)	5	Accrued Employee Leave
11,296	15,325	7,299	12,421	7,299	(8,025)	(2,903)	5	Accrued Employee salary & Wages
273,475	**293,098**	**270,311**	**235,204**	**261,245**	**(22,787)**	**(57,894)**		**Total current liabilities**
0	0	0	0	0	0	0		Crown loans
100	104	95	78	95	(9)	(25)		Restricted special funds
605	605	605	605	605	0	0		Insurance liability
6,564	6,564	6,564	6,296	6,564	1	(268)		Long-term employee provisions
7,269	**7,273**	**7,264**	**6,979**	**7,264**	**(8)**	**(294)**		**Total non-current liabilities**
280,744	**300,371**	**277,576**	**242,183**	**268,510**	**(22,795)**	**(58,187)**		**Total Liabilities**
398,485	**394,185**	**399,278**	**424,622**	**407,425**	**(5,093)**	**(30,436)**		**Net Assets**
814,173	811,815	812,773	791,977	816,257	(958)	19,838		Crown Equity
0	0	0	0	(3,484)	0	0		Capital repaid
(2,358)	0	0	0	0	0	0		Capital Injection
130,659	130,659	130,660	130,944	130,659	(1)	(285)		Reserves
(543,989)	(548,289)	(544,155)	(498,468)	(536,008)	(4,135)	(49,821)		Retained earnings
398,485	**394,185**	**399,278**	**424,621**	**407,425**	**(5,094)**	**(30,435)**		**Total Equity**

Balance Sheet

The DHB has budgeted a total Provision of $81m for the Holidays Act remediation across Employee Provisions and Accrued Employee Leave, with the actual provision recorded to Accrued Employee Leave. Settlement will require a large cash injection.

Cash flow

The DHB's overall cash position at the end of September was $19m in overdraft and is projected to reach $18m overdraft at the end of October, when the DHB receives its quarterly Electives funding from the Ministry.

The DHB's liquidity going forward is of concern as the current assets of $94m is significantly lower than the $293m of current liabilities, this means the DHB is solely reliant on crown funding to meet payments as they fall due.

Deficit support will be needed in the second half of 2020, to help manage the large expected overdrafts. Current projections do not include extraordinary cashflows such as Holidays Act settlements which may occur during the year, however the cash is expected to be funded for this settlement.

Capital Expenditure Summary September 2020

		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	Actual LTD Spend	To spend	Oct-20	Nov-20	Dec-20	Mar 21 Quarter	Jun 21 Quarter	Forecast cash spend to Jun 21*
Buildings	5,809,650	-	178,251	178,251	5,631,398	801,987	1,411,027	425,704	553,238	253,075	3,623,283
Clinical Equipment	2,679,826	-	644,782	644,782	2,035,045	303,389	378,247	1,211,764	141,645	-	2,679,826
ICT	503,191	-	41,960	41,960	461,231	114,148	98,819	96,061	114,151	38,050	503,191
2020-21 projects	**8,992,667**	-	**864,993**	**864,993**	**8,127,674**	**1,219,525**	**1,888,093**	**1,733,529**	**809,035**	**291,125**	**6,806,300**
Buildings	17,052,833	8,814,096	1,393,811	10,207,907	6,844,926	710,229	841,047	651,893	2,829,665	2,087,049	8,513,694
Clinical Equipment	44,253,673	21,222,465	7,253,593	28,476,057	15,777,616	1,774,234	1,739,084	993,575	7,129,931	976,206	19,866,622
ICT	9,003,154	6,711,200	1,048,058	7,759,257	1,243,897	277,081	225,533	182,980	394,724	324,805	2,453,180
Prior Year projects	**70,309,660**	**36,747,760**	**9,695,462**	**46,443,222**	**23,866,438**	**2,761,544**	**2,805,663**	**1,828,448**	**10,354,321**	**3,388,059**	**30,833,496**
Total	**79,302,327**	**36,747,760**	**10,560,455**	**47,308,215**	**31,994,112**	**3,981,069**	**4,693,757**	**3,561,977**	**11,163,355**	**3,679,184**	**37,639,797**

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

Key highlights to September 2020 (excludes New Children's Hospital, Water Remediation Project & ISU for MHAIDS):

- The development of business cases from the 2020/21 Capital Plan are at various stages. It is anticipated that $3m-$4m be presented for approval each month. $9.0m in projects have been approved to the end of September 2020
- Total spend in the September quarter was $10.6m which mostly related to prior year approved projects
- The forecast cash spend for the year is $46m-$48m funded from depreciation ($37m), Crown Equity, donations and leases. This is based on an average monthly spend of $3.5m-$4m. It presumes a steady flow of business cases approved, lessened disruption on workforce and supply chain logistics from COVID-19
- Forecast spend on clinical equipment for January 2021 is expected to be significantly high. This is due some high value clinical equipment projects: CSB Seismic Upgrade, Linac replacement and lights and pendants replacement in Kenepuru and Wellington theatres

HSC Information – Public

December 20

Health System Committee (HSC) Items for Board Approval and Update

Action Required

The Boards note:

(a) 2DHB Investment for Age-Related Frailty paper is being presented to the Boards for approval in the Public Excluded section of the meeting.

(b) Te Pae Amorangi and Taurite Ora reporting will be aligning with the Ministry of Health Māori Health Strategy *Whakamaua* starting in 2021.

(c) An overview of the two Māori Health Strategy updates will be provided in item 3.2 of the Public Excluded agenda.

(d) Health Care Home Programme was discussed and representatives from three Public Health Organisations presented.

(e) There was an update on the spike in the cases of Rheumatic Fever.

(f) The Ministry of Health Quarter Four Performance and COVID-19 Analysis was noted.

(g) The Public Health System Committee papers are available online and the full meeting pack is available to the Boards on Diligent.

Strategic Alignment	Annual Plans, Te Pae Amorangi, Taurite Ora and the Sub-Regional Disability Strategy 2017-2022
Endorsed by	Fionnagh Dougan, Chief Executive Health System Committee
Presented by	Sue Kedgley, Chair Health System Committee
Purpose	Gain Board approval for decisions endorsed by HSC, noting any discussions or areas of concern, and provide an update on the meeting of the Committee.
Contributors	As noted in the HSC papers
Consultation	As noted in the HSC papers

Executive Summary

The decisions seeking Board approval have been endorsed by the Health System Committee (HSC) in their meeting on 25 November 2020. Discussion points raised in relation to the age-related frailty paper were:

- Noting equity for Māori and Pacific age-related frailty needs work as frailty impacts these communities at a younger age. There is work being done to address how to provide access at the right times and in the right places.
- Noting frailty is a broad term and this is specifically focused on age-related frailty not disability or long term condition frailty.
- Suggestions to look at devolved funding to the groups on the ground who are working closer to the people with age-related frailty.

No specific concerns were raised and the full HSC papers can be located in the HSC Diligent Books. Items worth noting for the Boards in this meeting are noted above.

Strategic Considerations

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

1. Nil

Board Decision – Public

December 2020

Equity Definition, Goal and Principles

Action Required

The Boards approve:

(a) The proposed definition of Equity for our DHBs

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

(b) The proposed Equity Goal for our DHBs:

"ACHIEVE HEALTH EQUITY BY 2030" as measured by:

- Consumer Input, Access, Quality, Experience and Direct Results.
- Influence on fundamental causes *[of inequity and the impact of]* social determinants.

(c) Endorse the proposed seven Equity Principles for our DHBs:

1. Privilege their voice
2. Focus on whānau
3. Empower consumers
4. Prioritise access
5. Offer Kaupapa Māori (and equivalent) options
6. Invest proportionately
7. Challenge discrimination

The Boards note:

(a) Our plan to seek the Board's endorsement of a Pro-Equity Policy Framework (supported by advanced analytics and insights into our investment choices) beginning with a Pro-Equity Commissioning Framework in early 2021.

(b) Our plan to develop a three-phase communications and engagement strategy that will introduce and socialise the equity fundamentals, followed by deeper engagement, and ongoing monitoring and review, to grow our organisations' understanding of and commitment to addressing inequities.

