PUBLIC

HUTT VALLEY DHB / Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**AGENDA v.2** Held on Wednesday 3 March Location: **Hutt Hospital, Level 1, Clock Tower Building, Auditorium Room** Zoom: **876 5068 1844** Time: **9.30**am
	MEETING

	Item	Action	Presenter	Min	Time	Pg
1	**PROCEDURAL BUSINESS**					
1.1	Karakia		All members	15	9:30am	
1.2	Apologies	**ACCEPT**	Chair			
1.3	Public Participation - Nil	**VERBAL**	Public			
1.4	Continuous Disclosure 1.4.1 Combined Board Interest Register	**ACCEPT**	Chair			
	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	9:45am	
2	**DHB Performance and Accountability**					
2.1	HVDHB October 2020 Financial and Operational Performance Report 2.1.1 Report	**NOTE**	Chief Financial Officer Director Provider Services	10	10.05am	
2.2	CCDHB October 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**	Chair of HSC	20	10.15am	
4	**OTHER**					
4.1	General Business	**NOTE**	Chair	5	10.35am	
4.2	Resolution to Exclude the Public	**ACCEPT**	Chair			

11:00 am - MORNING TEA – 15 min

DATE OF NEXT FULL BOARD MEETING:

7 April 2021, Zoom: 876 5068 1844, Location: Wellington Regional Hospital, Level 11 Boardroom Grace Neil Block

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

22/02/2021

Name	Interest
Mr David Smol *Chair*	• Director, Contact Energy • Director, Viclink • Director, New Zealand Transport Agency • Chair, New Zealand Growth Capital Partners • Independent Consultant • Sister-in-law is a nurse at Capital & Coast District Health Board
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 • Staff seconded to Health and Disability System Review • Contact with Associate Minister for Health, Hon. Peeni Henare
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	• 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
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 • Member, Hutt Valley District Health Board • Daughter is a Lead Maternity Carer in the Hutt
John Ryall	• Member, Social Security Appeal Authority • Member, Hutt Union and Community Health Service Board • Member, E tū Union
Naomi Shaw	• Director, Charisma Rentals • Councillor, Hutt City Council • Member, Hutt Valley Sports Awards • Trustee, Hutt City Communities Facility Trust
Vanessa Simpson	• Director, Kanuka Developments Ltd • Executive Director Relationships & Development, Wellington Free Ambulance • Member, Kapiti Health Advisory Group
Dr Richard Stein	• Visiting Consultant at Hawke's Bay DHB • Chairman and Trustee, Crohn's and Colitis NZ Charitable Trust • Member, Executive Committee of the National IBD Care Working Group

	• Member, Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy • Clinical Senior Lecturer, University of Otago Department of Medicine, Wellington • Assistant Clinical Professor of Medicine, University of Washington, Seattle • Locum Contractor, Northland DHB, HVDHB, CCDHB • Gastroenterologist, Rutherford Clinic, Lower Hutt • Medical Reviewer for the Health and Disability Commissioner

CAPITAL & COAST AND HUTT VALLEY DISTRICT HEALTH BOARDS

Interest Register

EXECUTIVE LEADERSHIP TEAM

3 MAR 2021

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
Saira Dayal *ACTING HVDHB General Manager Quality, Service Improvement and Innovation*	•
Arawhetu Gray *2DHB 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
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 *2DHB 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
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
Declan Walsh *2DHB Director People, Culture and Capability*	• None
Sarah Jackson *ACTING CCDHB Executive Director, Quality Improvement & Patient Safety*	•
Junior Ulu *2DHB Director Pacific People's Health*	•

BOARD MEETING **PUBLIC**

	MINUTES Held on Thursday 3 December Location Helen Smith Community Meeting Room, Pātaka, Cnr Norrie & Parumoana streets, Porirua Zoom link: **889 4061 3779** Time: 9am
BOARD MEETING	**PUBLIC**

IN ATTENDANCE

David Smol	Chair, Hutt Valley and Capital & Coast DHBs		
Dr Kathryn Adams	Board Member	Josh Briggs	Board Member
Dr Tristram Ingham	Board Member	Yvette Grace	Board Member
Sue Kedgley	Board Member	Ken Laban	Board Member
Vanessa Simpson	Board Member	Prue Lamason	Board Member
Hamiora Bowkett	Board Member	Naomi Shaw	Board Member
		Dr Richard Stein	Board Member
		Keri Brown	Board Member
		John Ryall	Board Member
		Wayne Guppy	Deputy Chair

APOLOGIES

'Ana Coffey, Roger Blakeley and Chris Kalderimis

IN ATTENDANCE

Hutt Valley and Capital & Coast DHB	
Fionnagh Dougan	Chief Executive
Rachel Haggerty	Director Strategy, Planning and Performance
Joy Farley	Director Provider Services
Rosalie Percival	Chief Financial Officer
Helen Mexted	Director of Communication and Engagement
Christine King	Director Allied Health
Tracey Voice	Chief Digital Officer
Amber Igasia	Board Liaison Officer
Tofa Suafole-Gush	Director Pacific People's Health
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
Jenny Langton	General Manager Commissioning Older Adults and Primary Care
HVDHB	
Debbie Gell	General Manager, Quality Service Improvement and Innovation

BOARD MEETING **PUBLIC**

1 PROCEDURAL BUSINESS

1.1 KARAKIA

Tristram Ingham 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 – CCDHB STAFF PETITION, CAR PARKING

A CCDHB staff petition against fee increases for car parking was presented to the CCDHB Board. The presenter noted concerns on behalf of staff regarding the car parking situation at CCDHB. They specified concerns for the impact to lower wage staff, the lack of car parking spaces and the potential of added stress to an already stressful issue. Management noted there is extensive working underway to address the car parking situation and acknowledged the complexity that is faced due to location and demand. The DHB is working with the Greater Wellington Regional Council on potential public transport solutions however, it was noted the situation would require a suite of options which will have a range of impacts depending on what is proposed. No changes to fees had been made nor were planned in the immediate future and solutions to the broader car parking issue is still in progress.

A question was raised by the Board whether payment of parking fees guaranteed a park and it was noted this is not the case. Car parking demand fluctuates during any week but it has been noted that times of highest demand are around midday on Tuesday and Thursday, potentially due to outpatient appointments.

ACTION: Management to bring to the CCDHB Board a paper on what the issues are and the potential options available to a CCDHB Board only session in April at the earliest. Include likely cost, impact and taking into account equity. Hutt Valley Board will remain informed.

ACTION: Management to bring to Board a paper on the long term Climate Emergency Response Plan.

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	Prue Lamason	Naomi Shaw
CCDHB	Kathryn Adams	Sue Kedgley

1.6 MATTERS ARISING FROM PREVIOUS CONCURRENT MEETINGS

Nil

1.7 CHAIR'S REPORT AND CORRESPONDENCE

BOARD MEETING **PUBLIC**

The Chair noted the following in his verbal update:

- Appreciate the willingness of the two Board to support the continued operation as a concurrent larger Board.
- Thanked the Chief Executive and the DHB team for the support of the Boards over the past year with the added challenge of COVID-19.
- Looking forward with hope for the vaccination programmes.
- Wished everyone a COVID free and enjoyable break.

1.8 CHIEF EXECUTIVE'S REPORT

The Chief Executive report was noted and the Chief Executive thanked those members who had attended the excellence awards.

1.9 BOARD WORK PLAN 2020

The work plan was received and feedback is to be sent to the Board Liaison Officer. It was noted that there is work underway to shift the balance in the meeting to spend more time of substantive issues while also maintaining their monitoring role as governors. It was also noted that the Health System Review will likely bring about changes in 2021 and the plan will need to remain flexible for the year to come. It was also noted the Māori Partnership Board of CCDHB and the Iwi Relationship Board of HVDHB are discussing their future and how local iwi wish their structure for engagement with the DHBs to look and collaboration with one another.

A question was raised about the HVDHB Consumer Council and the CCDHB Citizen's Health Council. It was noted the CCDHB Citizen's Health Council has decided to disband as they believe the model of engagement with the DHB should be different. The change would mean consumer engagement would be specific to the project as they will have differing needs and key community groups for their area of focus. The members will continue to remain connected to the DHB. Management noted the DHBs are keeping these consumer groups engaged and noted a paper will be coming about the work agreed with the HVDHB Consumer Council.

ACTION: Board requested the HVDHB Consumer Council attend a meeting with the Hutt Board members only.
ACTION: Management to bring the engagement plan looking at alternative strategies back to the Board once complete.

2 DHB PERFORMANCE AND ACCOUNTABILITY

2.1 HVDHB SEPTEMBER 2020 FINANCIAL AND OPERATIONAL PERFORMANCE REPORTS

This report was taken as **READ.**
The Hutt Valley DHB Board noted:

(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.

	Moved	Seconded
HVDHB	John Ryall	Yvette Grace

ACTION: Maternity Deep Dive brought to the Board with Clinicians to attend.

2.2 CCDHB SEPTEMBER 2020 FINANCIAL AND OPERATIONAL PERFORMANCE REPORTS

This report was taken as **READ.**
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.

	Moved	Seconded
CCDHB	Kathryn Adams	Sue Kedgley

3 UPDATES

3.1 2DHB HEALTH SYSTEM COMMITTEE (HSC) UPDATE

Presenter: Chair of Health System Committee

The Boards noted:

(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.

ACTION: Board requested a Deep dive on Rheumatic Fever to be in the 2021 workplan.

3.2 EQUITY DEFINITION, GOAL AND PRINCIPLES

Presenter: Director of Māori Health

The Boards approved:

(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 noted:

(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.

ACTION: Rachel to follow up with DSAG on consultation.

	Moved	**Seconded**
HVDHB	Yvette Grace	Keri Brown
CCDHB	Kathryn Adams	Vanessa Simpson

3.3 ALIGNING WHAKAMAUA: MINISTRY OF HEALTH MĀORI ACTION PLAN WITH TE PAE AMORANGI AND TAURITE ORA

Presenter: Director of Māori Health

The Boards noted:

(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.

	Moved	**Seconded**
HVDHB	Prue Lamason	Keri Brown
CCDHB	Kathryn Adams	Sue Kedgley

3.4 PACIFIC HEALTH REPORT

Presenter: Director of Pacific Peoples Health

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.

3.5 3DHB SUB-REGIONAL PACIFIC STRATEGIC HEALTH GROUP (SRPSHG) UPDATE

Presenter: Chair of SRPSHG

The Chair of the Sub-Regional Pacific Strategic Health Group opened by wishing everyone a Merry Christmas on behalf of the group. Feedback was noted that it had been a difficult year with sporadic interaction with the Boards, recognising the impact of the COVID-19 pandemic response. The Chair noted the comprehensive engagement with the community for the Pacific Health & Wellbeing Strategic Plan for the Greater Wellington region and looked forward to seeing members of the Boards at the launch that evening.

4 OTHER

4.1 GENERAL BUSINESS

4.2 RESOLUTION TO EXCLUDE THE PUBLIC

	Moved	**Seconded**
HVDHB	Wayne Guppy	Naomi Shaw
CCDHB	Kathryn Adams	Sue Kedgley

5 NEXT MEETING

Wednesday, 3 March 2021. 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

MATTERS ARISING LOG

Action Number	Date of meeting	Due Date	Assigned	Status	Date Completed	Meeting	Agenda Item #	Agenda Item title	Description of Action to be taken	How Action to be completed
20-P0010	3-Dec-20	7-Apr-21	Chief Financial Officer	NEW		Board - Public	1.3	**PUBLIC PARTICIPATION – CCDHB STAFF PETITION, CAR PARKING**	Management to bring to the CCDHB Board a paper on what the issues are and the potential options available to a CCDHB Board only session in April at the earliest. Include likely cost, impact and taking into account equity. Hutt Valley Board will remain informed.	In progress
20-P0011	3-Dec-20	5-May-21	Chief Financial Officer	NEW		Board - Public	1.3	**PUBLIC PARTICIPATION – CCDHB STAFF PETITION, CAR PARKING**	Management to bring to Board a paper on the long term Climate Emergency Response Plan.	In progress
20-P0012	3-Dec-20	3-Mar-21	Board Secretary and ELT	NEW - Complete	3-Mar-21	Board - Public	1.9	Board Work Plan 2020	Board requested the HVDHB Consumer Council attend a meeting with the Hutt Board members only.	Attending 3 Mar 2021 meeting
20-P0013	3-Dec-20	TBC	Director Communications and Engagement	NEW		Board - Public	1.9	Board Work Plan 2020	Management to bring the engagement plan looking at alternative strategies back to the Board once complete.	Once completed will be brought to Board
20-P0014	3-Dec-20	3-Mar-21	Board Secretary and ELT	NEW - Complete	3-Mar-21	Board - Public	2.1	HVDHB FINANCIAL AND OPERATIONAL PERFORMANCE REPORTS	Maternity Deep Dive brought to the Board with Clinicians to attend.	Attending 3 Mar 2021 meeting
20-P0015	3-Dec-20	3-Mar-21	Board Secretary and ELT	NEW - Complete	3-Mar-21	Board - Public	3.1	2DHB Health System Committee Update	Board requested a Deep dive on Rheumatic Fever to be in the 2021 workplan.	Workplan updated

Chief Executive's Report

Prepared by: Fionnagh Dougan, Chief Executive

1 Introduction

This report covers the period from 18 November 2020 to 22 February 2021.

2 COVID-19 Update

2.1 Local cases

Number of current cases: 3 (managed isolation guests)
Number of days without cases, HVDHB: 97
Number of days without cases, CCDHB: 104

2.2 Managed Isolation Facilities

Number of COVID-19 cases: 3 (in quarantine facility)
Number of guests (as of 23/02/2021): 52

- Bay Plaza: 20
- Grand Mercure: 32

2.3 Testing statistics

	2DHB	HVDHB	CCDHB
Tests performed to date	119,419	27,141	92,278
People tested to date	92,491	23,316	69,175
Testing coverage (based on people tested)	19.6%	15.4%	21.5%
Tests performed last week (15/02 – 21/02)	3,788	829	2,959
Test performed since 11 August (Auckland cluster)	76,355	15,318	61,037

Please note that CCDHB processes surveillance tests, while HVDHB does not. This means CCDHB processes a higher number of tests, and this may impact testing coverage.

2.4 Testing statistics by ethnicity (to 22/2/2021)

	2DHB		HVDHB		CCDHB	
	Māori	Pacific	Māori	Pacific	Māori	Pacific
Tests performed to date	12,866	8,944	4,076	2,384	8,790	6,560
People tested to date (based on people tested)	9,988	6,875	3,445	1,984	6,553	4,891
Testing coverage	20.5%	21.4%	17.1%	17.9%	23.0%	23.3%
Tests performed last week (15/02 – 21/02)	458	267	165	64	293	203
Test performed since 11 August (Auckland cluster)	7,453	5,708	2,121	1,473	5,332	4,235

3 Communications and Engagement

3.1 External engagement with partners and stakeholders

During the period I have met with the Wellington Mayoral Forum to discuss health equity issues, launched the Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020 - 2025 alongside the Minister for Pacific Peoples, and marked the establishment of the Kāpiti Community Health Network the first of its kind in the region, with Te Ātiawa ki Whakarongotai Trust Board, Tu Ora Compass and a large group of regional stakeholders.

As part of ensuring ongoing engagement with local leaders, I have organised upcoming meetings with Lower Hutt, Porirua and Kāpiti Mayors and Chief Executives, and Greater Wellington Regional Council's Chair and Chief Executive. We also have upcoming meetings with regional leaders from the Ministry of Social Development and Oranga Tamariki – Ministry for Children.

3.2 External communications and engagement

3.2.1 Proactive external news and story-telling

Over recent months, we have begun to increase our focus on proactive external news media and story-telling through highlighting strategies, services and work programmes in our DHBs, along with a continued focus on examples of where we are improving health outcomes for the people of our regions and celebrating the success of our people in delivering that – a sample of these stories is below and featured on following pages. Our annual Celebrating Success awards held in November have provided significant material for us to showcase.

As part of our wider strategic communications and engagement approach for the two DHBs, we are beginning to introduce a new content approach, using five 'content streams', to lift engagement with the people of our regions: DHB strategies, living well, services, people and health promotion. This content will be shared across our channels and where possible featured in external media.

DHB	Subject	Outlet / Channel
3DHB	Pacific Health	Announced an initiative to enabling Pacific church leaders to be trained to provide mental health support. www.ccdhb.org.nz/news-publications/news-and-media-releases/2020-12-14-pacific-church-leaders-providing-mental-health-support/
2DHB	Public health	Advised people to see their GP and pharmacist to ensure they have everything they need ahead of the holiday season. www.ccdhb.org.nz/news-publications/news-and-media-releases/2020-12-15-stay-well-over-the-holiday-season/
CCDHB	Sustainability	Highlighted new community gardens at Wellington Regional Hospital. www.ccdhb.org.nz/news-publications/news-and-media-releases/2020-12-17-community-gardens-grow-relationships/

CCDHB	Child health	Highlighted a physiotherapist's work to predict cerebral palsy in babies. www.ccdhb.org.nz/news-publications/news-and-media-releases/2021-01-21-physiotherapist-helps-predict-cerebral-palsy-in-babies/
CCDHB	Midwifery	Highlighted our midwifery team who provide care to women with complex needs. www.ccdhb.org.nz/news-publications/news-and-media-releases/2021-02-02-community-midwives-go-the-extra-mile-to-support-women/

Blessing opens the way for local renal dialysis treatment

A small blessing ceremony has paved the way for people across both the Hutt Valley and the Wairarapa to begin receiving renal dialysis treatment closer to home.

Kaumatua, patients, and staff gathered before sunrise this morning for a small ceremony to bless Te Whare Takihi mo te Katoa – the region's new satellite renal dialysis unit. Located at the Hutt Valley Health Hub adjacent to Hutt Hospital, the 16-chair unit will enable more than 50 patients to receive treatment locally without having to travel to Wellington Regional or Kenepuru Community Hospitals three times a week.

"Travelling to Wellington or Porirua three times a week, for around five hours of treatment, is a significant burden for many of patients – especially those from our more disadvantaged communities. Te Whare Takihi mo te Katoa will help ease some of that burden," said 2DHB Director of Provider Services Joy Farley.

"With around 470-490 dialysis treatments having been delivered weekly for most of this year in Wellington and Porirua, the new unit will also increase our renal dialysis capacity for the region and better position us to meet growing demand into the future."

Gifted by local kaumatua Hepetema Taitua and his wife Mate, the name Te Whare Takihi mo te Katoa reflects its status as a 'kidney dialysis unit for all'.

"Te Whare Takihi mo te Katoa is built around a culture of whanau, aroha, and manaakitanga for all people and resonates with the whakatauki that states 'he waka eke noa', or 'we're all in this together'," said 2DHB Director of Māori Health Arawhetu Gray.

"A high proportion of these patients are Māori and Pacific and the unit and service are designed to support everyone – regardless of ethnic, cultural, religious, socio-economic, or other background community – the access safe quality treatment and support closer to home."

New strategy illustrates DHBs' commitment to Pacific health

Members of the Niuean community greet Minister for Pacific Peoples and Associate Minister of Health (Pacific Peoples) Hon Aupito William Sio at the launch of the 3DHB 'Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020 to 2025'.

Launched by Minster for Pacific Peoples and Associate Minister of Health Hon Aupito William Sio, the 'Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020-2025' will guide local DHBs' – Wairarapa, Hutt Valley, and Capital & Coast – work with Pacific communities.

"This strategy plan illustrates the three DHBs' strong commitment to improving the health and wellbeing of Pacific peoples," said 3DHB Director of Pacific People's Health Tofa Suafole Gush.

"It was developed in partnership with Pacific community providers, the 3DHB Sub Regional Pacific Health Strategic Group – covering Wairarapa, Hutt Valley, and Capital & Coast – and involved staff from across the DHBs alongside service providers including Te Awakairangi Health Network, Compass Health, Regional Public Health, Pacific Providers, and other mainstream providers."

'Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020-2025' is based around six priorities – 'Pacific child health and wellbeing', 'Pacific young people', 'Pacific adults and ageing well', 'Pacific health workforce & Pacific providers/non-governmental organisations', 'social determinants of health', and 'a culturally responsive and integrated health system'.

"Due to COVID-19, this past year has been challenging for us all – however it has also emphasised the tremendous strength and unity of our Pacific communities working to support one another.

"Wairarapa, Hutt Valley, and Capital & Coast DHBs will ensure the priorities set out in our plan are embedded in our daily work as part of our ongoing commitment to taking a whole-of-system approach to achieve better health outcomes for Pacific peoples in our communities."

'Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020-2025' is available from the Wairarapa DHB, Hutt Valley DHB, and Capital & Coast DHB websites.

Physiotherapist helps predict cerebral palsy in babies

A neonatal physiotherapist at Wellington Regional Hospital's Neonatal Intensive Care Unit (NICU) has been awarded for implementing a tool to help diagnose infants at high risk of motor disabilities such as cerebral palsy.

Alison Sheppard (*pictured*) received the Clinical Excellence award at Capital & Coast DHB's annual 'Celebrating Our Success' awards for her work with the General Movements Assessment (GMA) – one of three tools which, used together, are considered best practice for early diagnosis of motor disability.

"The GMA involves taking video footage of an infant's movements at specific ages – pre-term, term, and around 12 weeks – which are then scored by a specially trained team," Alison said.

"The patterns of movement quality over time provide us with information about how the infant's brain is developing."

It is recognised that early diagnosis and intervention – such as intensified physiotherapy – for infants at a high risk of motor impairment can change the trajectory of disability and result in better outcomes. Providing family support and active involvement in a child's treatment is also key.

"The earlier we support optimal movement and interactions, the more we can support quality of life opportunities. It is a privilege to work with our babies and their families during the initial stage of their developmental care journey."

Alison was one of several CCDHB people trained to use the tool to assess infants in 2018. She then began the GMA set-up process, which involved collaboration with medical colleagues and teams across the 3DHBs including the ICT and legal teams.

Thanks to the work of Alison and her colleagues, GMA is now used routinely in Wellington's NICU. Alison co-authored of a recently published article in the New Zealand Medial Association Journal describing the GMA implementation process, which will help other DHBs to set up similar processes.

Local clinicians recognised for COVID-19 leadership

Two local clinical leaders have been recognised and celebrated for their tireless efforts to respond to the COVID-19 pandemic that has dominated the health landscape this year.

Hutt Valley DHB (HVDHB) and Capital & Coast DHB (CCDHB) recently held their Ngā Tohu Angitu/Celebrating our Success Awards ceremonies, which saw HVDHB Infection Prevention & Control clinical lead Dr Matt Kelly receive the Outstanding Leadership award, and CCDHB Infection Services clinical lead Dr Michelle Balm receive the Chief Executive's award.

"It was an unexpected honour to be chosen from all the amazing work done this year," said Michelle who, as clinical lead for the 3DHB Incident Management team, provided technical advice on infection prevention and clinical management of COVID-19.

"We worked with the clinical teams to develop fit-for-purpose processes to screen and manage patients, and minimise risk to staff. Meanwhile, our lab team developed and scaled up COVID-19 lab testing. My role in each of these areas was mostly enabling others to get on and do their jobs.

"I'm proud of the way people pulled together. Every service across the two DHBs stepped up, adapted, and got on with the job."

Matt agreed that teamwork was at the heart of the DHBs' COVID-19 response.

"A huge amount can be achieved very quickly when everyone is working together for a common goal," said Matt, who was also clinical lead for the HVDHB Emergency Operations Centre.

"The hard work was really done by the others in the Infection Prevention & Control team, the COVID-19 response team, and the frontline services – much of my role was about keeping staff informed, listening to feedback and providing advice."

Both agree, however, that there is always more to learn. With COVID-19 likely to be a key part of the country's health landscape for months to come, the work continues.

Regional Public Health awarded for COVID-19 pandemic response

As the Public Health Unit for Capital & Coast, Hutt Valley and Wairarapa DHBs, the team at RPH were "delighted and humbled" to be recognised for their achievements on the back of a demanding 2020. "Absolutely everyone within RPH stepped up during the initial COVID-19 response. To then keep this momentum and energy going throughout the year as we continued our preparations to improve and refine our processes in anticipation of further cases, has been a phenomenal effort from our team. I am so proud to lead this gifted and passionate group of people," said Peter Gush, RPH General Manager.

Through a stream of media reports and daily media stand-ups, as a nation our collective knowledge of COVID-19 has grown immensely. It is hard to believe that the acronym 'COVID-19' didn't even exist in January. Prior to New Zealand going into lockdown, similarly, there was a somewhat unknown element to what RPH staff might be confronting on any given day.

"We had staff meeting international flights at 1am, to health screen passengers and facing that unknown possibility that passengers from that flight may have COVID-19. It's actually pretty inspiring when I think about the attitude and commitment our team displayed at that time – to prioritise the health of our communities above all else," said Peter.

"The Awards are a credit to the whole RPH whānau and what we were able to achieve for our communities. I think it also allows us to reflect on how far we've come. We're certainly enhanced our collaborative abilities as a workforce and strengthened our relationships with our communities and agency partners," said Peter.

While most awards typically recognise past achievements, the team at RPH were heartened by the acknowledgements they received at the ceremony, that for them the work continues. While 2020 has been a year many may struggle to reflect on with much positivity, RPH can certainly take heart that the events of this year have bolstered their ability to respond to future events like COVID-19, and help protect the health of our communities in general.

New community health network established for Kāpiti

Capital & Coast and Hutt Valley DHBs' joint Chief Executive Fionnagh Dougan and joint Board Chair David Smol today announced the establishment of a community health network for Kāpiti –a collaboration of health providers with an interest in improving the health and wellbeing of the local population and achieving equitable health outcomes.

The announcement is a significant step forward for Kāpiti healthcare services, and builds on the strong partnerships and good work already happening in the region.

"Community health networks are all about partnerships and relationships. Within a network, providers work together to coordinate and organise health service delivery to achieve shared goals and improve the health needs of the local population," said Fionnagh.

"Kāpiti is the first network to be established in our region. Impacting on equity of health outcomes will be an expectation in all that the network does, and its development will inform how we approach networks in other areas."

Te Ātiawa ki Whakarongotai, CCDHB, and Tū Ora Compass Health will develop and implement the network in partnership with other health providers – including GPs, community pharmacists, Aged Residential Care facilities, home and community support services, and NGOs.

"We cannot succeed without strong and trusting partnerships. They facilitate and drive more care in the community, and provide a local mechanism to organise health service delivery where people need it when they need it."

Almost 100 people, from healthcare providers to potential users of the service, attended the network launch at Paraparaumu's Southward Car Museum today.

"A lot of good work is already underway in Kāpiti, and there are many established connections and collaborations. We have built a strong foundation through the Health Care Home programme, which has strengthened primary care across the district. Networks will build off the strengths of the achievements of the Health Care Homes."

Ora Toa and Partners Porirua – our new partners in health services for young people

CCDHB Strategy, Planning & Performance (SPP) is the directorate charged with commissioning community health services and Director Rachel Haggerty says the investment in youth services for Porirua is well overdue.

“The YOSS is part of our commitment to improving services and outcomes for youth in Porirua. Our commitment is to outcomes, but it is the youth of Porirua who have defined what they need and want from their health service”.

General Manager Families and Wellbeing Rachel Pearce said the YOSS was designed by Porirua rangatahi and the procurement was led by a youth panel who call themselves #YouthQuake.

“All decisions in the process were supported by #YouthQuake – from writing the formal tender documents, to forming the evaluation panel, to #YouthQuake asking questions directly to applicants. CCDHB worked with the #YouthQuake panel to co-design a youth-friendly approach to Government procurement, which included ‘reading parties’ to go through the procurement documents, and using presentations and performances to support traditional written stages of the procurement process.”

#YouthQuake panel members held the balance of power in the ultimate decision on who would be the future provider for the YOSS. They made up four out of the six panel voting members and there were two non-voting members from #YouthQuake as well.

Rachel Pearce said Ora Toa and Partners Porirua partnered with a range of Porirua health and social care providers in a way that showed they really understand what a service needs to include to be successful for rangatahi.

“Their bid featured a performance delivered by rangatahi that showed the #YouthQuake how the YOSS would look and feel if they were awarded a contract.”

The presentation followed a young woman’s journey and her experience at a mainstream GP service where her name was mispronounced and she was sidelined as staff spoke to her mother about her care, rather than her directly.

“Throughout the presentation she wore message boards that showed how she was feeling inside… ‘no one understands’, ‘I can’t be me’, ‘I am ashamed’, ‘no one hears me’, ‘I am unnoticed’.

“After finding out about the YOSS she goes there and finds a bright place where she is welcomed, her name is pronounced correctly and they ask if she goes by any other name. One by one over the

interactions with staff and peers at the YOSS the message boards are taken away. 'That looks heavy, let me take that for you'."

The Ora Toa and Partners Porirua presentation also demonstrated the tuakana-teina approach the future service would adopt, including to support a new youth-led board to govern the service.

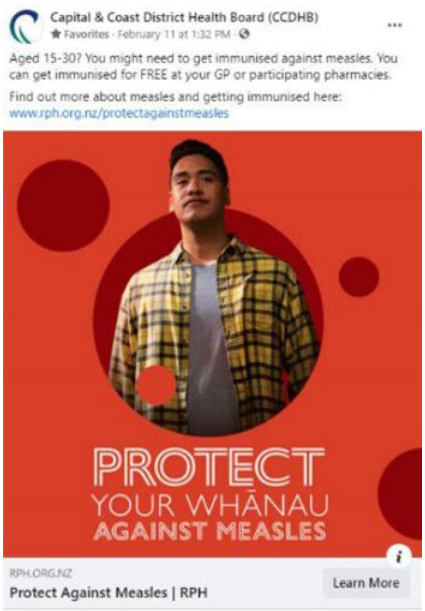
"The co-design approach to procurement and valuing the expertise of rangatahi have ensured that rangatahi in Porirua will immediately feel a connection with their YOSS," said Rachel.

CCDHB will continue to work with the #YouthQuake panel to design the contract for the new service, which is expected to be executed in late January 2021.

3.3 Health promotion campaigns

3.3.1 Measles

The 2019 Measles Outbreak in which 2,185 cases of Measles were detected, highlighted the equity gaps in age, ethnicity, deprivation and region. The immunity gap is highest in people who are 15-30 years of age, Māori and Pacific populations and people living in deprivation quintiles 4 and 5.



Our DHBs are adopting a 'simplify and intensify' approach to delivering the campaign by managing a central communications and engagement plan to support the services in primary care and pharmacies, and intensifying our engagement with priority groups less likely to engage in primary care services.

The team is working alongside health providers and our young people experts to engage with priority groups including Māori, Pacific and rangatahi living in areas of high deprivation.

Youth One Stop Shops (YOSS) are key to improving immunisation rates in this age bracket as they are experts in Youth Engagement; understand the barriers for Māori, Pacific and other priority populations; and provide holistic integration into other youth services. They will use mobile and pop up models to go where young people are and will use the MMR campaign as an opportunity to engage young people in their health and wellbeing.

The national campaign runs through until September 2021.

3.3.2 COVID-19

In the lead up to the 'Make Summer Unstoppable' campaign, RPH created key messages for event organisers. WREMO assisted us with the distribution of these key messages to reach all local councils to then distribute to event organisers. We partnered with Atiawa Toa radio to co-author key messages for our Māori communities, and Catalyst Pacific for our Pasifika communities.

- Event organisers - key messages
- Event organisers - key messages - Pasifika
- Kia haumaru i ēnei hararei

3.3.3 #ProtectOurWhānau

A new campaign has been launched on our social media channels, encouraging whānau to be well, stay well and live well.

The #ProtectOurWhānau, #TiakiWhānau campaign is the result of collaboration between CCDHB Māori Health Development Group and 2DHB Communications team. The messages about wellbeing and family connection speak to the whānau collective as well as members of a whānau or hapori (community).

3.4 Social media and news stories

CCDHB impressions	HVDHB impressions	RPH impressions
	Facebook: 445,153 Hutt Maternity Facebook: 42,175 Twitter: 35,231 Instagram: 15,831 LinkedIn: 37,861	Facebook: 39,324

Top Social Media posts

Capital & Coast District Health Board (CCDHB)
Favorites · January 26 at 11:18 AM ·

Welcome to our latest cohort of new gradate nurses! The Nurse Entry to Practice Programme (NETP) accommodates NETP graduates both within the hospital and primary care settings.

Find out more >> https://www.ccdhb.org.nz/.../first-year-of-practice.../

274 27 Comments 10 Shares

Hutt Valley District Health Board
January 22 at 1:19 PM ·

A big welcome to our latest group of new graduate nurses, who started at Hutt Hospital through the Nursing Entry to Practice (NETP) Programme this week!

332 61 Comments 4 Shares

Regional Public Health is with Shirley Pierce.
Published by Regional Public Health · 27 November 2020 ·

Wow! Last week RPH were awarded for our COVID-19 pandemic response at the Ngā Tohu Angitu | Celebrating Success Awards! While the work continues for us, we're hugely grateful to receive this acknowledgement! We are also highly appreciative of all the positive comments and recognition we received from our DHB friends and the wider health communities at the ceremony. Thanks everyone! Check out the full write-up here: https://bit.ly/36bcD4R

Hutt Valley District Health Board
November 27, 2020 ·

This morning we were excited to bless our new satellite renal dialysis unit in the Hutt Valley which, from next week, will mean Hutt Valley and Wairarapa patients will not have to travel all the way to Wellington and Porirua for treatment.

Read more: https://bit.ly/2V54V5V.

383 43 Comments 8 Shares

3.5 Website page views and stories

Our visits statistics are below along with the most commonly visited pages. Website banners (featured below) as well as feature stories continue to be a strong source of information to the public.

CCDHB	HVDHB	RPH	MHAIDS
335,179 page views	89,046 page views	34,232 page views	33,279 page views

Top five webpages CCDHB

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

Top five webpages HVDHB

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

Top five webpages RPH

- Coronavirus (COVID-19) frequently asked questions
- Current illnesses – early childhood centres
- Hand hygiene
- Fruit and Vege Co-ops
- Measles

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

3.5.1 Website banners

3.6 Internal Engagement and Communication

3.6.1 Intranet page views

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

CCDHB	HVDHB
623,153 page views	490,503 page views

3.6.2 Top intranet stories

Leadership training for Māori nurses and midwives 'inspirational'

Ngā Manukura o Āpōpō is a Māori clinical leadership programme.

It is designed to offer Māori nurses and midwives the opportunity to grow leadership skills, strengthen networks, and gain an understanding of current issues for Māori leaders.

"Ngā Manukura didn't teach you to be a better leader, rather it is designed to empower you to be the best version of yourself to inspire others," says Phoenix Ahomiro (pictured right), who is NETP co-ordinator and cultural support worker at CCDHB. "It gave me a way to weave together clinical and corporate knowledge with Tikanga, and holding strong to my own values."