Strategic Alignment	CCDHB Health System Plan 2030 (the 2030 Plan) HVDHB Our Vision for Change 2017-2027 CCDHB Taurite Ora Māori Health Strategy 2019-2030 HVDHB Te Pae Amorangi, Māori Health Strategy 2018-2027 The Pacific Health & Wellbeing Strategic Plan for the Wellington Region, 2020-2025 Sub-Regional Disability Strategy 2017-2022 Enabling Partnerships: collaboration for effective access to health services HVDHB Our Wellbeing Plan 2018 A Thriving Hutt Valley Subregion Living Life Well A strategy for mental health and addiction 2019-2025.
Authors	Chad Paraone, Consultant Jeanette Harris, Māori Health Development Catherine Inder, Principal Advisor, Strategy, Planning and Performance
Endorsed by	Fionnagh Dougan, Chief Executive
Presented by	Arawhetu Gray, Executive Director, Māori Health Development

Purpose	This paper seeks the Board's endorsements of an **Equity Definition**, an **Equity Goal** and associated set of **Equity Principles** for adoption by our 2DHBs.
Contributors	Rachel Haggerty, Executive Director, Strategy, Planning and Performance Rachel Noble, General Manager, Disability (Steering Group) Tofa Suafole Gush, Director, Pacific Health Helen Mexted, Director, Communications and Engagement
Consultation	The Māori Partnership Board The Sub-Regional Pacific Advisory Group The Sub-Regional Disability Advisory Group The Citizens Health Council.

Executive Summary

Our DHBs have agreed to reshape themselves as pro-equity organisations and have developed a definition of Equity; a high-level goal to achieve health equity by 2030; and, with input from stakeholders, seven Equity Principles for consideration. These will inform our whole of system work programme focused on transforming the inequities that exist for Māori, and for our priority populations: Pacific peoples and people with disabilities across both DHBs.

We believe that these are both credible and achievable and will resonate with our DHB staff, stakeholders and partners. They will also help us to deliver on our national, regional and local obligations and commitments.

The Equity Goal, Definition and Principles are the fundamentals for transforming our DHBs into pro-equity organisations. We are starting work on a communications and engagement strategy to bring these concepts to life and make them real for our staff and partners and also, a Pro-equity Policy Framework, to ensure there is clear guidance and direction to drive action and change.

The development of this paper was originally developed by CCDHB as part of a pro-equity work programme. This paper was delayed due to both the COVID response and the formation of the 2DHB operating environment. It is recommended to the Board that this Equity Definition, Goal and Principles are adopted for implementation across both DHBs. Being pro-equity is an act of leadership supported by a policy framework, education and communication strategy.

Strategic Considerations

Service	All services and community providers need to understand what the Equity fundamentals mean for their services and consider what is needed to ensure more equitable health outcomes for disadvantaged populations.
People	All staff and community partners need to understand what the Equity fundamentals mean for them and understand what it means to incorporate into their roles. Priority populations accessing health services can expect to find services more available, accessible, affordable, acceptable and appropriate.
Financial	All investment (workforce, organisation, service provision) needs to be considered through an equity lens. Resources will be prioritised to systematically address inequities proportionate to address the inequities that exist.
Governance	The system-wide transformation necessary to achieve health equity by 2030 requires that the Board provide governance for the emerging work programme and ongoing.

Engagement/Consultation

Mana Whenua	Māori Partnership Board
Patient/Family	Citizens Health Council
Clinician/Staff	The Equity Steering Group Arawhetu Gray, Director, Māori Health Development John Tait, Chief Medical Officer Rachel Haggerty, Executive Director, Strategy, Planning and Performance Joy Farley, Director, Provider Services Emma Hickson, Chief Nursing Officer Lupe Taumoepeau, Surgeon Rachel Noble, General Manager, Disability
Community	Sub-Regional Pacific Strategic Advisory Group Sub-Regional Disability Advisory Group

Identified Risks

Risk ID	Risk Description	Risk Owner	Current Control Description	Current Risk Rating	Projected Risk Rating
TBA	If our DHBs reprioritise resources to achieve equitable outcomes then this may lead to other services not being prioritised and these choices may be controversial and damage our DHBs' reputation	Chief Executive	Communications and engagement strategy on being Pro-Equity DHBs Implementation of Health System Plan 2030 (simplify care for those good resources and intensify care for those who don't)	17 High Risk (Probability **likely** and consequence **moderate**)	TBA
TBA	The public or workforce perception that prioritisation to achieve equity is unfair on others who don't experience inequity.	Chief Executive	Communications and engagement strategy on being Pro-Equity DHBs Education and learning opportunities on pro-equity, anti-racism and reducing ableism.	17 High Risk (Probability **likely** and consequence **moderate**)	TBA

Attachment

1. Summary of Partner and Stakeholder Input

1. BACKGROUND

The leads for this significant mahi were Chad Paraone, Consultant, and Jeanette Harris, Māori Health Development, CCDHB. A Steering Group was established to bring the Equity Definition, Goal and Principles to fruition, the members were: Arawhetu Gray, Director, Māori Health Development; John Tait, Chief Medical Officer; Rachel Haggerty, Executive Director, Strategy, Planning and Performance; Joy Farley, Director, Provider Services; Emma Hickson, Chief Nursing Officer; Lupe Taumoepeau, Surgeon; and, Rachel Noble, General Manager, Disability.

We engaged with four partner and stakeholder groups on the development of the Equity Definition, Goal and Principles and their contributions are summarised in the Appendix. The groups were:

- the Māori Partnership Board
- the Sub-Regional Pacific Strategic Advisory Group
- the Sub-Regional Disability Advisory Group
- the Citizens Health Council.

This work was preceded by a Pro-Equity Check-Up, the development of Taurite Ora and the Central Region Equity Framework.

1.1 Pro-equity check-up

In December 2018, the Executive Leadership Team (ELT) received an independent report on its success embedding a pro-equity approach into its work. The *Capital and Coast DHB Pro-equity check-up*, concluded:

While there is a stated high-level commitment to the goal of achieving equity, and a general awareness of the key issues, this has not translated into a consistent and comprehensive response across the whole of the DHB...

ELT accepted the report's findings, agreeing that its progress was insufficient to provide confidence that it was on track to transform existing inequities, and committed to a series of deliverables that were subsequently included in *Taurite Ora Māori Health Strategy 2019-2030* (Taurite Ora).

The *Central Region Equity Framework* also obligates our DHBS to address and improve the current inequities that exist across the Central Region health system of care.

1.2 Taurite Ora

Strategic priority 1 in *Taurite Ora* obligates our DHBs to becoming pro-equity organisations in response to the breadth of inequities experienced by Māori. The 10 Strategic priority 1 actions are our DHBs' commitment to becoming pro-equity organisations, and includes actions to deliver an equity goal, definition and principles:

- Action 1 - adopt health equity for Māori as a strategic priority for the Board and ELT
- Action 2 - Commit to a pro-equity programme of work that delivers:
    a) a clear equity goal and direction
    b) an agreed set of equity principles
    c) an operational framework that translates principles into policies and practices
    d) a performance framework to monitor and guide progress
    e) an agreed target-staged implementation.

1.3 Central Region Equity Framework

The Regional Services Plan outlines how the six Central Region DHBs (Hutt Valley, Capital & Coast, Wairarapa, Whanganui, MidCentral and Hawkes Bay) will work together to find better ways of organising, funding, delivering and continuously improving health services. One of the 2019/2020 focus areas is Equity. The *Central Region Equity Framework* requires action in four domains:

- Capability – capacity, training and development
- Strategic planning – needs assessment, annual planning
- Monitoring and evaluation – managing performance, evaluation
- Procuring services – designing and contracting services, shaping the structure of delivery.

2. WHY EQUITY?

Equity is a human right that embedded in the legislative frameworks of health, specifically the Health & Disability Act 2001. It is also committed to in the Ministry of Health commitment to Te Tiriti O Waitangi and a specific government strategies as well as the strategies of CCDHB and HVDHB.

2.1 Te Tiriti o Waitangi (The Treaty of Waitangi)

Te Tiriti is a statement of individual and collective rights, a charter for New Zealand as a whole, and a reminder to Government, and its agencies of their collective obligations in respect of the Tāngata Whenua of New Zealand. Our DHBs have an obligation to ensure that health outcomes for Māori are equal to those of non-Māori.

The Ministry of Health's Te Tiriti Framework provides an updated expression of the Crown's obligations in the context of the health and disability system, the principles that apply are:

- **Tino rangatiratanga** – providing for Māori self-determination and mana motuhake in the design, delivery and monitoring of health and disability services.
- **Equity** – being committed to achieving equitable health outcomes for Māori.
- **Active protection** – acting to the fullest extent practicable to achieve equitable health outcomes for Māori including ensuring that the Crown, its agents and its Treaty partner under Te Tiriti are well informed on the extent, and nature, of both Māori health outcomes and efforts to achieve Māori health equity.
- **Options** - providing for and properly resourcing kaupapa Māori health and disability services. The Crown is obliged to ensure that all health and disability services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.
- **Partnership** – working in partnership with Māori in the governance, design, delivery and monitoring of health and disability services.

2.2 Government strategies

The health and disability system recognise there are unfair and unavoidable deficits in Māori health and wellbeing and also for other priority populations, including Pacific peoples and people with disabilities. It is important to acknowledge that these groups are often intersecting.

The Government has committed to addressing these health inequities in the strategies and plans detailed below:

Māori

Whakamaua: Māori Health Action Plan 2020-2025 is the implementation plan for *He Korowai Oranga, New Zealand's Māori Health Strategy*. *Whakamaua* enables the health and disability system to implement actions that can contribute to the Crown meeting its obligations under Te Tiriti o Waitangi. Four outcomes respond to cultural, social, economic and population health challenges and four objectives guide the coordination of action and resources across priority areas:

- Outcome 2 – the health and disability system is fair and sustainable and delivers more equitable outcomes for Māori.
- Objective 3 – reduce health inequities and health loss for Māori.

Pacific peoples

'Ola Manuia: Pacific Health & Action Plan 2010-2025 sets out the National priority outcomes and actions that contribute towards achieving better health outcomes for Pacific people, families and communities.

People with disabilities

Whāia Te Ao Mārama: Māori Disability Action Plan 2018 to 2022 recognises that Māori are more likely to be disabled and aims to enable Māori disabled to achieve their aspirations, and to reduce barriers that may impede Māori disabled and their whānau from gaining better outcomes.

The *New Zealand Disability Strategy 2016-2026* guides the work of government agencies on disability issues through to 2026. There are eight interconnected outcomes and Outcome 3 aspires to the highest attainable standards of health and wellbeing. The *Disability Action Plan 2019-2023* presents priority work programmes and actions to advance implementation of the United Nations Convention on the Rights of Persons with Disabilities and the *New Zealand Disability Strategy*.

2.3 Our DHB strategies

Our DHBs are delivering on these strategies that have Achieving Equity as a core theme and goal:

- CCDHB Health System Plan 2030 (the 2030 Plan)
- HVDHB Our Vision for Change 2017-2027
- CCDHB Taurite Ora Māori Health Strategy 2019-2030
- HVDHB Te Pae Amorangi, Māori Health Strategy 2018-2027
- The Pacific Health & Wellbeing Strategic Plan for the Wellington Region, 2020-2025
- Sub-Regional Disability Strategy 2017-2022 Enabling Partnerships: collaboration for effective access to health services
- HVDHB Our Wellbeing Plan 2018 A Thriving Hutt Valley
- Subregion Living Life Well A strategy for mental health and addiction 2019-2025.

3. OUR EQUITY DEFINITION?

To enable our DHBs to progress a pro-equity agenda it is important to have both a clear definition of equity, and for the definition to be understood by all employees, stakeholders and community partners. A clear definition of equity provides the basis for the coordinated and collaborative efforts necessary to achieve equity in health.

Our DHBs' proposed Equity definition:

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

This definition has been primarily informed by the World Health organisation definition and the Ministry of Health definition.

3.1 World Health Organization (WHO)

The WHO defines equity as the absence of avoidable or remediable differences among groups of people. The full definition picks up on health inequities:

Equity is the absence of avoidable or remediable differences among groups of people. Health inequities therefore involve more than inequality with respect to health determinants, access to the resources needed to improve and maintain health or health outcomes. They also entail a failure to avoid or overcome inequalities that infringe on fairness and human rights norms.[1]

This definition acknowledges that not only are differences in health status unfair and unjust, but they are also the result of differential access to the resources necessary for people to lead healthy lives.

3.2 Ministry of Health

The Ministry of Health's formal definition of equity, adopted in February 2019, is clearly aligned with the WHO and locates equity within the NZ health and disability system:

In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.[2]

The key concepts of avoidable, unfair and unjust are central to this definition. It also makes it clear that people with different needs require different levels of resources.

4. WHAT DOES PRO-EQUITY MEAN FOR OUR DHBS?

[1] https://www.who.int/healthsystems/topics/equity/en/

[2] Achieving equity in health outcomes: summary of a discovery process. Ministry of Health. August 2019.

The 2030 Plan, sets out a strategy to improve the performance of our healthcare system and encourage better health and wellbeing and more equitable health outcomes for all our communities.[3] The *2030 Plan* aims to achieve this through the development of people-focused service delivery models that:

- Simplify care for those who have good health literacy and resources.
- Intensify care for those who have less resources and experience the greatest levels of avoidable poor health.
- Invest in processes that encourage early action to prevent avoidable costs from longer-term health care.[4]

The adoption of the equity definition by our DHBs will commit all employees to:

- working with partners, stakeholders and community providers to tackle avoidable and remediable differences in health
- accepting that variations in approach and resource allocation to different groups are required to achieve this.

In practice, this means that:

… resources are distributed, and processes are designed in ways most likely to equalise the health outcomes of disadvantaged social groups with the outcomes of their more advantaged counterparts.[5]

It is vital to build a common understanding of equity among employees and community partners. The approach to doing so is to firstly, set an **Equity Goal** for the organisation to focus on and secondly, to support this with a set of **Equity Principles** to guide the associated planning, behaviour and action needed to achieve the Equity Goal.

5. AN EQUITY GOAL

To deliver on its purpose, an equity goal for the 2DHBs will accomplish three things:

- establish a clear focus and direction for the organisation
- be both aspiring and achievable, and be seen as such, and
- be meaningful for all employees, in their various roles.

There are two ways of framing a health equity goal for our DHBs:

- **Equity in health care** – targets factors within the direct control of the DHBs (service focus).

[3] **CCDHB Health System Plan 2030, page 3.**

[4] **CCDHB Health System Plan 2030, section 2.9 Developing people-focused service delivery models, page 25.**

- **Equity in health outcomes** – targets overall health outcomes for the population (population focus) and is influenced by factors that are both within and outside our DHBs' direct control.

5.1 Equity in health outcomes approach

Our DHBs cannot set a goal that holds management and the wider organisation accountable for achieving equity in overall health outcomes. Even exemplary DHB performance is unlikely to be enough to overcome the collective weight of adverse socio-economic and environmental factors.

Factors beyond medical care play significant roles on a person's health and relate to the conditions and environments in which people are born, learn, live, work, play and age – and they affect a wide range of health, functioning and quality-of-life outcomes and risks.[6]

Achieving equity in health outcomes, including equity in length of life and quality of life, requires addressing racism and ableism in societal institutions as well as tackling more direct obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.[7]

Health outcomes are dependent upon the commitments and actions of a range of other players, including central and local government, other health sector agencies and businesses, social organisations, iwi, communities and family/whānau.

5.2 Equity in health care approach

The alternative is an equity goal that is focussed on factors within the control of our DHBs such as Access to care, Quality of care, Patient Experience of care, and the direct results of that care. The equity goal can also cover factors that our DHBs have a mandated role and level of influence over, such as healthy and lifestyle behaviours (e.g. diet, exercise, tobacco, alcohol, and other drug use).

This can be framed as a goal of **equity in health care** and relate to the organisation, design and delivery of care – focused on Access, Quality, Experience and direct Results of this care. This could be supplemented by emphasising the role of our DHBs in working with other sectors, agencies and society to tackle the underlying 'basic causes' and social determinants of health.

5.3 PROPOSED EQUITY GOAL

The proposed Equity Goal incorporates partner and stakeholder input (refer paragraph 2.4 above and the Appendix) in particular, the points raised about access, quality and the social determinants. The level of specificity meets three requirements for a health equity goal identified in paragraph 5.1 above.

The proposed Equity Goal for consideration for our DHBs is:

ACHIEVE HEALTH EQUITY BY 2030

[6] Achieving Equity in Health Outcomes: Highlights of important national and international papers. Ministry of Health. 2018

[7] https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html

As measured by:

a) Consumer input, Access, Quality, Experience and direct Results[8]

b) Influence on fundamental causes and social determinants.

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6. PROPOSED EQUITY PRINCIPLES

6.1 Criteria for Equity Principles

To support progress towards our DHBs' Equity Goal, the adoption of a set of Equity Principles will help guide the required behaviour, planning, decision-making, service commissioning and service provision from our employees and community partners.