Phoenix is one of several people at CCDHB who have completed the programme, which consists of four 2-day marae-based wānanga over a four-month period – and the reviews they give are glowing.

"I have never enjoyed a course more in my life, and it really challenged and inspired me," says Phoenix, while Maire Ransfield, Kaiwhakahaere at Te Whare Mārie Māori Mental Health Service, says "I cannot give enough praise for this uplifting, inspirational programme - wehi nā!"

As well as honing skills in leadership and management, clinical governance, Māori leadership models and more, participants complete a project as part of the training, which must challenge their leadership and intend to have a positive impact on patient outcomes.

"The disparities in health outcomes between Māori and non-Māori are the reason we need more leaders," says Phoenix. "We as a DHB need to support and grow our Māori leaders to foster working towards reducing inequities."

"It's important to offer these leadership opportunities so that Māori can reclaim our leadership rights and practices, incorporate a Māori worldview into the space we work in, and work in a way that is acceptable to our beliefs," says Maire. "The skills and knowledge I gained reinforced my beliefs and practices as a Māori leader."

"If you want to further your own professional and cultural development, this training is for you," says Phoenix. "The networking, opportunities and mentors that come from doing this course are truly inspiring. You are supported by awesome people in your rōpū and the tutors are phenomenal.

"He rangi tā matawhāiti, He rangi tā matawhānui - a person with narrow vision has restricted horizons, a person with wide visions has plentiful opportunities."

If you are interested in taking the course, email Professional.development@ccdhb.org.nz or find out more on the Digital Indigenous website.

Supporting students' transition to professionals

Allied Health, Scientific & Technical (AHST) graduate programmes are supporting new graduates and trainee interns to transition from students to professionals.

A general health programme was initiated in 2019 to help support AHST new graduates at CCDHB, and was extended to Hutt Valley DHB as a 2DHB initiative for the first time in 2020. 15 participants in their first year of employment at the DHBs took part, representing seven AHST professions – Physiotherapy, Occupational Therapy, Speech & Language Therapy, Dietetics, Audiology, Dental and Oral Health Therapy, and Medical Physics.

"AHST is made up of a very diverse group of professions, and graduates start their careers coming from a range of training programmes, with varied exposure to working in a health setting and limited knowledge of a number of other health professions they will be working alongside," says chief allied professions officer Chris King. "Some graduates are also adjusting to moving to the Wellington region, so it's a big transition for many."

At the DHBs there are varied levels of structured support for new graduates, and a need for a programme was identified to ensure every new graduate is supported. In 2020 four half-day sessions took place between August and December, covering topics including DHB values, collaborative practice between professions, Māori Health, Pacific Health, the patient experience, and staff and patient safety. Graduate feedback has been very positive.

"New graduates feel supported and more connected to the DHB, and get an opportunity to learn about some of the skills and capabilities that cross different professions while also getting an opportunity for learning relevant to all new graduates," says Chris.

The Allied Health New Entry to Specialist programme within the Mental Health, Addictions and Intellectual Disability Service (MHAIDS) is also in place, supporting Social Work and Occupational Therapy graduates. This programme has been in place for a number of years and is proving successful in supporting and growing the AH workforce within MHAIDS.

In 2020 the programme supported two occupational therapists and two social workers to complete post-graduate papers and supported mentored placements in clinical areas throughout their first year of practice. By the end of 2020 these new graduates were being supported to transition into permanent roles within MHAIDS.

Focussed on achieving Pacific health equity

Dr Avataeao Junior Ulu has started a new path as the 2DHB Director Pacific Peoples Health, leading the work of the Pacific Health team and implementation of the 3DHB Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region.

A member of the 2DHB Executive Leadership Team (ELT), Dr Ulu started his role in January of this year, supporting the transformation of Hutt Valley District Health Board (HVDHB) and Capital and Coast District Health Board (CCDHB) to achieve Pacific and Māori health equity and outcomes.

Our DHBs cover the greater Wellington, Kapiti and Hutt Valley regions and provide hospital and health services to a total population base of approximately 445,000 people.

Most of the population lives in Wellington and Lower Hutt and while Lower Hutt and Wellington's Māori and Pacific populations of Lower Hutt and Wellington are proportionally similar, the region's largest Pacific population is in Porirua. Kapiti and Upper Hutt have similar numbers of Māori and Pacific people.

As most people are enrolled with a General Practitioner near their place of residence, there is increasing focus on community-based healthcare, which is anticipated to lead to better health outcomes.

With a PhD in Development Studies from the Victoria University of Wellington, Dr Ulu has broad experience in both health and development. He is passionate about achieving equity in access and health outcomes for Pacific peoples and communities.

Most recently, he was the Director Pacific Development at the Pasifika Medical Association and prior to this worked with the Ministry of Foreign Affairs and Trade (MFAT), Oxfam, ChildFund, the United Nations Development Programme, Counties-Manukau DHB, and Volunteer Service Abroad.

In his new role, Dr Ulu will work in partnership with executive colleagues to measure, mentor and improve performance and provide leadership by establishing and maintaining national, regional and local networks and initiatives.

The core purpose of his role includes engaging and working with the Pacific community as partners towards improving health outcomes for Pacific people; providing proactive strategic thinking and leadership on issues that impact Pacific health outcomes; and ensuring the DHBs' strategy and plans are informed by the needs of Pacific peoples and key stakeholders are appropriately involved in service planning and provision.

He will lead the development and maintenance of effective networks and strategic relationships with key stakeholder groups whose mandate impacts upon the health outcomes of Pacific people; and help lead the design and development of workforce initiatives to increase the number of Pacific peoples working in the health workforce as well as increasing the capability of our workforce on Pacific people's issues.

It is a challenging task ahead - one which Dr Ulu is more than ready for. He will work, when needed, with the Wairarapa DHB to provide strategic support and advice on strategies and plans to improve the health outcomes for Pacific people in the region, and he holds operational responsibility for Pacific health services in both the CCDHB and HVDHB regions.

Launched last year, the Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020-2025 will guide the work our DHBs do with Pacific communities.

It illustrates the DHBs' strong commitment to improving the health and wellbeing of Pacific peoples and was developed in partnership with Pacific community providers, the 3DHB Sub Regional Pacific Health Strategic Group – covering Wairarapa, Hutt Valley, and Capital and Coast – and involved staff from across the DHBs alongside service providers including Te Awakairangi Health Network, Compass Health, Regional Public Health, Pacific Providers, and other mainstream providers.

Six priorities are the basis of the plan, including Pacific child health and wellbeing; Pacific young people; Pacific adults and ageing well; Pacific health workforce and Pacific providers/non-governmental organisations; social determinants of health; and a culturally responsive and integrated health system. The DHBs in the Greater Wellington Region will be ensuring these priorities are embedded in their work as part of their ongoing commitment to taking a whole-of-system approach to achieve better health outcomes for Pacific peoples.

Work Plan

Year	2021	2021	2021	2021	2021	2021	2021	2021	2021	2021	2021	2021
Month	January	February	March	April	May	June	July	August	September	October	November	December
Board Focus:	Annual Plan Planning Workshop (5)	No Meeting		Provider Arm Financial and Non Financial (1)	Equity and Integration, Multi-Year Plan (6)	Annual Plan (5) Equity and Integration (6)	Community Based Initiatives (2)			Annual Plan (5) Equity and Integration (6)	Hospital Network (3)	Equity and Integration - Multi-Year Plan (6)
Provider/Service	N/A	No Meeting	Maternity	TBC	TBC							
Patient Story:	N/A		Disability/MHAIDS	Orthopaedics	Dialysis				MHAIDS	Trauma		
DATE	**27-Jan**	**No Meeting**	**3-Mar**	**7-Apr**	**5-May**	**2-Jun**	**7-Jul**	**4-Aug**	**1-Sep**	**6-Oct**	**3-Nov**	**1-Dec**
Hutt Valley Board ONLY TIME	WORKSHOP		Hutt Valley Board		Hutt Valley Board		Hutt Valley Board		Hutt Valley Board		Hutt Valley Board	
Capital and Coast Board ONLY TIME				Capital and Coast Board		Capital and Coast Board		Capital and Coast Board		Capital and Coast Board		Capital and Coast Board
Regular Reporting	**27-Jan**	**No Meeting**	**3-Mar**	**7-Apr**	**5-May**	**2-Jun**	**7-Jul**	**4-Aug**	**1-Sep**	**6-Oct**	**3-Nov**	**1-Dec**
Workplace Health and Safety Report	WORKSHOP		Workplace Health and Safety Report	Workplace Health and Safety Report	Workplace Health and Safety Report	Workplace Health and Safety Report	Workplace Health and Safety Report	Workplace Health and Safety Report	Workplace Health and Safety Report	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		People, Capability and Culture Report		People, Capability and Culture Report		People, Capability and Culture Report		People, Capability and Culture Report
Facilities and Infrastructure Report inc. Enviro Sustainability	WORKSHOP			Facilities and Infrastructure Report	Facilities and Infrastructure Report				Facilities and Infrastructure Report		Facilities and Infrastructure Report	
Digital Report					Digital Report						Digital Report	
Children's Hospital												
Pacific Health Report	WORKSHOP											
Engagement	**27-Jan**	**No Meeting**	**3-Mar**	**7-Apr**	**5-May**	**2-Jun**	**7-Jul**	**4-Aug**	**1-Sep**	**6-Oct**	**3-Nov**	**1-Dec**
Māori Partnership Board (CCDHB)				TBC Māori Partnership Board (CCDHB)		Māori Partnership Board (CCDHB)		Māori Partnership Board (CCDHB)		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	WORKSHOP					Sub-Regional Pacific Health Strategy Group						Sub-Regional Pacific Health Strategy Group
Wellington Hospital Foundation											Wellington Hospital Foundation	
Intermittent Items	**27-Jan**	**No Meeting**	**3-Mar**	**7-Apr**	**5-May**	**2-Jun**	**7-Jul**	**4-Aug**	**1-Sep**	**6-Oct**	**3-Nov**	**1-Dec**
Budgets			Budgets			Budgets				Budgets		
Annual Plan	WORKSHOP		Annual Plan			Annual Plan				Annual Plan		
Annual Reports												
Planned Care Plan												
Internal Audit Plan	WORKSHOP											
Maternity Plan												
Master Site Plan												
Regular Items - every meeting	**WORKSHOP**	**No Meeting**	**3-Mar**	**7-Apr**	**5-May**	**2-Jun**	**7-Jul**	**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	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	Finance and Operational Performance Report	Finance and Operational Performance Report	Finance and Operational Performance Report	Finance and Operational Performance Report
Major Capital Projects Advisory Committee Report				Major Capital Projects Advisory Committee Report	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 items for Board Approval				FRAC items for Board Approval	FRAC items for Board Approval		FRAC items for Board Approval		FRAC items for Board Approval		FRAC items for Board Approval	
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		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				Te Pae Amorangi Quarterly Report
Taurite Ora Quarterly Report				Taurite Ora Quarterly Report		Taurite Ora 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			Pacific Health and Wellbeing Strategic Plan Quarterly Report			Pacific Health and Wellbeing Strategic Plan Quarterly Report
DSAC items for Board Approval	WORKSHOP			DSAC items for Board Approval		DSAC items for Board Approval				DSAC items for Board Approval		DSAC items for Board Approval

Board Information

December 2020

Hutt Valley DHB October 2020 Financial and Operational Performance Report

Action Required

The Hutt Valley DHB Board note:

(a) The DHB had a $439k surplus for the month of October 2020, being $1,599k favourable to budget;

(b) The DHB year to date had a deficit of ($1.6m), being $2.3m favourable to budget;

(c) The Funder result for October was ($0.1m) unfavourable, Governance $0.2m favourable and Provider $1.5m favourable to budget;

(d) Total Case Weighted Discharge (CWD) Activity was 11% 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 Service Rachel Haggerty, Director Strategy Planning and Performance
Endorsed by	Fionnagh Dougan, Chief Executive
Purpose	To update the Board on the financial performance and delivering against target performance for the DHBs
Contributors	Finance Team, Health Intelligence and Decision Support, 2DHB Hospital Services.

Executive Summary

October was unusually busy for the hospital ED with higher visits than budget and the same time last year placing pressure on our ED wait times and beds. Year to date, caseweights for Surgical are 6% over budget as services implement COVID-19 recovery plans. Other services are higher than budget due to more discharges under Neonatal and Maternity.

Addressing ESPI 2 and 5 waiting lists remains a significant challenge and risk for HVDHB with the numbers of patients waiting more than 120 days for treatment fluctuating month on month. We are waiting for confirmation from MoH on our submission for planned care recovery funding to secure additional outsourcing volume to meet a required reduction in ESPI2 and ESPI 5 waitlists with our system improvement project making good progress around all aspects of managing elective flow.

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.

Funder key areas of performance with a focus on core services and achieving equity;

- Working with WCTO providers, Regional Public Health, general practices and outreach immunisation providers to make services for accessible, improve engagement with families, undertaking proactive follow-up on missed checks and immunisations.
- Working to improve children's dental health through oral health promotion, healthy food and drink policies, proactive follow-up on missed appointments, and additional fluoride varnish applications in low decile schools.
- We provide the Healthy Active Learning programme to schools and early learning services, in partnership with Sport Wellington, which promotes wellbeing, healthy eating and physical activity.
- Concern regarding the ongoing decline in performance in diabetes services has been discussed with PHOs. Specialist support to primary care is underway, with areas for expansion being considered.
- Developing sustainable strength and balance programmes to improve our response to frailty, particularly for Māori and Pacific older peoples.

For October, the Hutt Valley DHB has a surplus of $0.4m which is $1.6m favourable to budget. Of this surplus $0.4m is in the provider arm services and includes additional revenue relating to 19/20 IDF wash-ups. More detail can be found in the Provider Arm summary.

Strategic Considerations

Service	Financial performance and funding is a key to delivering the services for the Hutt Valley population.
People	Staff numbers are 139 below plan with additional costs in outsourced personnel for roles employed by CCDHB for ICT and MHAIDs.
Financial	Planned deficit $10.6 million, with no COVID-19 or Holidays Act provision impacts included.
Governance	The FRAC committee is accountable for scrutinising the financial and operational performance on behalf of the board, and reporting back to the board on issues as identified by the committee.

Engagement/Consultation

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

Identified Risks

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

Attachment

3.2.1 Hutt Valley DHB October 2020 Financial and Operational Performance Report

Monthly Financial and Operational Performance Report

For period ending
30 October 2020

Reported in November
2020

Contents

Section 1

Financial and Performance Overview and Executive Summary

Executive Summary

- October was unusually busy for the hospital ED with higher visits than budget and the same time last year placing pressure on our ED wait times and beds. Year to date, caseweights for Surgical are 6% over budget as services implement COVID-19 recovery plans. Other services are higher than budget due to more discharges under Neonatal and Maternity.
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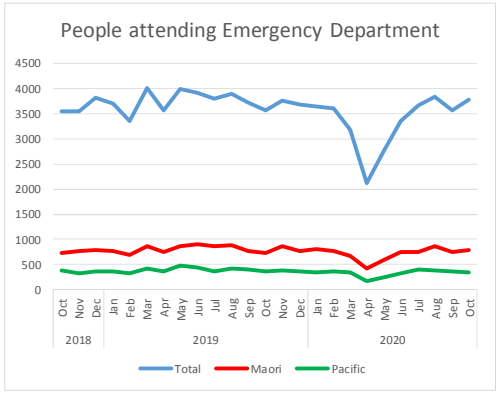
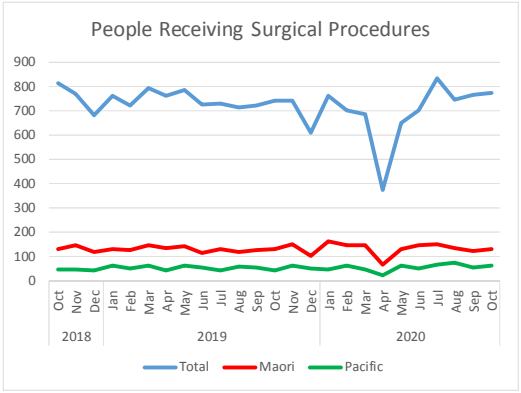
- For October, the Hutt Valley DHB has a surplus of $0.4m which is $1.6m favourable to budget. Of this surplus $0.4m is in the provider arm services and includes additional revenue relating to 19/20 IDF wash-ups. More detail can be found in the Provider Arm summary.

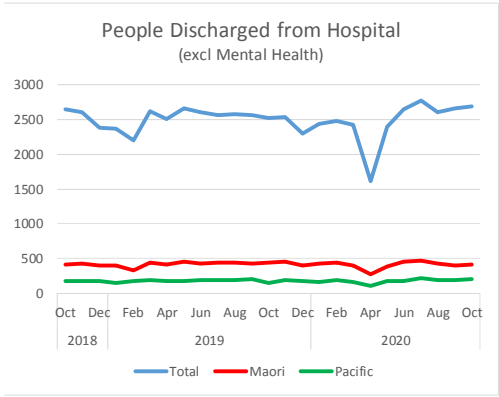
Performance Overview: Activity Context (People Served)

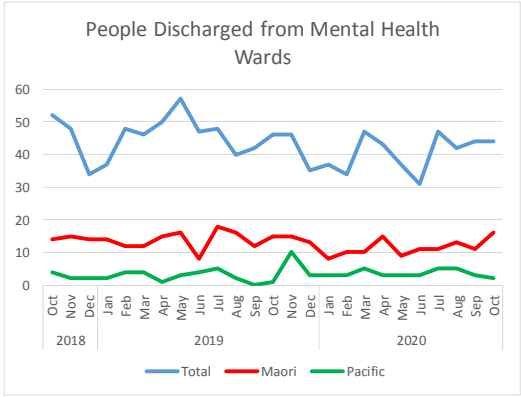
The numbers below count individuals once and are based on Hutt Valley DHB being the DHB of Service. Our services have returned to delivering services to our population without the restrictions due to COVID-19. Services continue to take necessary precautions.