For the principles to be effective, they must be:

- clear and meaningful and **speak** to the different DHB audiences, each of which has a different operational focus and set of requirements. These audiences include:
  - Board, Board Committee and Executive Leadership Team members
  - Clinicians, staff and management in the Provider Arm (hospitals and community services) and Mental Health and Addiction services – delivering front line care
  - Staff in the Strategy, Planning & Performance team – purchasing/commissioning services, monitoring performance and managing contracts
  - Strategic CCDHB partners – such as mana whenua, advisory groups, providers and communities
- **focus attention on the key things that matter from an equity perspective** in all our DHB processes – whether clinical or administrative - in order to achieve the Equity Goal
- **be consistent with our DHBs established principles**, such as those set out in our DHB strategies and plans (see paragraph 3.3 above).

6.2 Partner and stakeholder input

To get a stronger sense of what might work locally, the four key DHB partner and stakeholder groups were asked for input on a set of equity principles (see paragraph 2.4 and the Appendix). While the feedback was broad and varied key points raised concerned:

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[8] The inclusion of 'Consumer Input' is intended to ensure that the voice of the consumer/patient is heard in health care design and delivery and provides for shared decision-making and control over their health care experience. The term 'direct Results' means the healthcare outcomes arising from an episode of care.

- **Proportional universalism** – applying additional resources, proportionate to address the inequities that exist
- Prioritise and value whānau/aiga and disabled people's own communities
- **Co-design** - value cultural and disabled leaders, providers and services as key knowledge holders
- **Accessibility** - services are available, affordable, accessible (environment, communication and information) and acceptable
- **Respect** - for culture, difference, dignity and autonomy
- **Local focus** - look to local communities for solutions and deliver more services locally
- **Options** - protect the availability and viability of Kaupapa Māori, Pacific and Disability solutions
- **Social determinants** – be active and deliberate in addressing these.

6.3 Proposed Equity Principles for our DHBs

Considering this feedback alongside the other points from the literature, and the criteria established earlier, the following table proposes a set of seven equity principles for adoption:

1. Privilege their Voice	**Amplify and value the voice of individuals and families/whānau from priority groups. Put them at the centre**. Seek out and give favourable treatment to their views. Ensure these sit at the heart of information gathering and decision making – in strategy, policy, process, service design and delivery.
2. Focus on Whānau	**Expand the focus from individuals to include the family unit**. Design and deliver services that are oriented not just to individuals – but also to their whānau and household realities and circumstances. Explore and design so as to mitigate confounding factors to good health in the whānau environment.
3. Empower Consumers (Rangatiratanga)	Actively work to **empower individuals, whānau and communities to take control of their health, and become agents of their own change**. Foster their mana motuhake (autonomy, independence, self-management). Share power, influence and decision-making over the design, delivery and governance of health services.
4. Prioritise Access	Prioritise service access, quality and experience - by adapting service strategy, policy, process, design and delivery to ensure key services for individuals and whānau from priority groups are available, accessible, affordable, acceptable and appropriate.
5. Offer Kaupapa Māori (and equivalent) Options	**Transform health services by developing and fostering Kaupapa services** alongside generic service models - to enable choice for Māori, Pacific, Disability, other priority group consumers. Kaupapa services cover models of care and services designed and delivered by Māori, Pacific, Disability and other priority groups for all. Equally, hold general healthcare models and services accountable for transforming and prioritising culturally safe care that caters for Māori and other indigenous traditions and worldviews, and disability worldviews, in ways that address disadvantage in care access or quality.

6. Invest Proportionately	**Intensify care for those who have less resources and experience the greatest levels of avoidable poor health**. Deploy reasonable additional resources where required, proportionate to address the inequities that exist.
7. Challenge Discrimination	Advance an environment of open communication, supported inquiry, learning and development around discrimination in all forms, including racism, ableism and bias. Support employees and partners in the conversation. Call out conscious and unconscious discrimination on all levels - personal, institutional and structural.

7. TOWARDS ACHIEVING HEALTH EQUITY BY 2030

7.1 Communications and engagement strategy

We will support progress towards our DHBs' Equity Goal with the development of a communications and engagement strategy promoting the Equity Goal, Definition and Principles, in three phases:

a) **Phase 1 Introduction and socialisation** – internal and partner launch from the Chief Executive and ELT on our equity fundamentals, including simple resources that bring the concepts to life.

b) **Phase 2 Engagement** - tools and resources to support different teams and partners to understand what the equity fundamentals could mean for them and how to incorporate into their roles.

c) **Phase 3 Review, monitoring and progress** – checking the maturity of our staff and our partners' understanding of the equity fundamentals; their impact on behaviours and decision-making, and ensuring that the commitment to achieving health equity and what that involves continues to be both live and real.

This work will also be introduced and integrated within our wider communications on our strategic narrative and priorities.

7.2 Pro-Equity Policy Framework

We will support proactive progress towards our DHBs' Equity Goal with a Pro-Equity Policy Framework covering three domains:

a) Pro-Equity Commissioning policy

b) Pro-Equity Workforce Development policy

c) Pro-Equity Organisational Development policy.

This pro-equity policy framework will embed the approaches developed and implemented by CCDHB over the last three years. This includes a commitment to pro-equity analytics so that our workforce and partners have the tools that enable them to understand how what they do contributes to addressing inequities.

We will seek the Board's endorsement of the three core policy documents that will encompass the Pro-Equity Policy Framework sequentially and present the Pro-Equity Commissioning policy in early 2021.

Appendix

Summary of Partner and Stakeholder Input

Four stakeholder groups provided to the development of an equity goal and principles for CCHDB: the Māori Partnership Board, the Sub-Regional Pacific Strategic Advisory Group, the Sub-Regional Disability Advisory Group, and the Citizens Health Council.

The **Māori Partnership Board** (MPB) feedback referenced the goal established by *Taurite Ora: CCDHB Māori Health Strategy 2019-2030*, of:

Pae Ora Mō Ngā Iwi i te Ūpoko ki te Uru Hauora

Health Equity and optimal health for Māori by 2030[9]

The MPB suggested that anything less than health equity by 2030 would undermine Taurite Ora, and noted it aligned nicely with a recommendation in the Baker Jones Pro-Equity check-up report[10] of being specific, speaking to 'achieving equity', and being time-bound.

The **Sub-Regional Pacific Strategic Advisory Group** (SRPSAG) suggested goals that focused on a Pacific peoples' outlook, such as Pacific people being prosperous, strong and confident in their Pacific identity, self-determining what they need to be successful, influencing decision-making on matters that affect Pacific people, being better supported to be healthy, and experiencing improved determinants of health.

The group's feedback also pointed out that CCDHB has control over Access and Quality of care issues and so should be deliberate about eliminating inequities in Access to services and Quality of care by 2025. This extends to being proactive in reaching out to other sectors to collectively address the social determinants of health.

Feedback from the **Citizens Health Council** emphasised a goal that includes Quality in health, on the basis that Quality will be an embedded directive and point of emphasis for the DHB and health sector that will not vary over time. The Council also noted that having a target date can be a distraction and undermine the need for a constant long-term effort, monitoring and adjustment.

As well as ensuring the CCDHB equity approach explicitly recognises and caters for disability worldviews, feedback from the **Sub-Regional Disability Advisory Group** (SRDAG) also emphasised the impact of 'intersectionality' - recognising the multiple layers of disadvantage that can exist among those

[9] Taurite Ora: CCDHB Māori Health Strategy 2019-2030, pg 7, CCDHB. Note that Hutt Valley DHB has declared an aim of achieving Māori health equity by 2027. See Te Pae Amorangi Hutt Valley DHB Māori Health Strategy 2018-2027 (http://www.huttvalleydhb.org.nz/your-health-services/maori-health/tepaeamorangiwebtempupdated.pdf)

[10] CCDHB Pro-Equity Check-up, Baker & Jones, December 2018

with a disability, such as whānau hauā (Māori with disabilities) who might face cultural and socio-economic challenges when accessing health care, layered on top of service, system and attitudinal bias from the health care system itself. SRDAG highlighted that CCDHB's approach needs to recognise and factor in the impact of these overlapping and interdependent levels of discrimination and disadvantage.

SRDAG also noted that 'access' and having 'accessible' services takes on additional meaning, a more specific meaning, for people with a disability – more so than with the general population. It includes, for example, the range of physical, visual, auditory and other support elements required to enable people with different disabilities to be appropriately supported in accessing health care – much more than just the medical care itself. For example, addressing 'access' requires considering the whole journey an individual might require support with - from the home to the service – not just activity at the facility itself.