People attending ED	**3,780**	782 Maori, 337 Pacific
People receiving Surgical Procedures	**773**	129 Maori, 63 Pacific
People discharged from Hospital (excl Mental Health)	**2,679**	407 Maori, 198 Pacific
People discharged from Mental Health wards	**44**	16 Maori, 2 Pacific









Performance Overview: Activity Context (People Served)

People seen in Outpatient & Community

8,859

1,347 Maori, 614 Pacific

Mental Health and Addiction Contacts

1,450

332 Maori, 96 Pacific

Primary Care Contacts

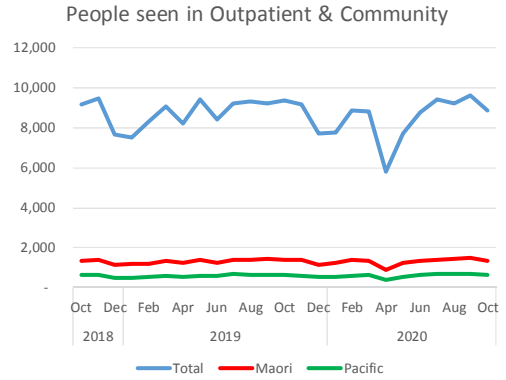
35,175

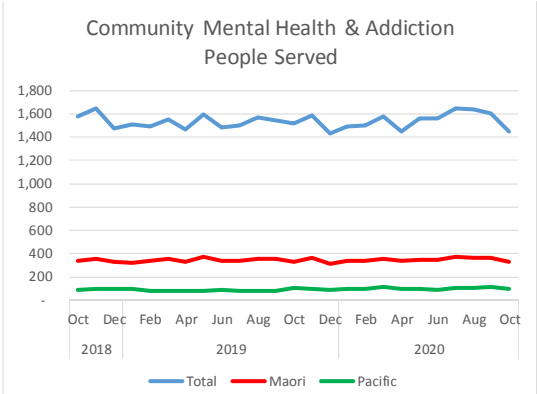
5,239 Maori, 2,472 Pacific

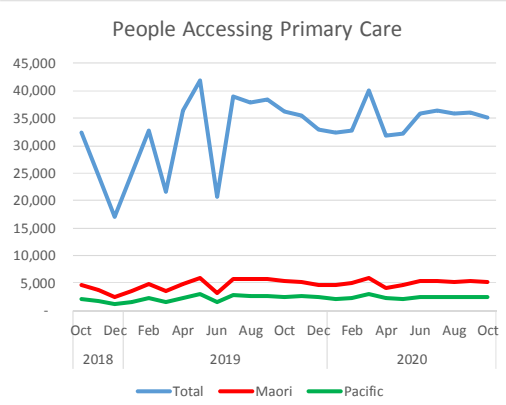
People in Aged Residential Care

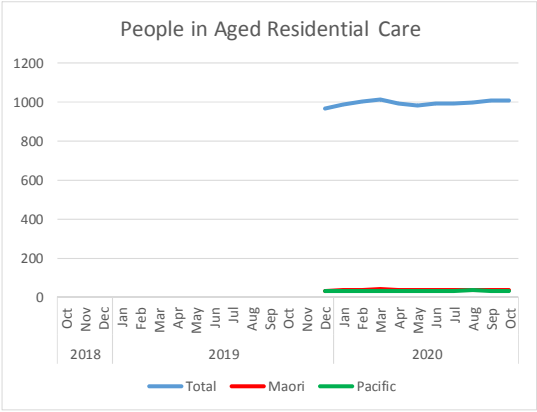
1,011

37 Maori, 31 Pacific









Financial Overview – October 2020

YTD Operating Position	YTD Provider Position	YTD Funder Position	YTD Capital Exp
$1.6m deficit	$3.6m deficit	$1.8m surplus	$3.2m
Against the budgeted deficit of $3.9m.	Against the budget deficit of $3.8m.	Against the budget deficit of $0.04m.	

YTD Activity vs Plan (CWDs)	YTD Paid FTE	Annual Leave Accrual
11% ahead	1,919	$20.6m
237 CWDs ahead PVS plan for October. IDFs were 4 CWD over budget for the month	YTD 139 FTE below annual budget of 2,058 FTE. Note: The MHAIDS restructure contributed 85FTE 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 – October 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
88%	992	724	75%
7% below the ED target of 95%, 2% below October 2019.	Against a target of zero long waits a monthly movement of 77.	Against a target of zero long waits a monthly movement 50	We did not achieve the 62 day target. The 31 day target was achieved at 87%

YTD Activity vs Plan (CWD)	YTD Standard FTE	Serious Safety Events
11% ahead	1,981	2
237 CWDs ahead PVS plan for October. IDFs were 4 CWD over budget for the month	55 below YTD budget of 2,036 FTE. Month FTE was 213 under budget an upwards movement from September of 19 FTE.	An expectation is for nil SSEs at any point.

Section 2

FUNDER PERFORMANCE

Executive Summary – Funder

- Overall the funder has a positive variance of $1.853m year to date, with revenue for IDFs being significantly ahead of budget by $1.8m due to wash-ups from last year.
- The overspend in laboratory and capitation investment is expected to return to budget and is due to normal variation. The IDF underspend is expected to be reversed based on current patients from HVDHB in Wellington Hospital with significant complexity.
- Pharmaceuticals are overspent as variation due to the effects of COVID are felt on price and script fees. This is currently being fully explored.
- Regional Public Health remain focused on COVID activity including 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. We are responding to the needs of our children.
    - We are working with WCTO providers, Regional Public Health, general practices and outreach immunisation providers to make services for accessible, improve engagement with families, undertaking proactive follow-up on missed checks and immunisations.
    - We are working to improve children's dental health through oral health promotion, healthy food and drink policies, proactive follow-up on missed appointments, and additional fluoride varnish applications in low decile schools.
    - We provide the Healthy Active Learning programme to schools and early learning services, in partnership with Sport Wellington, which promotes wellbeing, healthy eating and physical activity.
    - Concern regarding the ongoing decline in performance in diabetes services has been discussed with PHOs. TeAHN has committed to moving practices to pro-active planning, working at an individual patient level. Specialist support to primary care is underway, with areas for expansion being considered.
    - We are developing sustainable strength and balance programmes to improve our response to frailty, particularly for Māori and Pacific older peoples.

Funder Financial Statement – September 2020

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

Month					$000s	Year to Date					Annual				
Actual	Budget	Variance	Last Year	Variance		Actual	Budget	Variance	Last Year	Variance	Forecast	Budget	Variance	Last Year	Variance
					Revenue										
37,970	37,970	0	34,735	3,235	Base Funding	151,879	151,879	0	138,939	12,940	455,637	455,637	0	416,816	38,821
2,859	2,341	518	2,085	774	Other MOH Revenue	10,977	9,363	1,614	11,659	(681)	29,704	28,090	1,614	38,006	(8,302)
46	36	10	582	(536)	Other Revenue	392	142	250	688	(295)	677	427	250	619	58
11,039	9,229	1,810	9,197	1,841	IDF Inflows	39,552	36,914	2,638	34,798	4,754	113,044	110,742	2,302	102,280	10,765
51,913	**49,575**	**2,339**	**46,599**	**5,314**	**Total Revenue**	**202,801**	**198,298**	**4,502**	**186,083**	**16,718**	**599,062**	**594,895**	**4,166**	**557,721**	**41,341**
					Expenditure										
416	416	0	383	(33)	DHB Governance & Administration	1,662	1,662	0	1,532	(130)	4,987	4,987	0	4,597	(390)
22,795	21,029	(1,766)	20,284	(2,511)	DHB Provider Arm	85,889	84,121	(1,768)	80,458	(5,431)	254,009	252,577	(1,432)	241,131	(12,879)
					External Provider Payments										
4,459	3,341	(1,118)	3,269	(1,190)	Pharmaceuticals	15,025	13,216	(1,809)	13,064	(1,961)	40,676	38,866	(1,809)	37,365	(3,311)
4,319	4,369	50	4,233	(86)	Laboratory	17,764	17,475	(290)	16,926	(838)	52,664	52,424	(240)	50,903	(1,761)
2,587	2,541	(46)	2,389	(198)	Capitation	10,531	10,165	(366)	10,159	(372)	30,861	30,495	(366)	29,563	(1,298)
1,076	1,235	159	1,010	(66)	ARC-Rest Home Level	4,755	4,901	145	4,042	(713)	14,538	14,543	5	11,877	(2,661)
1,564	1,920	355	1,533	(32)	ARC-Hospital Level	7,010	7,617	607	6,462	(548)	22,347	22,604	257	19,154	(3,193)
2,588	2,688	100	1,401	(1,187)	Other HoP & Pay Equity	9,611	10,751	1,141	9,183	(428)	31,814	32,354	541	35,108	3,294
902	1,089	187	891	(11)	Mental Health	3,177	4,332	1,155	3,009	(168)	12,690	13,045	355	9,580	(3,110)
472	482	10	728	257	Palliative Care / Fertility / Comm Radiology	1,911	1,927	17	2,954	1,044	5,765	5,782	17	5,788	23
1,530	1,362	(168)	1,409	(121)	Other External Provider Payments	6,758	5,569	(1,189)	5,068	(1,691)	18,609	17,420	(1,189)	19,247	638
9,352	9,151	(202)	9,363	11	IDF Outflows	36,894	36,602	(292)	33,779	(3,116)	110,098	109,807	(292)	101,298	(8,800)
0	0	0	0	0	Provision for IDF Wash-ups	0	0	0	15	15	0	0	0	0	0
52,060	**49,621**	**(2,439)**	**46,893**	**(5,167)**	**Total Expenditure**	**200,988**	**198,338**	**(2,650)**	**186,650**	**(14,338)**	**599,058**	**594,905**	**(4,154)**	**565,610**	**(33,448)**
(147)	**(46)**	**(101)**	**(293)**	**147**	**Net Result**	**1,813**	**(40)**	**1,853**	**(567)**	**2,380**	**3**	**(9)**	**13**	**(7,889)**	**7,893**

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 $518k for October, driven by additional funding for COVID-19.
- Other revenue is favourable $10k for the month.
- IDF inflows are $1,810k favourable for the month, driven by prior year wash-ups .

Other MOH Revenue Variance	MTH $000's	YTD $000's
In- Between Travel	(168)	(431)
Capitation Funding	22	294
COVID-19 Funding	944	2,311
COVID-19 Funding - RPH	(127)	(509)
Crown funding agreements		
Rheumatic Fever Prevention Services	(31)	(12)
B4 School Check Funding	(45)	1
Tobacco Control	36	87
Measles Immunisation Campaign 2020	(141)	(141)
Other CFA contracts	(29)	(14)
Year to date Variance $000's	**518**	**1,614**

Expenditure:

Governance and Administration are on budget. Provider Arm payments are variances IDF Wash-up Payments to the Provider.

External Provider Payments:

Pharmaceutical costs are unfavourable ($1,118k) for the month and ($1,809k) YTD. This is reflects increased drug costs and possible timing issues.

Laboratory costs are favourable $50k for the month and unfavourable ($290k) YTD. This is expected to reverse as the year progresses.

Capitation expenses are ($46k) unfavourable for the month, offset by changes to revenue.

Aged residential care costs are $514k favourable for the month.

Other Health of Older People costs are favourable by $100k for the month and $1,141k YTD.

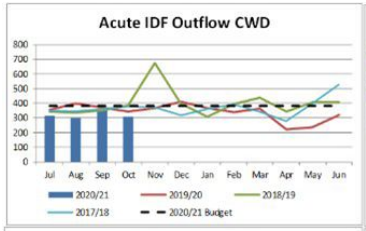
Mental Health costs are favourable $100k for the month, reflecting timing of contracts.

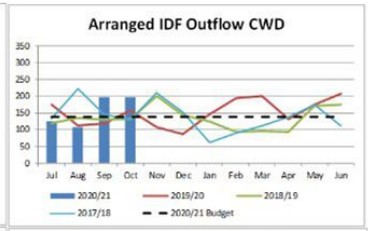
Palliative Care, Fertility and Community Radiology costs are favourable by $187k for the month.

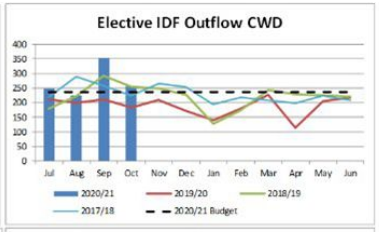
Other external provider costs are unfavourable to budget ($168k) for the month.

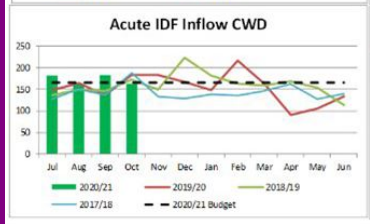
IDF Outflows are unfavourable ($202k), due to Current Year Wash-up payments.

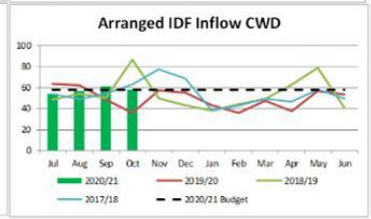
Inter District Flows (IDF)

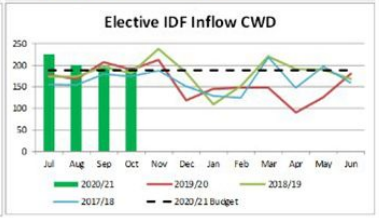












IDF Wash-ups and Service Changes Oct 2020		
IDF Inflows ($000s)	Variance to budget	
	Month	YTD
CCDHB - GWRC Alcohol and Drug	(23)	(93)
CCDHB - Primary Mental Health	11	44
WAI - Mental Health Acute Beds	(70)	(170)
WAI - Child Epidemiology	0	2
Wash-ups		
2020/21 Inflows	225	497
2020/21 PHO	28	28
2019/20 Non-Casemix	-	(1)
2019/20 Inflows	1,639	1,639
2019/20 ATR	-	0
2019/20 Community Pharmacy	-	(44)
2019/20 Wairarapa MH	-	3
2019/20 FFS	-	(8)
2019/20 HCSS	-	742
IDF Inflow variance	**1,810**	**2,638**

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):

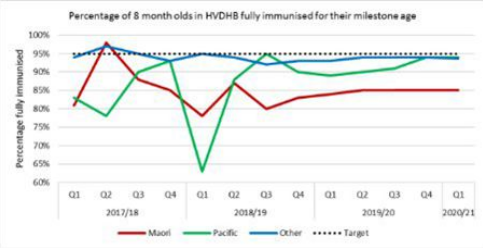
- Based on the data available, overall IDF inflows are above budget YTD by $828k, mainly in Plastics, Orthopaedics, Rheumatology and Gastroenterology. This result is likely to change as data is updated. Services have been implementing recovery plans since June to catch up after COVID-19 restrictions.

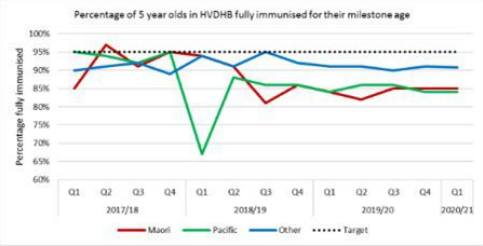
IDF Outflow (expense):

- Based on the data available, overall IDF outflows are over budget by ($292k) year to date, mainly due to inpatient outflows being over budget by ($463k). This result is likely to change as data is updated. We have 7 admissions currently in Capital & Coast DHB which are expected to cost at least $272k.