Board Information – Public

December 2020

Aligning Māori Strategies with Whakamaua	
Action Required **The Boards note:** (a) The intention to align Māori Health reporting in 2021 with the Ministry of Health Māori Action Plan, Whakamaua. (b) Taurite Ora and Te Pae Amorangi will continue to be delivered against as separate strategies however, resources and activities will be aligned and shared as appropriate. (c) Both strategies share common themes and actions but place different emphasis and priority on the activities undertaken to achieve them. (d) The draft example provided. (e) This paper was discussed at the 2DHB Health System Committee meeting on 25 November 2020.	
Author	Arawhetu Gray, Executive Director Māori Health Kiri Waldegrave, Director Māori Health
Endorsed by	Fionnagh Dougan, Chief Executive
Presented by	Arawhetu Gray, Executive Director Māori Health
Purpose	Update on proposal to consolidate reporting for Taurite Ora and Te Pae Amorangi and align their respective work programmes with the Ministry of Health Māori Health Strategy: Whakamaua.
Contributors	Jeanette Harris, Project Manager, Māori Health
Consultation	N/A

Executive Summary

As part of the shift to a 2DHB Executive Leadership team reporting against the two Māori Health strategies, Taurite Ora at Capital & Coast DHB and Te Pae Amorangi at Hutt Valley DHB, will be consolidated. The consolidated report will map activities to Whakamaua, the Ministry of Health's Māori Health Strategy 2020 – 2025 to ensure our focus aligns with the governments priorities for the health and disability system.

The separate activities outlined in each strategy will be maintained however opportunities to integrate work programmes as appropriate will be undertaken. This is to ensure greater use of resources to enable successful outcomes against the shared themes. It is important to stay mindful that each region is home to different mana whenua and that partnership with iwi is guided in part by the kaupapa outlined in the strategies.

Strategic Considerations

Service	Alignment with the Whakamaua ensures the services of the DHBs are meeting the MOH and wider health system obligations to Māori.
People	N/A

Financial	Two to three year implementation cost is estimated at $0.5M per annum
Governance	Equity Leadership Team is established

Engagement/Consultation

Patient/Whānau	Targeted involvement with Māori whānau occurs through the Māori health team.
Clinician/Staff	Ongoing involvement with a broad range of staff.
Community	Ongoing active relationships and engagement with Māori communities and leaders.

Identified Risks

Risk ID	Risk Description	Risk Owner	Current Control Description	Current Risk Rating	Projected Risk Rating
1	Māori Health Equity is under prioritised	CCDHB and HVDHB Boards ELT	Bowtie risk assessment complete. Mitigations require the actions under the two strategies.		

Attachments

Nil. Report follows.

1. TWO DISTRICT HEALTH BOARDS - MĀORI HEALTH STRATEGY

Alignment with Whakamaua, Ministry of Health (MOH) Māori Health Strategy 2020 - 2025

1.1 CCDHB and HVDHB currently report separately against their respective Māori Health Strategies. The recent establishment of the 2DHB Director Māori Health provides an opportunity to identify synergies across our plans and to map the two DHBs combined progress against the Ministry of Health's Māori Health Plan – Whakamaua.

1.2 *Whakamaua: the Māori Health Action Plan 2020 - 2025* was released by the Ministry of Health earlier this year. The Strategy outlines the government's priorities for the health and disability system, including improving child, mental and general wellbeing by developing a strong and equitable public health and disability system:

1.3 Each will continue to implement our separate work plans and we are committed to identifying opportunities to integrate our programmes where appropriate and share resources to achieve aligned goals. Both strategies share common themes and actions but place different emphasis and priority on the activities undertaken to achieve them.

1.4 The plans were conceived as living documents with the ability to evolve over time and as priorities shift. Moving forward it will become more apparent where combined efforts will make the most difference. It is known that complex change and system shifts cannot be achieved quickly so mahi continues to be organised with a long term focus.

1.5 Relationships with iwi in both regions will be maintained, recognising that each mana whenua will have different priorities. They will be closely engaged with to improve Māori health outcomes and support local-level Māori development and kaupapa Māori service solutions. This maintains the current relationship with mana whenua.

1.6 Regular detailed reporting and dashboards will be provided in 2021. It will give a performance overview of Taurite Ora and Te Pae Amorangi, mapped to Whakamaua. The dashboard we adopt will be similar to the following example. The initiatives are not a complete list of the activities under the workforce heading, but used here to provide an example of how a report may look.

Example:

Whakamaua: Māori health and disability workforce

Purpose: To increase the capacity and capability of the Māori health and disability workforce at all levels of the health and disability system

Areas of focus in Whakamaua	**2DHB initiatives that align with Whakamaua**
• Pro-equity training • Review and strengthen recruitment strategies • Workforce plan and marketing profile • Workforce data • Graduate nursing and midwifery framework • Mana Motuhake for Māori workforce supported • Career Pathways • Tuakana Teina	• Develop a pro-Māori Equity training package for all staff • Develop cultural competencies and expectation for all staff to address racism • Develop a quality improvement framework which includes goals and metrics related to health equity • Support our workforce to achieve increased equity outcomes, particularly for Māori, Pacific and people with disabilities (2DHB) • Co-design innovative models of maternity care with Māori and Pacific women in order to improve outcomes (2DHB) • Offer education, advice and transport to clients who have previous missed appointments to Breast, Cervical or Colonoscopy Services (2DHB) • Develop a guide for providers/practitioners to guide conversations with families declining immunisations, with a focus on co-designing with Māori and Pacific families and providers (2DHB) **Capital and Coast initiatives** • Re-establish Tu Pounamu workforce programme **Hutt Valley DHB initiatives** • Develop Kaitaki Haakui positions to supportthe ongoing development of cultural safety frameworks and recruit to the role and commit to a pro-equity programme of work that delivers a clear CCDHB equity goal and direction, an agreed set of equity principles, and an operational framework • Set action points for Māori health equity and outcomes • Develop *Matariki Achieving Excellence in Māori* Health annual awards

Indicators	Description	Rationale	Targets	Performance – three year trend Key: Māori — Pacific — Other —	Comments

Board DECISION – Public

December 2020

First Quarterly Update & Launch of the Pacific Health & Wellbeing Strategic Plan for the Greater Wellington region 2020-2025

Action Required

The HVDHB and CCDHB Boards note

(a) The Pacific Health & Wellbeing Strategic Plan for the Greater Wellington region 2020-2025 will be officially launched 3 December by the Minister of Pacific Peoples

(b) The first Quarterly update on the Plan's first 3 priorities is attached.

Strategic Alignment	Ministry of Health *Ola Manuia* Pacific Health Plan 2020-2025 CCDHB Health System Plan 2030 HVDHB Vision For Change 2017-2027 WrDHB Well Wairarapa –Better Health for All Vision 2017 Faiva Ora National Pacific Disability Plan Ministry of Pacific Peoples Priorities
Author	Tofa Suafole Gush, Director Pacific Health
Endorsed by	Fionnagh Dougan, Chief Executive Officer, CCDHB & HVDHB
Purpose	Update the Boards in relation to the implementation of initiatives related to the Pacific Strategic Plan.
Contributors	Candice Apelu-Mariner, Integration Lead Pacific
Consultation	3DHB Sub Regional Pacific Strategic Health Advisory Group, Pacific communities in Wairarapa, Hutt Valley and Porirua.

Executive Summary

The three DHB boards endorsed and approved the final draft of the Plan in July 2020. The Pacific Health & Wellbeing Strategic Plan for the Greater Wellington region 2020-2025 (the Plan) outlines strategies to address the key areas of concern for Pacific Health. The six priorities identified have been developed through extensive consultation with Churches, community groups, Young people, Providers of Health services across the region and DHB workforce.

The Plan will be launched officially on the evening of Thursday 3 December 2020 with implementation already having commenced.

Strategic Considerations

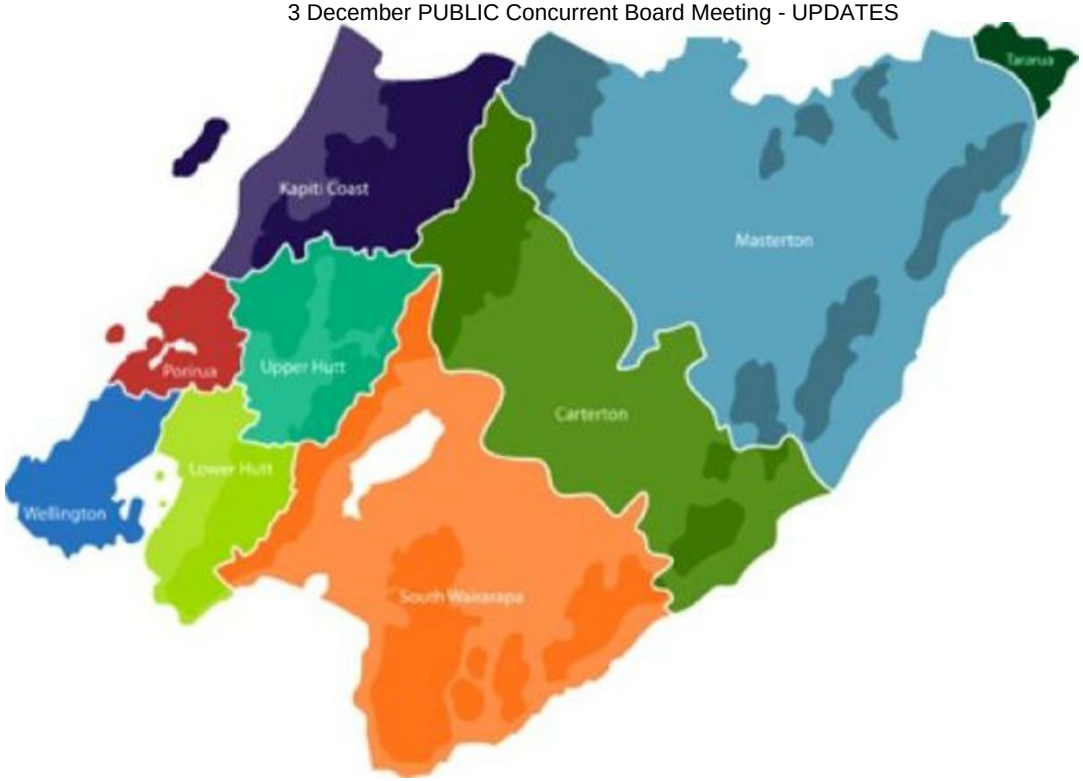
Service	NA
People	NA
Financial	Investment to implement the Plan
Governance	The Pacific Health & Wellbeing Strategic Plan for the Greater Wellington region,2020-2025 be jointly owned by the DHBs and the Pacific communities; The DHBs consider seriously recommendations from the community even if the recommendations do not currently have identified funding.

Identified Risks

Risk ID	Risk Description	Risk Owner	Current Control Description	Current Risk Rating	Projected Risk Rating
Insert risk #	Limited additional investment to implement the Plan	Tofa Suafole Gush Rachel Haggerty	Ensure approval of funding investment for out years are sought	3	Medium risk

Attachment/s

1. RESOURCE FOLDER: Quarterly Report against 3 priorities.



3DHB Pacific Health Update November 2020

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

HUTT VALLEY DHB

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

RIORITY ONE:
acific child health and wellbeing

fic children and their families the best possible start in life									
utcome	How will we know there's been improvement?	Measures of improvement	CCDHB			HVDHB			
			Target	Pacific	Other	Target	Pacific	Other	
itiatives to parents, babies	• Increased uptake and improved access of Pacific mothers to antenatal and postnatal maternity services • Responsive child health, oral health and disability support services wrapped around to support the needs of Pacific mothers and children.	% of Pacific pregnant women registered with a Lead Maternity Carer within the first trimester of pregnancy		45%	76%		49%	74%	
		% of Pacific mothers using antenatal services							
		% of Pacific mothers rating services as meeting their needs							
riate safe g up Pacific homes, smoke n, safe sleeping, ohol	• A decrease in avoidable admissions for Pacific children • Increase the number of Pacific children living in healthy homes that are warm and smoke-free • Improved Pacific provider system integration and coordination between community, across primary, secondary, and tertiary care providers and other sector partners.	Rate of Ambulatory Sensitive Hospitalisations for children aged 0-4 years (per 100,000 people)	11,328	9,577	4,033	15,158	1,5979	5,791	
		% of Pacific babies living in smoke-free households at 6 weeks	54%	41%	64%		44%	66%	
		Rate of hospitalisations potentially related to housing conditions per 1,000 population for children under 15 (2018)		23	7		28	12	
holders to es campaigns ates and and Pacific	• Strengthened approach through inter-agency partnerships to address timely access to maternity services and birthing options, • Strengthen Pacific breastfeeding services, and child immunization services.	% of Pacific infants fully or exclusively breastfed at 3 months	≥60%	50.0%	67%	≥70%	40%	56%	
		% of Pacific children fully vaccinated at eight months old	≥95%	91%	94%	≥95%	94%	91%	
		% of Pacific children fully vaccinated at two years old	≥95%	93%	94%	≥95%	93%	93%	
		% of Pacific children fully vaccinated at five years old	≥95%	91%	90%	≥95%	84%	89%	
ic Children meet key childhood developmental milestones through culturally responsive and quality services and support.									
			Target	Pacific	Other	Target	Pacific	Other	
ild Tamariki Ora fic Well Child and build up the most	• Increase in children receiving all their core checks • Better collaboration between Well child Tamariki Ora services through collective programmes and projects developed across the health system.	% of Pacific children accessing Well Child Tamariki Ora services and completing Core Checks (all checks by 1yrs)		64%	86%		55%	80%	
		% of eligible Pacific children receiving and completing a B4 School Checks (19/20)	≥90%	54%	63%	≥90%	60%	63%	
Bee Healthy es and key and initiatives to ening and nterventions	• Increased knowledge and understanding of parents and caregivers of healthy foods to nourish young children • More Pacific children with healthy teeth • Increase in number of children receiving their annual dental examinations	% of Pacific children (0-12) enrolled in Community and DHB oral health services overdue for their scheduled examinations	≤10%	7%	5%	≤10%	5%	4%	
		% of Pacific children caries free at 5 years	≤69%	43%	78%	≤66%	47%	63%	
		% of Pacific children caries free at 12 years old	≤69%	84%	81%		51% (2018)	72% (2018)	
key e prevalence Pacific	• Strengthen support for initiatives that address Family violence and work with relevant stakeholders on preventative measures. • Increased role of health services through inter-	Number of referrals to relevant services during discharge planning							
		Number of inter-agency collaborations with the DHB to support Pacific families and ensure they access the right							

RIORITY TWO:
acific young people

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

utcome	How will we know there's been improvement?	Measures of improvement	CCDHB			HVDHB			
			Target	Pacific	Other	Target	Pacific	Other	Targ
itiatives that eople to adopt formed choices about d risk-taking	• More Pacific Youth are making healthy lifestyle choices	% of age-standardised rate of overweight and obesity in Pacific aged 15+ years		91%	58% (Total)		89%	68% (Total)	
		% of Pacific young people accessing sexual and reproductive health services either through GPs or youth specific services							
innovations that focus mental health, self-	• Increased number of Pacific young people engaging with programmes and initiatives such as the Piki free youth Mental Health services, YouthQuake, community driven mental health programmes and others.	% of eligible Pacific young people's accessing Community Youth mental health services (primary services)	0.8%	1.0%	1.5%		3%	1%	
		% of Pacific young people accessing suicide prevention and self- harm education services and support							
romote health that reach and g people	• Pacific young people receive and respond to health messages on media that they use often	% of Age-standardized rate of overweight and obesity in Pacific aged 15+ years		91%	58% (Total)		89%	68% (Total)	
partnerships with al and educational	• Increased access to health and disability services that are youth centred	% of Pacific students seen by School based health services – routine health assessment	95%	16%	21%		21%	14%	
		Number of contacts at Youth Health services (YOSS) -19/20		659			52	361	
grammes that n of Pacific young cision-making s to enhance their	• Number of collaborations with identified Colleges and High Schools to promote health as a career but also to collaborate on health promotion initiatives driven by Pacific young people	% of Pacific young people involved in DHB and Primary Care relevant Consumer and Health Steering Groups							
		% of scholarships offered for relevant Pacific young people to complete health related studies at Universities and Polytechnics.							