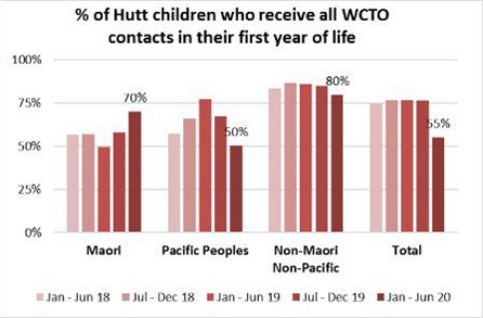
Children 0-4 years – Healthy start

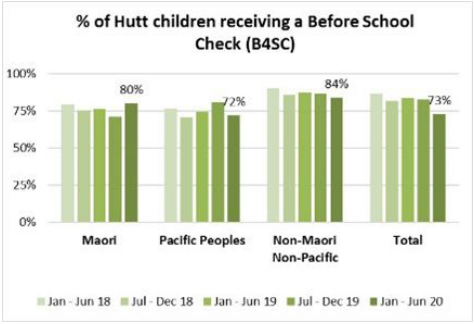
Receive all their scheduled immunisations



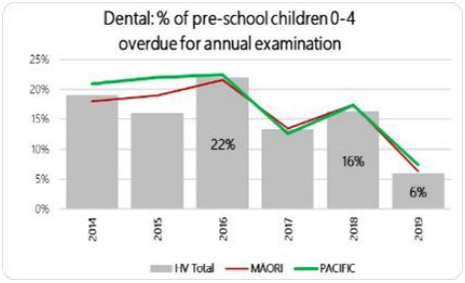


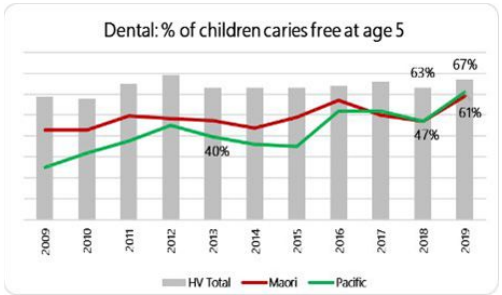
Receive all their Well Child / Tamariki Ora (WCTO) checks





Have healthy teeth





Performance at Quarter One 2020/21

PHO enrolment: 98% of estimated population is enrolled with a PHO - 91% of Maori, 97% of Pacific, 7% enrolled with PHO outside of Hutt DHB

Babies immunised at 8 months: Maori at 85%, Pacific & Other just below target at 94% at 2020/21; Children at 5 years – little change average Maori 84% Pacific 85% Other 91%

WCTO checks – healthy development, screening for potential problems:

- 80% Other, 70% Māori, 50% Pacific had all 5 core checks in first year of life
- 84% Other, 80% Māori, 72% Pacific had B4 School Check at four years old, which is all less than the national target of ≥90%

Children's dental health is linked to regular care of teeth, healthy food and overall health. Children are enrolled with Dental service at birth and recalled at 2-4 years for examination. WCTO checks also provide oral health information

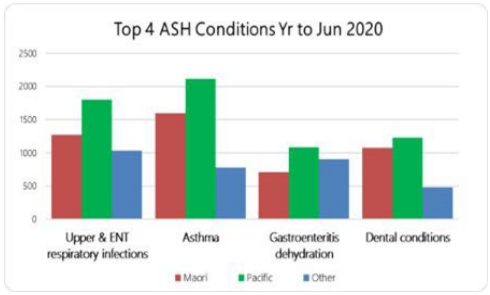
- In 2019, 6% of preschool children were overdue annual examination, which show improved performance from the previous year when 16% were overdue
- In 2019, there was a significant improvement in Māori and Pacific children's dental health, with a 14% increase in Māori and Pacific who had caries free teeth at age 5

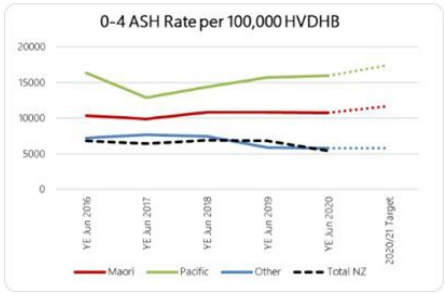
What are we doing?

- We are working with WCTO providers, Regional Public Health, general practices and outreach immunisation providers to make services for accessible, improve engagement with families, undertaking proactive follow-up on missed checks and immunisations.
- We are working to improve children's dental health through oral health promotion, healthy food and drink policies, proactive follow-up on missed appointments, and additional fluoride varnish applications in low decile schools.
- We provide the Healthy Active Learning programme to schools and early learning services, in partnership with Sport Wellington, which promotes wellbeing, healthy eating and physical activity.

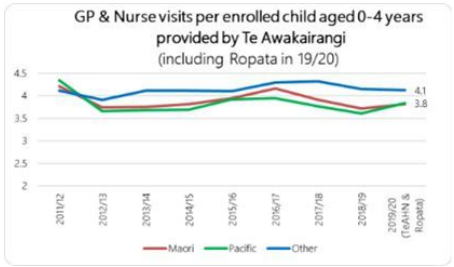
Children 0-4 years – Acute Care

Ambulatory Sensitive Hospitalisations (ASH) – Avoidable Hospitalisations

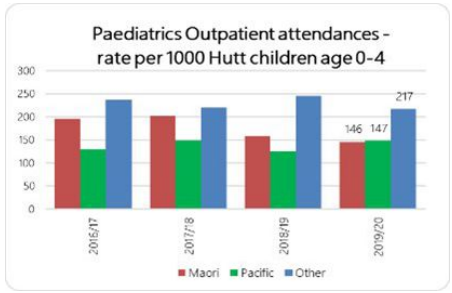


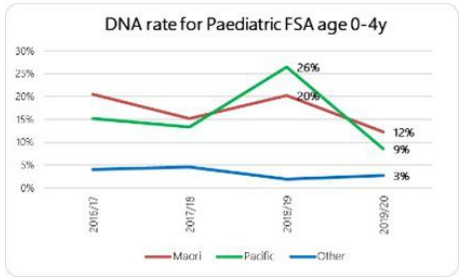


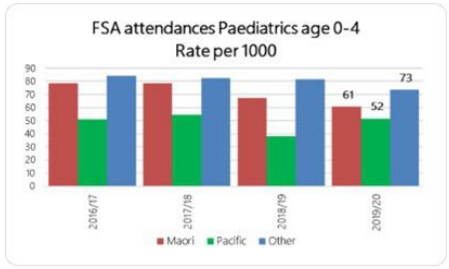
Seen by General Practice



Seen at Paediatric Specialist







Performance at Quarter One 2020/21

Ambulatory Sensitive Hospitalisations (ASH) – Avoidable Hospitalisations

- Māori 2x higher than Total NZ and Pacific 3x higher than Total NZ
- Mostly asthma, respiratory infections, dental conditions for Māori & Pacific
- Mostly respiratory and gastroenteritis/dehydration conditions for Other

Access to GP care

- Māori and Pacific had on average 4 GP & Nurse visits at Te Awakairangi practices – similar to Other ethnicities
- During COVID lockdown, there was significant drop in visits to ED at Hutt hospital, visits to general practices and visits to After Hours - as children stayed at home
- 90% of Hutt children, including Māori and Pacific, saw their GP in first 2 years of life, with on average 11 visits per child in first 2 years
- 44% of children in first 2 years of life went to Lower Hutt After Hours service – 5 visits on average. More Maori and Pacific (59%) went to After Hours and had on average 6 visits.
- In their first 2 years of life, 65% of Pacific children went to ED; 57% of Maori went to ED.

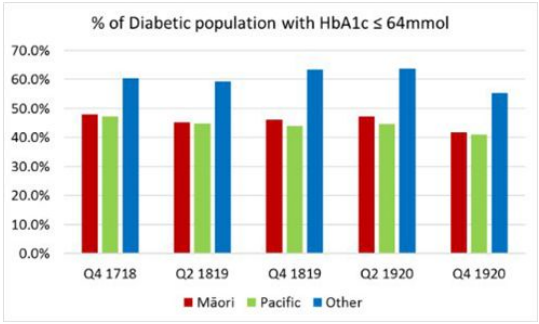
Paediatric outpatients

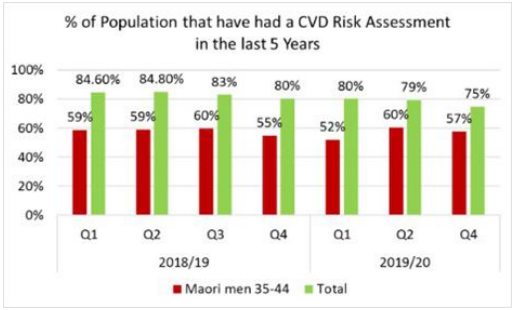
- Māori and Pacific have lower rates of First Specialist Appointments (FSAs) and total outpatient attendances than Other
- Did Not Attend (DNA) rates for FSAs have decreased in 2019/20 but Māori and Pacific still have higher DNA rates than Other

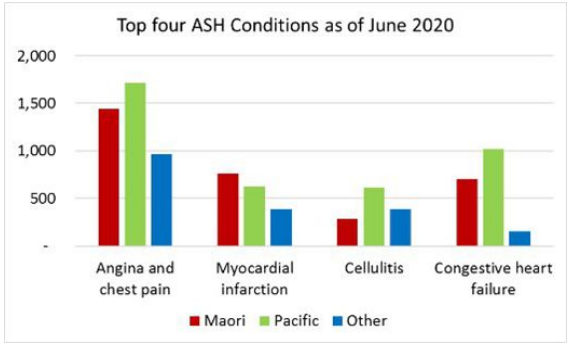
What are we doing?

- We are promoting healthy lifestyles, improving the responsiveness of general practice by rolling out of the Health Care Homes model of care, and developing Community Health Networks to provide integrated care to people in the community
- We are implementing the Respiratory Work Programme: specialist respiratory support model for primary care; consistent respiratory self-management plans across primary, secondary and community; and proactive planning for long-term-condition and high user patients
- We are removing barriers to attending specialist appointments, including proactive contact to avoid DNAs for FSAs e.g. we send 2 reminder texts and provide taxi-chits if needed.

Primary Care: Long Term Conditions







Performance at Quarter One 2020/21

Diabetes management

- The population with HbA1c ≥ 64 (unmanaged diabetes) has been increasing.
- The population with HbA1c ≤ 64 mmol (well-managed diabetes) has been decreasing over the last three years.
- The number of people without any HbA1c result has been increasing with 1,262 diabetics currently without one.

CVD risk assessment

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

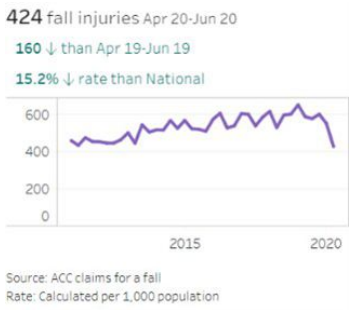
Avoidable hospitalisations (ASH)

- Angina and Chest Pain highest has decrease for Pacific and Other, constant for Maori, but is still the highest condition.
- Congestive heart failure has significantly increased from 177 (70 Events) to 301 (119 Events), with Other and Pacific events doubling.

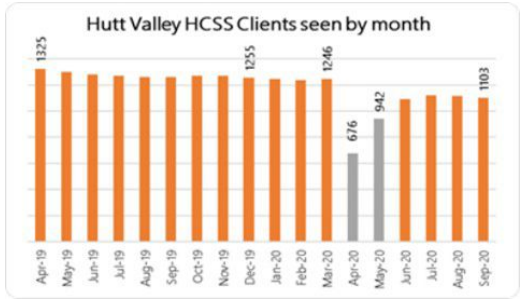
What are we doing?

- Concern regarding the ongoing decline in performance in diabetes services has been discussed with PHOs.
- TeAHN has committed to moving practices to pro-active planning, working at an individual patient level.
- Specialist support to primary care is underway, with areas for expansion being considered
- A Community Health Network / neighbourhood approach to integration is being trialed in a population with high priority population to support specialist support to primary care, and integration with community health services

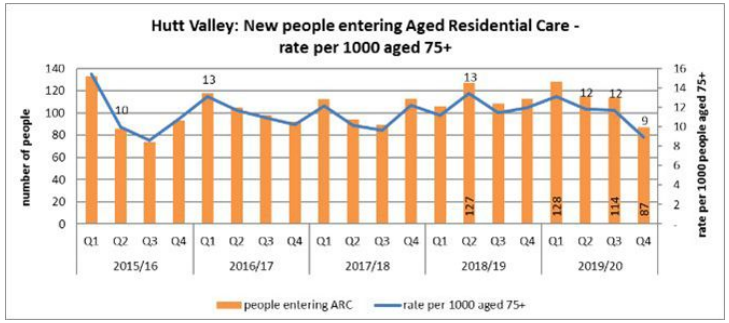
Health of Older & Frail People – community services

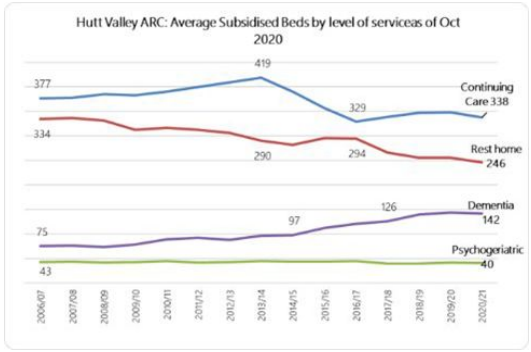


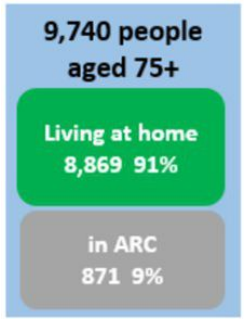
Supported to stay at home safely



Supported in residential care







Performance at Quarter One 2020/21

We are supporting older people to maintain their independence at home and stay healthier for longer with a good quality of life.

- About 91% (8,869) people aged 75+ years live at home, and 9% (871 clients) in Aged Residential Care facilities as at Oct 2020.
- 1,103 people received Home support during September

COVID Impact

- The number of people entering Aged Residential Care (ARC) remained steady in 2018/19 and 2019/20 until COVID 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 lockdown, only 13 people entered ARC but returned to usual in May-Jun.
- Prior to lockdown, average 1271 Hutt people received Home support Jan-Mar 2020. This dropped during COVID lockdown as the service prioritised essential services to the most frail. HCSS providers delivered on average 3,101 support hours per week during April –May COVID level 4 lockdown
- ACC claims by people aged 75+ for Falls injuries dropped during Apr-Jun 20 due to COVID-19 lockdown

Aged Residential Care:

- Rest home level – bed days 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
- Continuing care – highest level of care – has been steadily increasing since 2016/17.

What are we doing?

- We are developing sustainable strength and balance programmes to improve our response to frailty, particularly for Māori and Pacific older peoples.
- We are improving our data to inform the development of initiatives to reduce falls. We are participating in a Regional Equity forum to improve equitable outcomes for dementia.
- We are strengthening primary care with more specialist support, embedding telehealth models of care that started during COVID-19, and continuing the roll out of the Health Care Homes to help keep older people healthy and well in the community.

Section 3

Hospital Performance

Executive Summary – Hospital Performance

- October was unusually busy for ED with higher visits than budget and the same time last year placing pressure on our ED wait times and beds . Year to date, caseweights for Surgical are 6% over budget as services implement COVID-19 recovery plans. Other services are higher than budget due to more discharges under Neonatal and Maternity.

- Addressing ESPI 2 and 5 waiting lists remains a significant challenge and risk for HVDHB with the numbers of patients waiting more than 120 days for treatment fluctuating month on month. We are waiting for confirmation from MoH on our submission for planned care recovery funding to secure additional outsourcing volume to meet a required reduction in ESPI2 and ESPI 5 waitlists with our system improvement project making good progress around all aspects of managing elective flow.

- The positive feedback for our applications for capital funding to support our planned care and maternity services has boosted the opportunities to develop new models of care for our patients – planning is underway to implement these changes.

- 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.
- Medical and Surgical service costs remain unfavourable to budget although overall the provider is close to break even due to additional revenue relating to 19/20 IDF wash-ups. The pressure in Medical and Surgical services 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 again this month taking us well ahead of plan in line with the increased surgery. 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.
- On a positive note accrued annual leave has decreased as has sick leave. Leave planning is in place for the holiday period.

Hospital Throughput

Month					Hutt Valley DHB Hospital Throughput YTD Oct-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							
1,169	1,124	(45)	1,071	(98)	Surgical	4,810	4,462	(348)	4,211	(599)	12,950	12,797
1,951	1,735	(216)	1,867	(84)	Medical	7,891	6,936	(955)	7,704	(187)	20,240	19,506
444	439	(5)	427	(17)	Other	1,810	1,680	(130)	1,752	(58)	4,871	5,474
3,564	**3,298**	**(266)**	**3,365**	**(199)**	**Total**	**14,511**	**13,078**	**(1,433)**	**13,667**	**(844)**	**38,061**	**37,777**
					CWD							
1,207	1,182	(24)	1,162	(45)	Surgical	5,062	4,778	(284)	4,780	(282)	13,889	12,852
1,158	1,074	(84)	1,165	7	Medical	4,620	4,353	(266)	4,677	57	12,225	11,991
429	357	(72)	435	6	Other	1,627	1,470	(158)	1,598	(29)	4,305	4,698
2,793	**2,613**	**(181)**	**2,762**	**(32)**	**Total**	**11,309**	**10,601**	**(708)**	**11,055**	**(254)**	**30,419**	**29,540**
					Other							
4,272	4,006	(266)	4,054	(218)	Total ED Attendances	16,589	16,321	(268)	16,818	229	48,696	47,491
1,023	943	(80)	983	(40)	ED Admissions	4,082	3,991	(91)	4,023	(59)	11,386	11,847
804	816	12	789	(15)	Theatre Visits	3,269	3,218	(51)	3,055	(214)	9,370	9,271
131	127	(4)	138	7	Non- theatre Proc	571	515	(56)	528	(43)	1,500	1,891
7,167	7,032	(135)	7,494	327	Bed Days	30,092	28,637	(1,455)	30,483	390	82,873	85,515
4.25	4.50	0.25	4.80	0.55	ALOS Inpatient	4.43	4.50	0.07	4.49	0.06	4.50	4.29
1.93	2.18	0.25	2.32	0.39	ALOS Total	2.00	2.18	0.18	2.20	0.20	2.18	2.20
9.33%	8.02%	-1.31%	6.86%	-2.47%	Acute Readmission	8.08%	8.02%	-0.07%	7.81%	-0.27%	7.31%	7.36%

For the month of October, Medical discharges and caseweights were higher than budget but similar to the same time last year. Year to date, caseweights for Surgical are 6% over budget as services implement COVID-19 recovery plans. Other services are higher than budget due to more discharges under Neonatal and Maternity.

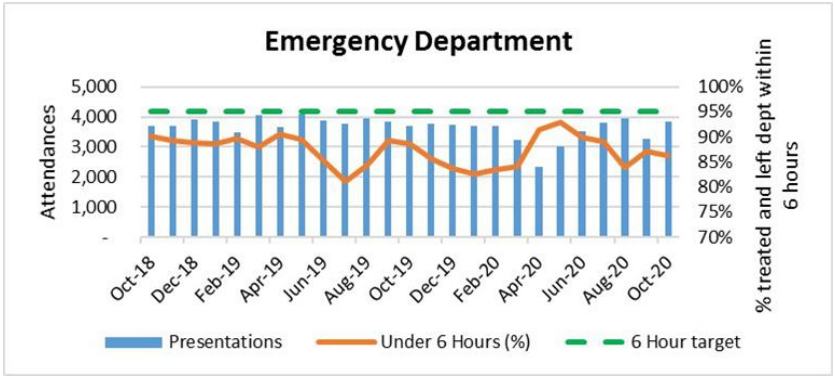
October was unusually busy for ED with higher visits than budget and the same time last year. The number of patients who were admitted from ED at 24% is close to budget. Theatre visits were close to budget for the month, and year to date. Non-theatre procedures are higher than budget year to date. Bed days were close to budget in October and lower than the same time last year. Inpatient ALOS in October was lower than budget and lower than the same time last year. The acute readmission rate was higher than budget.

Operational Performance Scorecard – 13 mths

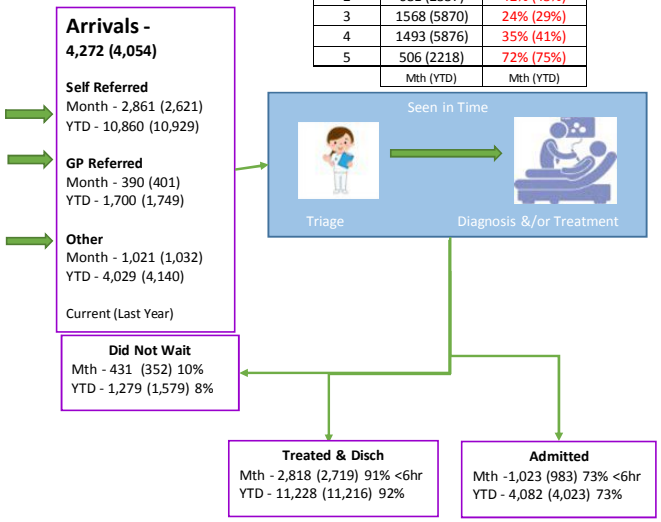
Domain	Indicator (MoH KPIs highlighted yellow)	2019/20 Target	13 Months Performance Trend												
			Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Safe	Serious Safety Events[1]	Zero SSEs	6	3	0	1	4	1	2	2	2	3	3	1	2
	SABSI Cases [2]	Zero	0	0	0	2	2	1	0	0	0	1	0	1	2
	C. difficile infected diarrhoea cases	Zero	2	2	1	2	2	4	0	2	0	3	4	1	1
	Hand Hygiene compliance (quarterly)	≥ 80%	84%			83%			87%			82%			
	Seclusion Hours- average per event (MH Inpatient ward TWA)[3]		81.0	126.8	36.4	21.8	14.0	31.1	39.1	16.3	13.8	27.7	36.7	11.4	13.3
Patient and Family Centred	Complaints Resolved within 35 calendar days[4]	≥90%													
	Patient reported experience measure[5] (quarterly)	≥80%	N/a			N/a			N/a			N/a			
Timely	Emergency Presentations	49,056	4,054	4,239	4,133	4,053	4,028	3,558	2,405	3,104	3,721	4,039	4,281	3,997	4,273
	Shorter Stays in ED (SSiED) % within 6hrs	≥95%	88.7%	84.6%	83.7%	82.6%	83.5%	83.9%	91.4%	93.0%	89.9%	89.2%	84.0%	87.2%	86.3%
	SSiED % within 6hrs - non admitted	≥95%	92.7%	90.1%	90.9%	89.5%	90.1%	90.1%	95.7%	97.0%	94.7%	93.3%	90.7%	91.5%	91.0%
	SSiED % within 6hrs - admitted	≥95%	77.7%	71.0%	64.5%	63.1%	64.4%	66.6%	81.1%	82.4%	76.1%	78.6%	64.5%	75.1%	73.2%
	Total Elective Surgery Long Waits -ESPI 5	Zero Long Waits	435	535	625	726	719	821	1,012	1,077	1,130	1,082	913	915	992
	No. Theater surgeries cancelled (OP 1-8)		169	137	116	134	98	194	50	72	98	140	148	154	141
	Total Elective & Acute Operations in MainTheatres 1-8[6]		788	769	664	784	743	704	389	673	733	868	792	805	804
	Specialist Outpatient Long Waits- ESPI 2	Zero Long Waits	587	631	891	1,130	1,194	1,265	1,396	1,384	1,240	1,096	798	674	724
	Outpatient Failure to Attend %	≤6.3%	6.8%	6.9%	7.6%	7.1%	7.6%	6.9%	6.1%	7.4%	8.3%	6.8%	6.3%	5.4%	5.5%
	Full Year Forecast surplus / (deficit) $m - Provider (1) (2)	($2.03)	($6.90)	($5.21)	($5.21)	($6.57)	($8.19)	($10.37)	($13.04)	($13.59)	($14.20)	($10.61)	($10.61)	($15.38)	($12.54)
	Full Year Forecast surplus / (deficit) $m - DHB (1) (2)	($8.14)	($8.14)	($8.58)	($8.58)	($8.76)	($10.39)	($13.04)	($14.64)	($15.64)	($21.45)	($10.65)	($10.65)	($13.37)	($12.31)
	% Theatre utilisation (Elective Sessions only)[7]	≤90%	87.1%	86.5%	85.5%	87.9%	89.6%	86.4%	74.5%	85.2%	87.6%	85.7%	87.9%	90.4%	85.0%
	Overnight Patients - Average Length of Stay (days)	≤4.3	4.82	4.52	4.37	4.34	4.35	5.31	4.90	4.26	4.44	4.39	4.76	4.52	4.26
	Long Stay Patients Not Yet Discharged (>14 days)	≤5	13	10	23	15	16	7	12	15	14	16	21	17	15
	Overnight Beds (General Occupancy) - Average Occupied	≤130	135	138	137	131	136	129	105	118	136	141	151	144	130
	Overnight Beds (General Occupancy) - % Funded Beds Occupied	≤85%	87.9%	89.5%	89.0%	87.2%	88.2%	79.5%	65.1%	73.1%	84.2%	86.8%	93.1%	88.8%	80.4%
	All Beds - ave. beds occupied[8]	≤250	242	244	232	231	244	223	179	207	241	244	254	249	231
	% sick Leave v standard	≤3.5%	3.5%	2.9%	2.7%	2.0%	2.5%	3.6%	7.5%	6.9%	3.1%	4.3%	4.2%	4.0%	3.4%
	% Nursing agency v employee (10)	≤1.49%	2.6%	2.3%	1.7%	3.9%	3.0%	2.6%	2.3%	3.3%	2.0%	1.6%	1.2%	2.2%	26.20%
	% overtime v standard (medical) (10)	≤9.22%	8.7%	11.2%	5.9%	11.6%	9.3%	7.6%	9.2%	9.7%	9.2%	6.7%	7.8%	8.1%	9.20%
	% overtime v standard (nursing)	≤5.47%	12.4%	13.8%	11.5%	17.9%	14.1%	10.6%	13.2%	12.6%	12.3%	10.8%	13.6%	12.3%	12.31%

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

Shorter Stays in Emergency Department (ED)

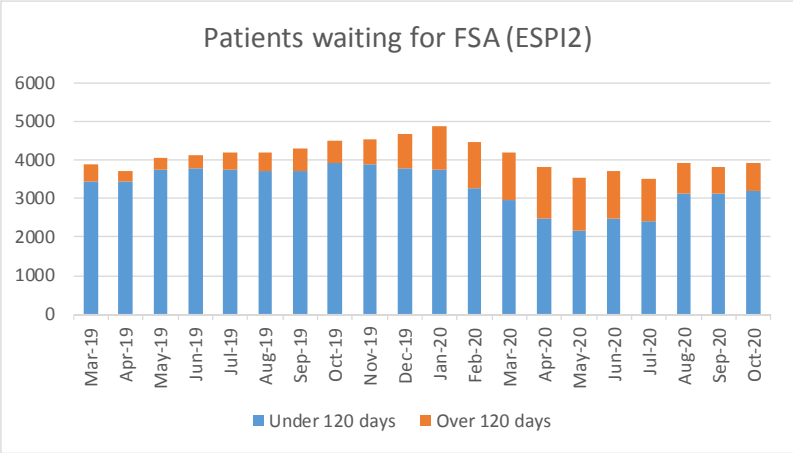


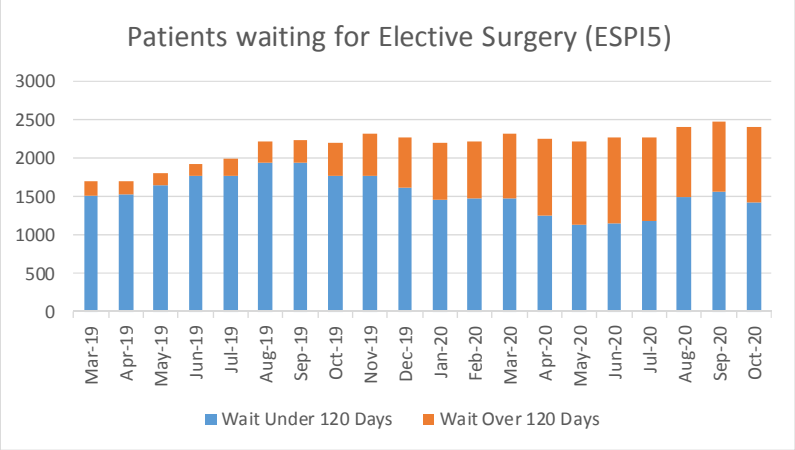
Category	Volume	% Seen in time
1	24 (88)	100% (100%)
2	681 (2537)	42% (45%)
3	1568 (5870)	24% (29%)
4	1493 (5876)	35% (41%)
5	506 (2218)	72% (75%)
	Mth (YTD)	Mth (YTD)



- **What is this Measure**
  - The percentage of patients admitted, discharged and transferred from an Emergency Department within 6 hours.
- **Why is it important**
  - This indicator measures flow through the whole system it is impacted by the number planned of people arriving at ED, how fast ED treats them, availability of beds in the hospital and community service availability.
- **How are we performing**
  - Performance of the target improved during April with lower numbers through the ED however the performance has fallen since to 86% in October.
- **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 Comments**
  - ED presentations increased in October, impacting negatively on the 6 hour wait.
  - The renamed "APU " continues to work well, with September and October seeing record numbers of patients through the department. This includes approximately 25% General Surgical and 5% Gynaecology. This pilot is due to review in February but all reports are favourable to date.
  - CCDHB has had high utilisation over the past month, with Hutt accepting some CCDHB ED patients to assist with flow in CCDHB
  - The planned expansion of the Early Supported Discharge team to improve efficiency of discharge planning and "pull" patients home from ED and wards the 2DHB Care Coordination pathway. Guidelines developed for have seen the successful discharge of three complex patients with assessment process underway for a further patient who ahs bene an inpatient for over one year.

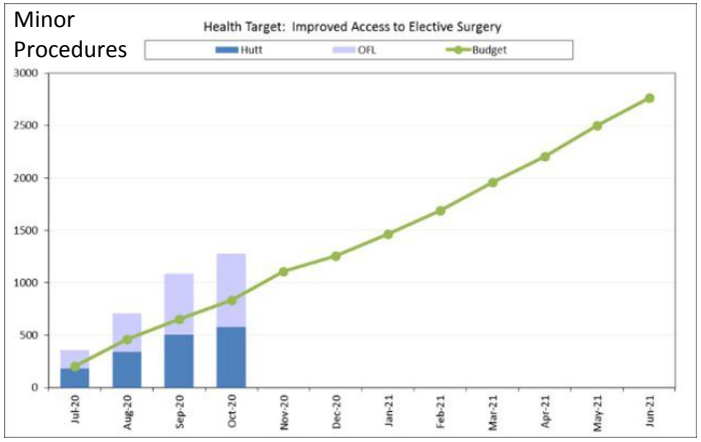
Waiting times - Planned Care

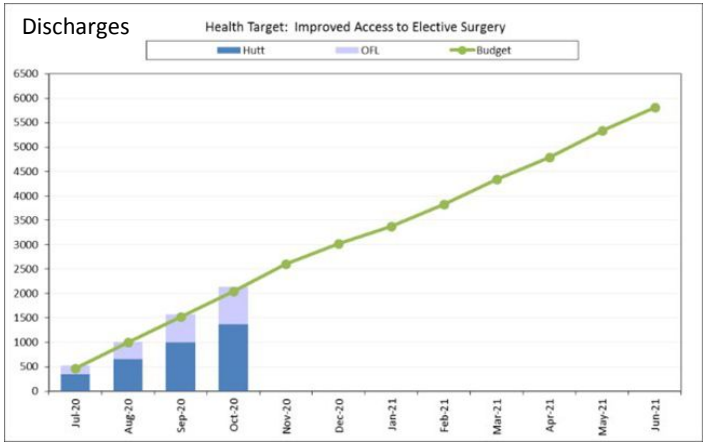




- **What is this measure?**
  - The delivery of Specialist assessments or Treatment within 120 days
- **Why is it important?**
  - It is important to ensure patients receive care at the most appropriate time to support improved health.
- **How are we performing?**
  - The total waiting for an FSA decreased 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.
  - A statement of work outsourcing contract is in place until March 2021 which will see an additional 65 cases (40 General Surgery and 25 orthopaedic) undertaken
  - We are waiting for confirmation from MoH to our submission for planned care recovery funding to secure additional outsourcing volume to meet a required reduction in ESPI2 and ESPI 5 waitlists
  - Our system improvement project is in progress around all aspects of managing elective flow.

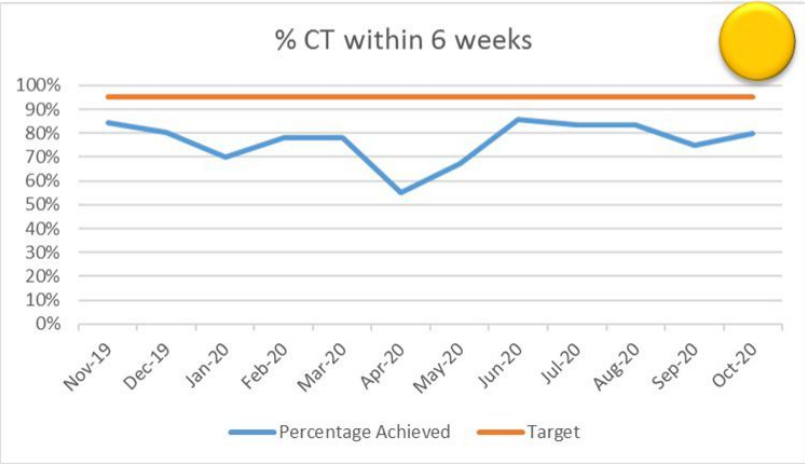
Planned Care – Inpatient discharges and Minor procedures

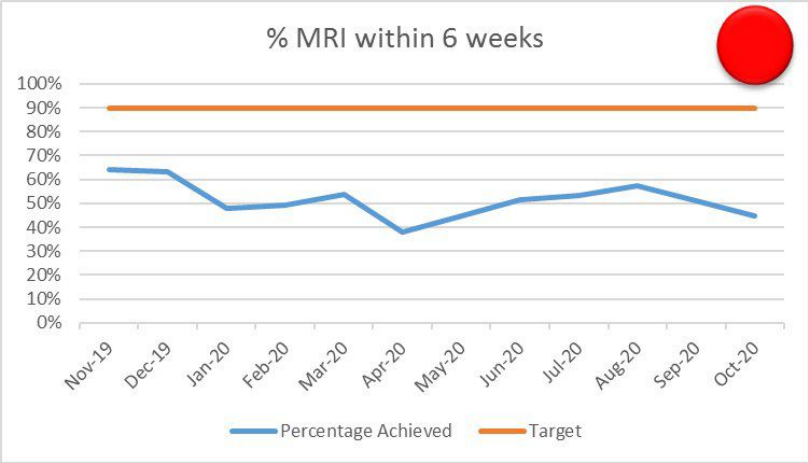




- **What is this measure?**
  - The delivery of an agreed number of inpatient surgical discharges and minor procedures to the Hutt Valley Population
- **Why is it important?**
  - It is important to ensure patients are receiving the planned care procedures required.
- **How are we performing?**
  - Phasing 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 October planned care target was met.
  - Work continues with our SMO's to schedule surgery and utilise private providers to reduce our surgical waiting list. Based on those with greatest clinical urgency and risk of deterioration.
  - We were successful in our two submissions to MoH for additional funding of $3,921,945.00 to increase Planned Care activity:
    - An orthopaedic initiative to reduce ESPI 2 $274,950 in 2020-2021 will see a new primary-secondary model of care with an advanced physiotherapist and MDT involved with FSAs.
    - Capital investment of $3,646,995 to establish a 5 room procedure suite. A Light Single Stage Business case has been provided in November to MoH.