IORITY THREE:
acific adults and ageing well

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

Outcome	How will we know there's been improvement?	Measures of improvement	CCDHB			HVDHB			T
			Target	Pacific	Other	Target	Pacific	Other	
th key stakeholders age participation in rvical, bowel, breast) cessation support	• More Pacific people participate in Bowel, Breast and Cervical screening programmes for early diagnosis of cancer • Pacific people receive cancer treatment sooner	% of eligible Pacific women (25-69 years old) completing cervical screening	≥80%	64%	72%	≥80%	64%	72%	
		% of eligible Pacific women (50-69 years old) completing breast screening	≥70%	60%	67%	≥70%	64%	64%	
		% of eligible Pacific population (60+) completing bowel screening testing				60%	43%	62%	
		% of Pacific patients who receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer	≥90%	57%	91%	≥90%	75%	71%	
stem-wide health rgeted activities ronic disease ion	Increased support and uptake of risk assessment, and early intervention programs for: • Diabetes checks • Cardiovascular disease • Respiratory disease • Smoking • High Blood Pressure Increased access to medications and Pharmaceuticals by decreasing the number of prescriptions unfilled due to cost	% of Pacific adults with diabetes who have completed their annual review					67%	72%	
		% of the eligible Pacific population assessed for CVD risk	≥80%	76%	74%	≥80%	78%	82%	
		Ambulatory sensitive hospitalisation rate for Pacific adults aged 45-64 (per 100,000 people)	2,537	7,409	2,460	8,455	7,140	3,448	
		% of unfilled prescriptions at PHARMAC							
health education and s that draw on Pacific guages and cultural k factors and	• Reduced ASH rates and Pacific people admitted to hospital due to complications from chronic conditions	% of Pacific people registered under the Long Term Conditions programme attending 100% of appointments and getting necessary care							
		% of Pacific people with diabetes aged 15-74 years enrolled with a PHO whose latest HbA1c in the last 12 months was <=64 mmol/mol	65%	44%	59%	≥70%	41%	55%	
g initiatives and ies to support Pacific in their homes.	• Increased uptake of specific initiatives for Pacific adults that focus on healthy living and effective socialisation of Advanced Care Planning with Pacific families and communities.	% of Pacific patients waiting longer than four months for their first specialist assessment							
		% of Pacific patients reporting living good quality lives in surveys							
ange levers in design that will ct on health tural competency workforce that	• Non-Pacific workforce improve their understanding Pacific peoples worldview and what would influences them • Pacific people better understand their health, their medications and other factors that influence their condition	% of Pacific families and patients enrolled in Primary care utilising patient portals							
		% of Pacific patients answering "Yes, always" to question: "Were you given information you could understand about things you should do to improve your health?" in Primary Care patient experience survey							

Our Pacific Children's Current Health Status

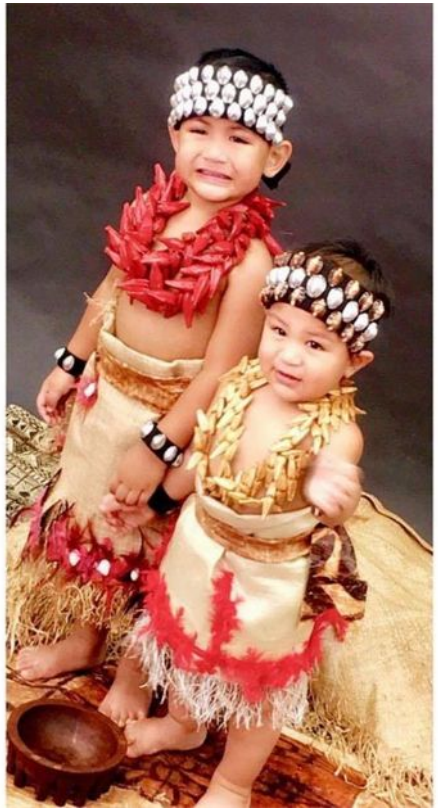
92% fully vaccinated at 8 months old (target 95%)

69 children under the age of 5 hospitalisations related to housing conditions

42% living in smoke-free households. Which means 58% are living NOT living in smoke-free households. (Target 54%)

32%
Enrolment rate in ECE

57%
Caries free at 5 years old. And 43% with caries.



48% (target ≥65%)
Pacific Pregnant Women are registered with a Lead Maternity Carer within the first Trimester. 30% less than Other ethnicities.

64%
Pacific children accessed Well Child Tamariki Ora and completed Core Checks by 1 years. 36% did not

High ASH Conditions for Pacific Children (0-4years)

Asthma, Dental conditions, Gastroenteristi/dehydration, Upper Respiratory Tract infections and Cellulistis

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

HUTT VALLEY DHB

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

Sub-Regional Pacific Strategic Health Group

Mr Fa'amatuainu Tino Pereira MNZM (Chairperson)

Mr Pereira currently the managing director of his company Niu Vision Group. Mr Pereira continued to play leadership roles across Pacific Island communities. These roles touch on core dimensions of Pacific Island community life, social, economic, ecumenical and demographic. He has been involved in many forums raising and developing critical issues affecting Pacific and wider health sector. He has over 20 years of chairmanship and participation in many public sector and community organisations. Mr Pereira currently holds the chairmanship for the Pasefika Healthy Home Trust, Ministry of Social Development Pacific Advisory Forum, Pacific Business Trust, Council of Pacific Collectives, and Pacific Panel for Vulnerable Children and Central Pacific Trust

Reverend Tavita Filemoni

Mr Filemoni has strong links with Pacific communities in particular his links with the Wellington Region Samoa Council of ministers and community leaders and secretary of the Wellington Samoan Ministers Fratenal will be instrumental in linking in with Pacific people who attend Pacific churches.

Dr Sunia Foliaki

Dr Foliaki currently working as a Research officer with the Centre for Public Health Research at Massey University since 2002 and has been involved in health research and review of various aspects of New Zealand health topics and issues. Dr Foliaki's PHD research on the prevalence of asthma amongst Pacific people in Tonga, Fiji, Samoa, Cook Islands, Niue, Tokelau. He is the Regional Coordinator for Oceania International study of asthma and allergies. Dr Foliaki's links to the Pacific communities is through the chairperson of the Tongan Cancer Society, Tongan church and community, social activities.

Dr Margaret Southwick

Dr Margaret Southwick, of Porirua, received the Queen's Service Medal on 25 March 2009 for services to the Pacific Islands community. Dr Southwick has been involved with the health of the Pacific Islands community in Wellington for many years. She was instrumental in the establishment of the Pacific Health Research Centre and School of Pacific Health Education at the Whitireia Community Polytechnic. She is the lead researcher for Searching for Pacific Solutions: a Community-Based Joint Intervention Project of the Ministry of Health, the Health Research Council, the Alcohol Advisory Council and ACC. She is a member of the Pacific Research Advisory Committee and the Health Workforce Advisory Committee of the Ministry of Health. Dr Southwick is a councillor of the New Zealand Nursing Council, where she helped to develop the Making Waves Pacific Community Sexual Health Trainers Programme.

Dr Alvin Mitikulena

Dr Alvin Mitikulena is a Director of the Kilbirnie Medical Centre of which is run by the Mitikulena family. He is of Niuean and Samoan descent. Dr Mitikulena is an active member of the Pacific community. The Kilbirnie Medical Centre were recent winners of the Clinical Excellence Award based on patient initiative pilot based on Cardiovascular Risk Assessment for high needs patients.

Sandhaya (Sandy) Bhawan (RegPharmNZ, FPS), BSc, BPharm (Hons), PGCertPhcy

Born and raised in Fiji, Sandy is a fourth generation Fiji Indian who now resides in Te Awakairangi (the Hutt Valley) in Wellington New Zealand, with her husband and their two beautiful children.

She is the Principal Adviser for the Access Equity team at PHARMAC Te Pātaka Whaioranga, the pharmaceutical Management agency for New Zealand. In this role she gives effect to PHARMAC's bold goal which is to eliminate inequities in access to medicines, and is the lead author of PHARMAC's recent publication on *Achieving medicine access equity in Aotearoa: towards a theory of change.* In her current role Sandy is also providing quality improvement advice and support to the Health Quality & Safety Commission's Whakakotahi 2019 medicine access equity projects.

Te Hau Winitiana

Te Hau is a performing artist, dance teacher and choreographer of pacific dance, and currently the director and co-creator of Pacifit Group Limited, Artistic Director of Inano Dance Company and School. Winitana is a qualified group fitness instructor who delivers Community group fitness program Hula Active. A dance based group fitness class that is currently being delivered to Lower Hutt and Porirua communities since 2013.

In 2015, Cook Islands dance tutor for the KIWI DANCE programme offering Cook Islands dance and Siva Samoa workshops in High Schools and tertiary institutions. Relieving Cook Islands dance tutor at Whitireia Performing Arts Programme and assistant tour director/seasoned performer for Whitireia Performing arts group. Te Hau completed a Bachelor of Applied Arts in performing arts from Whitireia NZ. As a student from 2010 – 2012, Te Hau has toured extensively performing nationally and internationally during her 6 year career as a performing artist and choreographer.