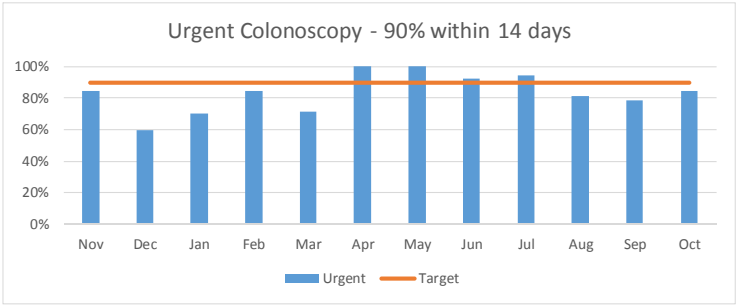
CT & MRI wait times



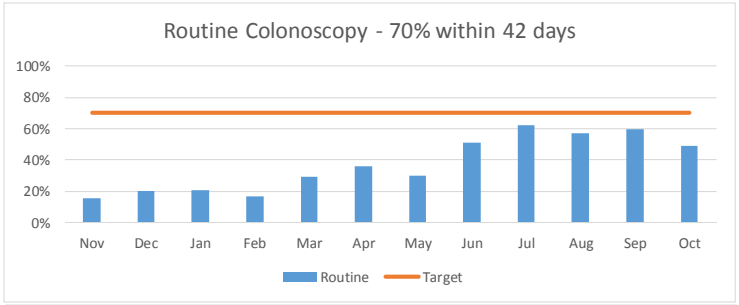


- **What is this measure?**
  - The delivery of computerised tomography (CT) scans and Magnetic Resonance Imaging (MRI) scans in a timely fashion to non-acute patients (within 42 days of referral).
- **Why is it important?**
  - Delayed diagnostic results can negatively affect health outcomes.
- **How 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.

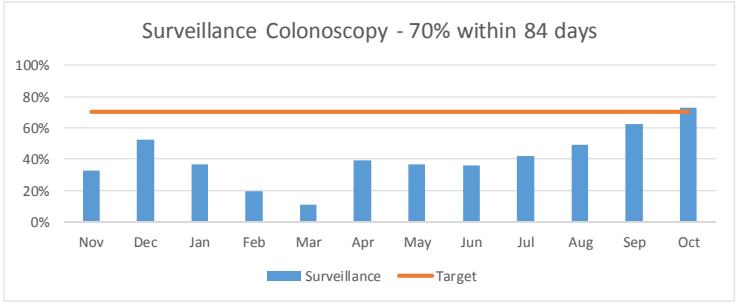
Colonoscopy Wait Times



Urgent
84% YTD



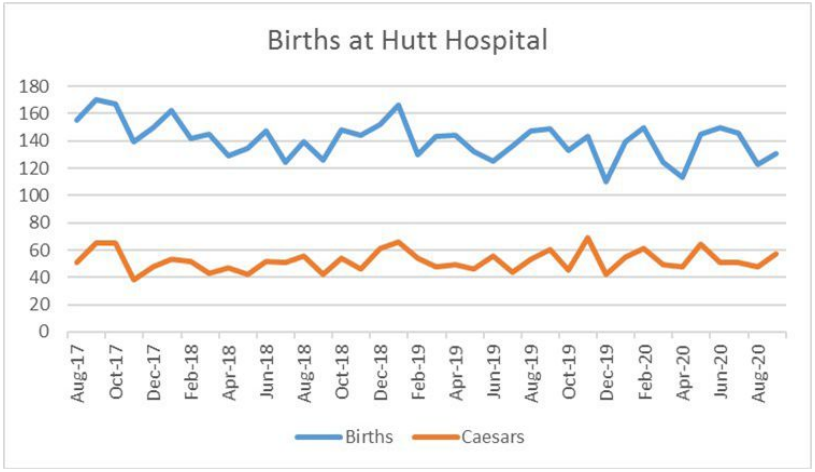
Routine
49% YTD

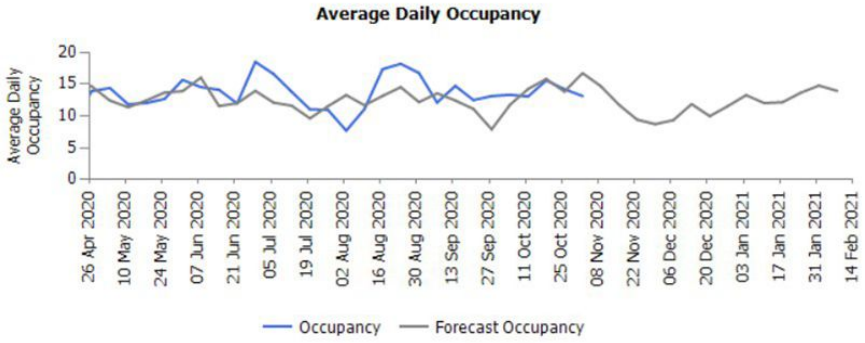


Surveil
73% YTD

- **What is this measure?**
  - The delivery of Colonoscopy, urgent within 14 days, routine 42 days and surveillance within 84 days of being due.
- **Why is it important?**
  - Delayed diagnostic results can negatively affect health outcomes.
- **How are we performing?**
  - We have met the target for Surveillance and are close to target for Urgent colonoscopies. However we continue to struggle with routine
- **What is driving performance?**
  - 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 developing a recruitment plan for a Nurse Endoscopist to support sustainable service delivery.
  - 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%. 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) was endorsed by the Capital Investment Committee and is waiting for the Ministers sign off approval on this investment.

Section 4

Financial Performance & Sustainability

Summary the Financial Performance for October 2020

Month					Hutt Valley DHB Operating Report for the month of October 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										
40,829	40,313	517	36,820	4,009	Devolved MoH Revenue	162,856	161,250	1,606	150,597	12,259	485,356	483,750	1,606	454,822	30,534
1,982	1,642	339	1,544	438	Non Devolved MoH Revenue	7,885	6,687	1,198	6,436	1,449	21,095	20,049	1,046	19,272	1,823
667	635	32	520	147	ACC Revenue	2,488	2,478	11	2,484	4	7,230	7,219	11	6,457	773
520	525	(6)	1,151	(632)	Other Revenue	2,137	2,123	14	2,702	(565)	6,323	6,309	14	6,074	250
11,039	9,229	1,810	9,197	1,841	IDF Inflow	39,552	36,914	2,638	34,800	4,752	113,044	110,742	2,302	102,288	10,756
1,140	303	837	474	667	Inter DHB Provider Revenue	3,367	1,213	2,154	1,331	2,036	9,038	3,637	5,401	4,507	4,531
56,176	**52,647**	**3,529**	**49,707**	**6,470**	**Total Revenue**	**218,286**	**210,665**	**7,622**	**198,350**	**19,936**	**642,087**	**631,707**	**10,380**	**593,420**	**48,667**
					Expenditure										
					Employee Expenses										
5,037	5,362	325	4,995	(42)	Medical Employees	20,950	21,138	188	19,680	(1,270)	59,832	63,310	3,477	60,010	177
5,738	6,474	736	6,199	460	Nursing Employees	24,650	25,883	1,233	24,185	(464)	69,875	76,767	6,892	75,339	5,464
2,272	2,897	625	2,609	337	Allied Health Employees	10,115	11,537	1,422	10,407	292	28,579	34,601	6,022	32,175	3,596
794	699	(95)	712	(82)	Support Employees	3,138	2,793	(345)	2,852	(286)	8,761	8,394	(367)	8,676	(85)
2,215	2,597	382	2,324	109	Management and Admin Employees	9,113	10,382	1,270	9,826	713	26,916	30,812	3,896	28,166	1,251
16,056	**18,028**	**1,973**	**16,838**	**783**	**Total Employee Expenses**	**67,965**	**71,733**	**3,768**	**66,950**	**(1,015)**	**193,963**	**213,884**	**19,921**	**204,366**	**10,403**
					Outsourced Personnel Expenses										
1,144	247	(896)	528	(616)	Medical Personnel	2,084	989	(1,096)	1,228	(857)	7,096	2,965	(4,130)	3,763	(3,333)
1,357	91	(1,266)	162	(1,195)	Nursing Personnel	1,651	364	(1,287)	645	(1,006)	8,159	1,093	(7,067)	2,002	(6,157)
971	87	(884)	63	(908)	Allied Health Personnel	1,097	350	(747)	194	(903)	6,634	1,049	(5,584)	583	(6,051)
46	20	(26)	3	(43)	Support Personnel	208	81	(127)	144	(64)	371	244	(127)	522	151
527	159	(367)	161	(366)	Management and Admin Personnel	1,749	487	(1,262)	489	(1,260)	5,363	1,765	(3,598)	1,671	(3,692)
4,045	**605**	**(3,440)**	**916**	**(3,129)**	**Total Outsourced Personnel Expenses**	**6,789**	**2,271**	**(4,519)**	**2,699**	**(4,090)**	**27,623**	**7,116**	**(20,507)**	**8,541**	**(19,082)**
(813)	697	1,510	839	1,651	Outsourced Other Expenses	3,661	2,788	(874)	3,116	(546)	9,281	8,363	(919)	9,845	563
2,555	2,336	(219)	2,503	(52)	Treatment Related Costs	10,235	9,443	(792)	9,896	(339)	29,854	28,666	(1,189)	27,169	(2,685)
2,823	1,588	(1,235)	1,915	(907)	Non Treatment Related Costs	8,773	6,224	(2,548)	6,904	(1,869)	26,125	18,467	(7,658)	37,215	11,091
9,352	9,151	(202)	9,363	11	IDF Outflow	36,894	36,602	(292)	33,779	(3,116)	110,098	109,807	(292)	101,298	(8,800)
19,497	19,026	(471)	16,863	(2,635)	Other External Provider Costs	76,543	75,953	(589)	70,881	(5,661)	229,963	227,534	(2,429)	218,583	(11,381)
2,222	2,377	154	2,294	71	Interest, Depreciation & Capital Charge	8,979	9,508	529	9,209	230	27,488	28,517	1,029	25,186	(2,302)
55,738	**53,808**	**(1,930)**	**51,531**	**(4,207)**	**Total Expenditure**	**219,839**	**214,522**	**(5,317)**	**203,433**	**(16,405)**	**654,396**	**642,352**	**(12,044)**	**632,203**	**(22,192)**
439	**(1,161)**	**1,599**	**(1,824)**	**2,263**	**Net Result**	**(1,553)**	**(3,857)**	**2,305**	**(5,083)**	**3,530**	**(12,309)**	**(10,645)**	**(1,663)**	**(38,784)**	**26,475**
					Result by Output Class										
(147)	(46)	(101)	(417)	270	Funder	1,813	(40)	1,853	(691)	2,504	3	(9)	13	(7,889)	7,893
157	(11)	167	(144)	300	Governance	255	0	254	(25)	280	230	(25)	254	634	(404)
429	(1,104)	1,533	(1,387)	1,816	Provider	(3,620)	(3,817)	198	(4,490)	871	(12,542)	(10,611)	(1,931)	(31,528)	18,986
439	**(1,161)**	**1,599**	**(1,948)**	**2,387**	**Net Result**	**(1,553)**	**(3,857)**	**2,305**	**(5,207)**	**3,655**	**(12,309)**	**(10,645)**	**(1,663)**	**(38,784)**	**26,475**

There may be rounding differences in this report

Executive Summary – Financial Position

Financial performance year to date

- Total Revenue favourable $7,622k
- Personnel and outsourced Personnel unfavourable $751k
  - Medical unfavourable ($908k); Nursing unfavourable ($53k); Allied Health favourable $675k, Support Staff unfavourable ($472k); Management and Admin favourable $9k; Annual leave Liability cost has increased by $1,409k since October 2019
- Outsourced other expenses unfavourable ($874k), includes MHAIDs changes
- Treatment related Costs unfavourable ($792k)
- Non Treatment Related Costs unfavourable ($2,548k), includes Holiday Act provision.
- IDF Outflow unfavourable ($292k)
- Other External Provider Costs unfavourable ($589k)
- Interest depreciation and capital charge favourable $529k

Analysis of Operating Position – Revenue

- **Revenue:** Total revenue favourable $3,529k for the month
  - Devolved MOH revenue $517k favourable, driven by COVID-19.
  - Non Devolved revenue $339k favourable driven largely by the recognition of COVID-19 Pharmaceutical Revenue.
  - ACC Revenue $32k favourable.
  - Other revenue ($6k) unfavourable for the month reflecting lower than expected co-patient revenue.
  - IDF inflows favourable $1,810k for the month driven by prior year wash-ups.
  - Inter DHB Revenue favourable $837k, 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 - October 2020	Funder [1] (4)	Provider (excl. Regional Public Health)	Provider - Regional Public Health (RPH) [1][3]	Total
$000s	Actual	Actual	Actual	Actual
Revenue				
MoH Revenue Recognised - COVID19 [2]	2,311	214	509	3,035
Expenditure				
Employee Expenses				
Medical Employees		(4)	91	87
Nursing Employees		1	206	208
Allied Health Employees		14	239	253
Support Employees		36	0	36
Management and Admin Employees		17	58	75
Total Employee Expenses	**0**	**64**	**595**	**659**
Expenses				
Outsoruced - Provider	0	17	21	37
External Providers - Funder	2,050			2,050
Clinical Expenses - Provider	0	2	17	19
Non-clinical Expenses- Provider	0	208	82	290
Total Non Employee Expenses	**2,050**	**227**	**119**	**2,396**
Total Expenditure	**2,050**	**291**	**714**	**3,055**
Net Impact	**261**	**(77)**	**(205)**	**(20)**

(1) RPH COVID19 Funding now through MoH Contract - not Devovled Funding
(2) Includes funding via Whanganui DHB
(3) Excludes overhead charges
(4) Includes technology grant

- The October year to date financial position includes $3.1m additional costs in relation to COVID-19.
- Revenue of $3.0m has been received to fund additional costs for community providers and Regional Public Health.
- The net impact year to date is $0.02m additional costs currently unfunded.

Analysis of Operating Position – Personnel

- **Total Personne**l including outsourced unfavourable ($1,467k) for the month
  - Medical personnel incl. outsourced unfavourable ($572k). Outsourced costs are ($896k) unfavourable, Medical Staff Internal are $325k favourable driven by the move to the new MHAIDS structure $281k.
  - Nursing incl. outsourced ($530k) unfavourable. Employee costs are $736k favourable, driven by moving to the new MHAIDS structure $616k. Excluding MHAIDS, the favourable movements were Senior Nurses $59k, Registered Nurses $139k, Registered Midwives $147k and Health Care Assistants $39k, partly offset by Internal Bureau Nurses and Health Care Assistants ($241k). This reflects the partial implementation of the Care Capacity Demand Management (CCDM) process and Maternity Review recommendations.
  - Allied Health incl. outsourced ($259k) unfavourable, with outsourced unfavourable ($884k), internal employees favourable $625k. Employee costs were driven by MHAIDS restructure $47k, with the balance in Regional Public Health vacancies.
  - Support incl. outsourced unfavourable ($120k), with Outsourced ($26k) unfavourable, and employee costs ($95k) unfavourable, driven by Orderlies ($32k), Cleaners ($13k), Sterile Supply Assistants ($24k) and Facilities ($31k).
  - Management & Admin incl. outsourced favourable $14k; internal staff favourable $382k, Outsourced unfavourable ($367k). This reflects the transition of ICT and MHAIDS Staff to the new structures.
  - Sick leave for October was 3.4%, which is lower than the same time last year, which was 3.5%.

FTE Analysis

Month					FTE Report	Year To Date					Annual	
Actual	Budget	Variance	Last Year	Variance	Oct-20	Actual	Budget	Variance	Last Year	Variance	Budget	Last Year
					FTE							
277	289	12	273	(4)	Medical	281	286	5	283	2	287	294
749	830	81	784	35	Nursing	792	831	39	793	1	829	818
341	416	75	382	40	Allied Health	370	416	47	394	25	417	402
149	137	(12)	141	(8)	Support	146	137	(9)	139	(7)	137	143
309	388	79	365	56	Management & Administration	331	388	57	371	40	388	365
1,826	**2,061**	**235**	**1,945**	**119**	**Total FTE**	**1,919**	**2,058**	**139**	**1,980**	**61**	**2,058**	**2,023**
					$ per FTE							
18,091	18,561	470	18,323	231	Medical	74,459	73,943	(516)	69,524	(4,936)	209,593	215,094
7,649	7,797	148	7,902	253	Nursing	31,122	31,158	37	30,490	(632)	84,955	93,878
6,647	6,958	312	6,837	190	Allied Health	27,359	27,713	355	26,404	(955)	69,697	86,026
5,310	5,095	(214)	5,040	(269)	Support	21,506	20,357	(1,149)	20,502	(1,004)	63,698	58,552
7,170	6,695	(475)	6,368	(802)	Management & Administration	27,535	26,772	(763)	26,516	(1,019)	69,828	84,348
8,773	**8,749**	**(24)**	**8,658**	**(115)**	**Average Cost per FTE all Staff**	**35,393**	**34,858**	**(535)**	**33,811**	**(1,582)**	**94,986**	**105,729**

Medical under budget for the month by 12 FTE, driven by the MHAIDS restructure 14FTE:
Excluding MHAIDS the contribution to movements were; SMOs under budget by 7FTE, offset by RMO's & House Officers combined

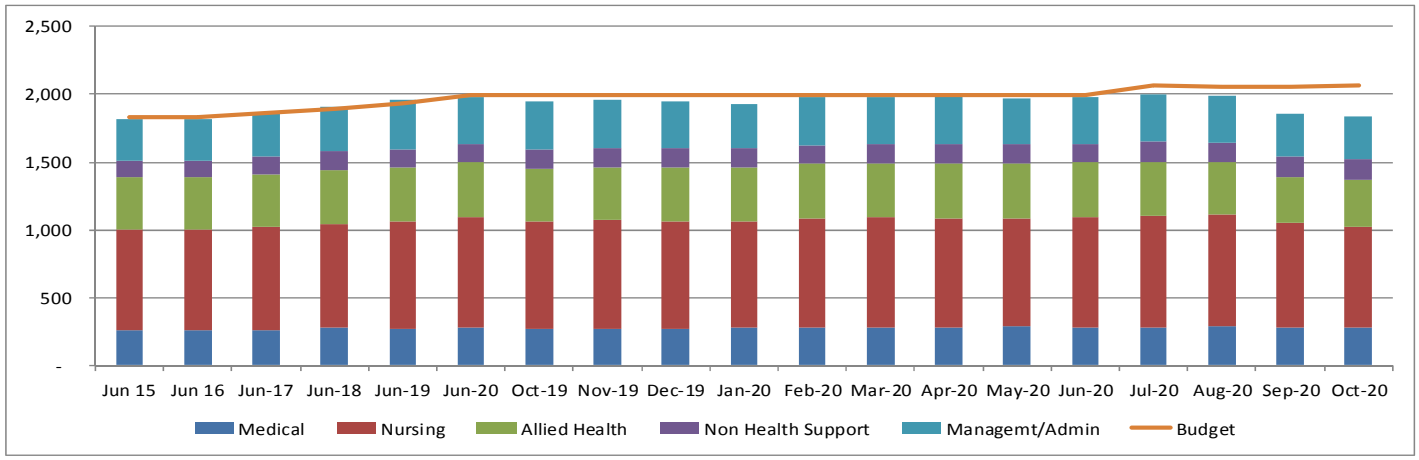
Nursing under by 81 FTE for the month, driven by MHAIDS restructure 75 FTE:
Excluding MHAIDS the contribution to movements were; Internal Bureau Nurses and HCA's are over budget (24) FTE mostly driven by General Medical (14) FTE, ED (2) FTE and other variances. This is offset by Registered Nurses and Health Care Assistants under budget 10 FTE and Registered Midwives 18 FTE. This reflects the transition of changes made under both CCDM recommendations and the Maternity Review.