Pati Umaga

Pati Umaga is a disability advocate and the current chair National Enabling Good Lives Leadership Group. He sits on a number of boards and advisory groups involved with the UNCRPD, NZDS and the Disability Action Plan. He is passionate in advocating for all people with disabilities and has a particular interest for Pasefika disabled community and leadership. He is also a musician and in 2015 received an Arts Access Leadership Award for the release of his music video SIVA (Dance).

Merivi Tiai

My name is Merivi Tiai. I am a youth representative on the Sub Regional Pacific Strategy Advisory Group. I graduated from the University of Otago in 2016 with qualifications in physical education and public health. I am inspired by a Samoan proverb *"O le ala I le pule o le tautua" – "The path to leadership is through service"* and see this role as an opportunity to serve my community. I hope that in my time here I will be able to positively impact the status of pacific health and wellbeing, particularly for young people throughout the wider Wellington region.

Kalo Kaisa

I am Tongan. I am a presbyter of Hutt City Uniting Congregations, Lower Hutt. I previously ministered at Mangere-Otahuhu, South Auckland Methodist multi-cultural parish for 6 years. I am involved with Wellington Tongan Leaders Council and work together with Tongan ministers of different denominations.

Adi Elisapeci Samanunu Waqanivala

Currently runs her own company as Managing Director of Grow Vuna Initiatives Limited which researches Indigenous Knowledge in the Pacific using her home District as a Case Model. Elisapeci serves as Deputy Chair for Wellington Pacific Leaders Forum. She chairs the Fijian Language Society and works as an Interpreter for Interpreting New Zealand.

She also serves as a Board Member with Interpreting New Zealand and does Fijian Language Translation works. Successfully completed her Masters in Strategic Studies with specific focus on Political Science and International Relations at Victoria University in Wellington. Is a professional member for Royal New Zealand Society. Major interests to see Health Data in particular; Ethnicity Classifications and Statistics of Pacific Peoples in Aotearoa designed and captured accurately.

3DHBs Sub Regional Pacific Strategic Health Group

TERMS OF REFERENCE

October 2015

1. Purpose

The 3DHBs Sub Regional Pacific Strategic Health Group (SRPSHG) will assist the 3 DHBs by:

- Providing high level strategic advice to the Boards regarding Pacific health issues and solutions;
- Informing the DHBs of the issues and barriers that are impacting on Pacific health such as access and utilisation of health services;
- Ensuring that projects and services for Pacific peoples are well linked to Planning & Funding processes
- Strengthening the relationship and rebuilding trust between the DHBs and Pacific communities;
- Providing an in-house monitoring role for health outcomes for Pacific people in both areas;
- Follow up decisions made by the Board of Governance in reference to Pacific Health;
- Providing a dedicated channel to the Pacific community in the district;
- Providing appropriate Pacific cultural advice.

2. Role

The 3DHBs SRPSHG will:

- Provide relevant input into the development of Pacific project plans;
- Carry out and achieve its purpose and role in a collaborative manner within the agreed timeframe;
- Work in partnership with the DHBs Pacific Health Directorates in the development of a direction for sustainable health services for Pacific peoples in the Wellington region;
- Work in partnership with Pacific communities to address their needs regarding accessible health services;
- Reach agreement by consensus on the support and advice to the three boards;
- Be accountable to the Boards of the 3 DHBs;
- Monitor how both 3DHBs respond to the needs of Pacific people in both areas through DHB reports on milestones as set out in the District Annual Plans, Regional Service Plans, Health Targets, Health Needs Assessments and PHO Performance Programme.

3. Membership

The SRPSHG will consist of individuals who:

- Have applied and supported by their community or have demonstrated relevant skills and links to their communities;
- Have a clinical background;
- Have knowledge of the health and other sectors;
- Have governance, strategic and policy skills;
- At least two member of the group will represent youth; and

- Have knowledge of the disability sector.

In attendance

- Pacific Health Director- Pacific Directorate C&CDHB;
- Pacific Health Director – Hutt Valley & Wairarapa DHBs;
- Chair of both DHBs and CEOs to be ex-officio.(We recommend 6 monthly);
- PHOs Pacific Representatives to be ex-officio.

Others may be invited to attend and/or be co-opted onto the RSPHG as required.

4. Meeting Frequency

The 3DHBs SRPSHG will meet bi-monthly alternating between HVDHB and C&CDHB venues.

5. Term of Appointment

Appointment to the 3DHBs SRPSHG will be for two years term unless otherwise agreed.

6. Chair and Deputy Chair

The Board chairperson of C&CDHB, HVDHB and WDHB will appoint the Chair and Deputy Chair. The position of Chair and deputy chair will be for two years.

7. Member Responsibilities

Members of the SRPSHG will:

- Participate in a professional, open, honest and mature manner;
- Respect the view of others;
- Abide by the decisions of the SRPSHG;
- Ensure confidentiality of all information gained as a SRPSHG member;
- Be actively involved in community consultation;
- Commit to their purpose and undertake the necessary preparatory work to fulfil their role;
- Not allow any personal agenda to influence contributions or decision-making, or use the role to advance their interests;
- Assist the 3DHBs in their aims to improve the health status of the Pacific people.

8. Secretariat Support

The administration of the SRPSHG will primarily be the responsibility of the C&CDHB HVDHB & WDHB Pacific Directorates. A draft agenda and relevant meeting papers will be circulated to members of the SRPSHG at least seven days prior to a meeting date. Payment of members will be in accordance with standard policy.

11. Reporting

The Chair will report to the 3DHBs Boards bi -monthly, outlining its achievements against the work programmes, against its functions (to be determined) and any issues identified by the group that is relevant to improving services to the Pacific community for the DHBs to consider;

SRPSHG representatives on the DHBs sub committees to report issues to those committees and will be required to report sub committee decisions back to the SRPSHG.

12. Performance Review

Qualitative collection of

- Feedback from members of the group;
- Feedback from the Chairperson and Board members and CEOs;
- Consider the achievement of the work programme and key milestones;

Quantitative measurement of

- Attendance rates.

13. Quorum

More than half of the members of the group must be present for the group to have a quorum.

14. Non attendance

If a SRPSHG member is absent from three consecutive meetings, with or without an apology, their membership on the group will be forfeited and the Chair may announce a vacancy.

15. Vacancies

When the Chair announces a vacancy on the group, the Chair and the C&CDHB & HVDHB & WDHB Pacific Health Directors have the discretion to appoint a replacement for the reminder of the vacant term.

16. Payment

The remuneration for this group will follow the guidelines for C&CDHB and HVDHB External committee members' fees and expense reimbursement Policy, which align with SSC Guidelines.

17. Confidentiality

Unless otherwise required by law or mutually agreed to, the parties will keep all information acquired as a result of this partnership in confidence. Breach of confidentiality will result in disciplinary action according to the C&CDHB and HVDHB Code of Conduct under Serious Misconduct and the State Services Commission Code of Conduct – First Principle: Release of Official Information

18. Conflict of Interest

The SRPSHG shall develop a Conflict of Interest register, which will be continuously reviewed and updated at its monthly meetings.

Capital and Coast DHB and Hutt Valley DHB

CONCURRENT Board Meeting

Meeting to be held on 3 December 2020

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, commercial and industrial negotiations.
Report from Chair – Part II.	As above	As above
Report from Chief Executive – Part II.	As above	As above
CCDHB Quality and Safety Report	As above	As above
HVDHB Quality and Safety Report	As above	As above
MHAIDs Quality and Safety Report	As above	As above
CCDHB Serious Adverse Event Report 2019-20	As above	As above
HVDHB Serious Adverse Event	As above	As above

Report 2019-20		
Staff Health and Safety Reports	As above	As above
People, Culture and Capability Update	As above	As above
HVDHB October 2020 Financial and Operational Performance Report	As above	As above
CCDHB October 2020 Financial and Operational Performance Report	As above	As above
Annual Reports	As above	As above
Frailty Patient Story/Service Spotlight	As above	As above
2020 Progress and Performance 2021/22 Draft Work Programme	As above	As above
Destravis Strategic Infrastructure Brief	As above	As above
Quarterly Digital Report	As above	As above
Clinical Workspace	As above	As above
Change Request Cardiac Theatre Lights and Pendants Project	As above	As above
Dental Digital Imagery Project	As above	As above
HVDHB Procedure Suite Proposal	As above	As above
BSB Licence to Occupy Agreement for e-bike storage facilities	As above	As above
HVDHB Radiology Department Mobile X-ray Machines	As above	As above
Relationship Agreement with Medical Research Institute of New Zealand	As above	As above
WRH Copper Pipe Replacement Main Works RFP	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.