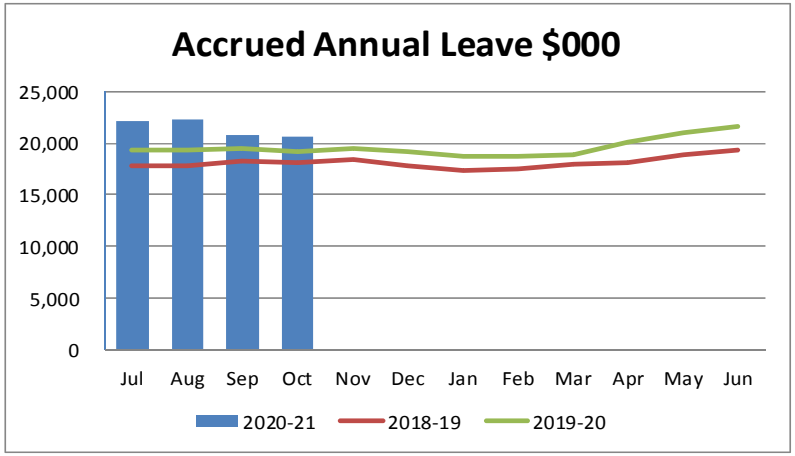
Allied FTEs are under by 75 FTEs for the month, driven by the MAHIDS restructure 62:
Excluding MHAIDS the contribution to movements were; Favourable variances in Health promotion 5 FTE, Other Allied Health 3 FTE, Pharmacists 2 FTE.

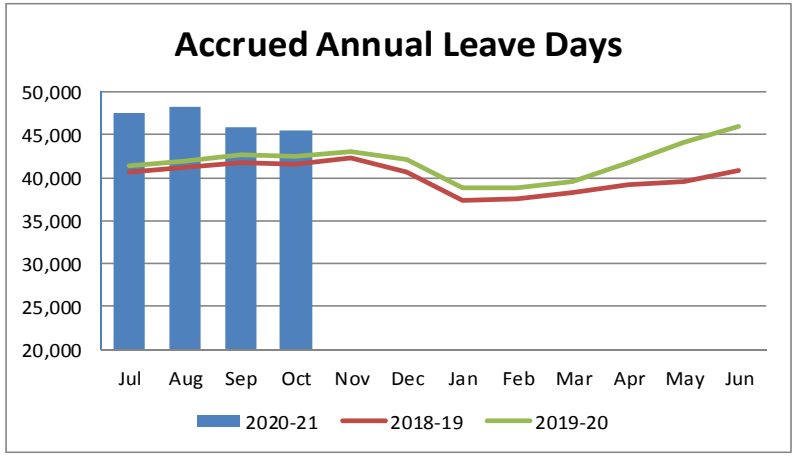
Support FTEs are (12) FTEs over budget driven by Food services (2) FTE, Cleaning (2) FTE and Orderlies (8) FTE.

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 favourable $1,510k for the month, $2,235k driven by 3DHB MHAIDS charges recoded to outsourced personnel. This is a one-off to correctly classify these costs. Excluding MHAIDS the balance ($725k), was driven by the Regional TAS work plan.
  - Treatment related costs ($219k) unfavourable. Treatment Disposables ($62k), Health Promotion and Education ($70k) and other minor variances.
  - Non Treatment Related costs unfavourable ($1,235k) including the provision for Holidays Act settlement ($227k) which is not budgeted as advised by MoH, Rent ($16k) non-clinical MHAIDS recoveries by CCDHB ($795k – prior months included in External Provider cots), Security ($12k) related mainly to COVID-19, Linen & Laundry ($18k) Food and Groceries ($16k) and other minor variances.
  - IDF Outflows ($202k) unfavourable for the month, reflecting current year wash-up payments.
  - Other External Provider costs unfavourable ($471k), driven by Public Health ($144k) predominantly related to COVID-19, Community Pharms ($985k), partly offset by Disability Support Providers $953k and other minor variances.
  - Interest, Depreciation & Capital Charge favourable $154k, driven by depreciation $151k.

Section 5

Additional Financial Information & Updates

Financial Position as at 31 October 2020

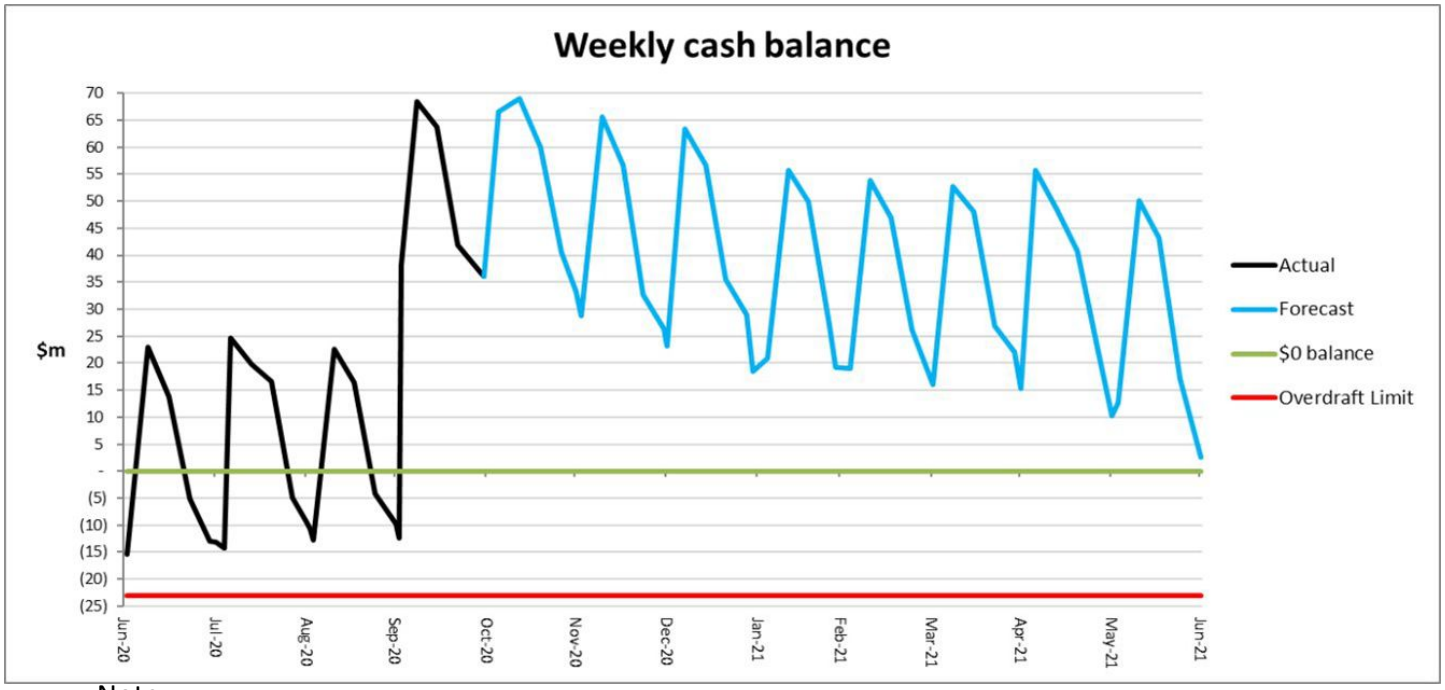
$000s	Actual	Budget	Variance	Jun 20	Variance	Explanation of Variances Between Actual and Budget
Assets						
Current Assets						
Bank	36,073	(22,724)	58,797	(10,986)	47,059	Average bank balance in Oct-20 was $50.2m, $35m equity injection received Oct-20
Bank - Non DHB Funds *	2,231	4,927	(2,696)	4,927	(2,696)	
Accounts Receivable & Accrued Revenue	22,639	27,577	(4,938)	27,577	(4,938)	
Stock	2,256	2,200	57	2,199	58	
Prepayments	2,115	815	1,300	815	1,300	
Total Current Assets	**65,315**	**12,795**	**52,520**	**24,532**	**40,783**	
Fixed Assets						
Fixed Assets	227,079	236,538	(9,458)	229,790	(2,711)	
Work in Progress	15,679	12,501	3,178	14,001	1,678	
Total Fixed Assets	**242,758**	**249,039**	**(6,281)**	**243,791**	**(1,033)**	
Investments						
Investments in Associates	1,150	1,150	0	1,150	0	Allied Laundry
Trust Funds Invested	1,236	1,347	(111)	1,347	(111)	Restricted Trusts
Total Investments	**2,386**	**2,497**	**(111)**	**2,497**	**(111)**	
Total Assets	**310,459**	**264,331**	**46,128**	**270,820**	**39,639**	
Liabilities						
Current Liabilities						
Accounts Payable and Accruals	77,021	66,274	(10,747)	73,615	(3,406)	Includes Holidays Act Provision of $28.4m
Crown Loans and Other Loans	28	42	14	42	14	
Capital Charge Payable	4,141	0	(4,141)	0	(4,141)	
Current Employee Provisions	27,944	26,018	(1,926)	26,518	(1,426)	
Total Current Liabilities	**109,134**	**92,334**	**(16,800)**	**100,175**	**(8,959)**	
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	2,231	4,927	2,696	4,927	2,696	
Trust Funds	1,274	1,347	72	1,347	72	
Total Non Current Liabilities	**12,656**	**15,426**	**2,770**	**15,424**	**2,768**	
Total Liabilities	**121,790**	**107,759**	**(14,030)**	**115,598**	**(6,191)**	
Net Assets	**188,669**	**156,572**	**32,098**	**155,222**	**33,447**	
Equity						
Crown Equity	158,916	129,123	29,793	123,916	35,000	Equity Deficit Support injection received $35m
Revaluation Reserve	146,289	146,289	0	146,289	0	
Opening Retained Earnings	(114,982)	(114,982)	0	(76,199)	(38,784)	
Net Surplus / (Deficit)	(1,553)	(3,857)	2,305	(38,784)	37,231	
Total Equity	**188,669**	**156,572**	**32,098**	**155,222**	**33,447**	

* NHMG - National Haemophilia Management Group

Statement of Cash Flows to 31 October 2020

$000s	Jul Actual	Aug Actual	Sep Actual	Oct Actual	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	42,820	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	18,597	9,602	9,936	9,938	9,938	9,938	9,938	9,938	9,938
Receipts from Other Government Sources	721	778	753	770	834	710	683	750	638	677	638	750
Other Revenue	1,833	1,581	(2,392)	1,408	380	380	388	380	380	383	380	380
Total Receipts	**53,100**	**54,861**	**51,678**	**63,595**	**52,782**	**53,006**	**52,890**	**52,967**	**53,046**	**52,989**	**52,953**	**53,121**
Payments for Personnel	(21,092)	(16,745)	(18,276)	(19,398)	(17,869)	(19,334)	(17,884)	(17,195)	(19,396)	(18,675)	(17,948)	(18,679)
Payments for Supplies (Excluding Capital Expenditure)	(4,686)	(5,368)	(4,330)	(4,464)	(5,160)	(3,192)	(8,172)	(7,342)	(5,041)	(5,333)	(5,303)	(5,322)
Capital Charge Paid	0	0	0	0	(0)	(6,210)	(0)	(0)	(0)	(0)	(0)	(7,260)
GST Movement	(710)	75	230	1,030	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)	(10,119)	(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)	(19,353)	(20,818)	(19,148)	(18,907)	(18,092)	(18,814)	(19,187)	(19,366)	(19,088)
Total Payments	**(54,427)**	**(49,991)**	**(50,784)**	**(52,305)**	**(52,647)**	**(56,684)**	**(53,765)**	**(53,780)**	**(54,401)**	**(53,345)**	**(54,267)**	**(56,150)**
Net Cashflow from Operating Activities	**(1,327)**	**4,871**	**894**	**11,290**	**135**	**(3,679)**	**(875)**	**(813)**	**(1,355)**	**(356)**	**(1,314)**	**(3,029)**
Investing Activities												
Interest Receipts	0	0	0	28	21	21	21	21	21	21	21	21
Dividends	0	0	0	0	4	4	4	4	4	4	4	4
Total Receipts	**0**	**0**	**0**	**28**	**25**	**25**	**25**	**25**	**25**	**25**	**25**	**25**
Capital Expenditure	(913)	(1,399)	(964)	(512)	(8,772)	(1,772)	(272)	(1,772)	(5,772)	(14,772)	(1,972)	(4,773)
Increase in Investments and Restricted & Trust Funds Assets	99	57	13	(58)	0	0	0	0	0	0	0	0
Total Payments	**(814)**	**(1,343)**	**(951)**	**(571)**	**(8,772)**	**(1,772)**	**(272)**	**(1,772)**	**(5,772)**	**(14,772)**	**(1,972)**	**(4,773)**
Net Cashflow from Investing Activities	**(814)**	**(1,343)**	**(951)**	**(542)**	**(8,747)**	**(1,747)**	**(247)**	**(1,747)**	**(5,747)**	**(14,747)**	**(1,947)**	**(4,748)**
Financing Activities												
Equity Injections - Capital	0	0	0	0	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**	**35,000**	**0**	**0**	**0**	**0**	**4,000**	**13,000**	**0**	**0**
Interest Paid on Finance Leases	(9)	(5)	(3)	(3)	(6)	(6)	(6)	(6)	(6)	(5)	(5)	(5)
Total Payments	**(9)**	**(5)**	**(3)**	**(3)**	**(6)**	**(6)**	**(6)**	**(6)**	**(6)**	**(5)**	**(5)**	**(5)**
Net Cashflow from Financing Activities	**(9)**	**(5)**	**(3)**	**34,997**	**(6)**	**(6)**	**(6)**	**(6)**	**3,994**	**12,995**	**(5)**	**(5)**
Total Cash In	53,100	54,861	51,678	98,624	52,807	53,031	52,915	52,992	57,071	66,014	52,978	53,146
Total Cash Out	(55,250)	(51,338)	(51,738)	(52,878)	(61,425)	(58,463)	(54,043)	(55,558)	(60,179)	(68,123)	(56,245)	(60,929)
Net Cashflow												
Opening Cash	(10,986)	(13,136)	(9,613)	(9,673)	36,073	27,455	22,023	20,895	18,329	15,221	13,113	9,846
Net Cash Movements	(2,150)	3,523	(60)	45,746	(8,618)	(5,432)	(1,128)	(2,566)	(3,108)	(2,108)	(3,267)	(7,783)
Closing Cash	**(13,136)**	**(9,613)**	**(9,673)**	**36,073**	**27,455**	**22,023**	**20,895**	**18,329**	**15,221**	**13,113**	**9,846**	**2,063**

Weekly Cash Flow – Actual to 31 October 2020



Note

- the overdraft facility shown in red is set at $23 million as at October 2020
- the lowest bank balance for the month of October was $12.4m overdrawn
- there was an equity injection of $35m in October.

Summary of Leases – as at 31 October 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 (*Lease renewal currently in negotiation)		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)			35,545	426,534		Ongoing	Ongoing	Operating
			35,545	**426,534**				
Equipment Leases	**Supplier**							
MRI Ingenia 1.5T	De Lage Landen (paid monthly in arrears)		22,498	269,981	1,349,905	19/09/2019	19/08/2024	Operating
Fluoroscopy Combi Diagnost	De Lage Landen (paid monthly in arrears)		9,753	117,037	585,185	1/08/2019	31/07/2024	Operating
Plastics Micro Power Tools	Stryker New Zealand Ltd	293,188	3,490	41,884	125,652	1/10/2018	30/09/2025	Finance
Orthopaedic Tools	Stryker New Zealand Ltd		9,024	108,292	758,044	1/09/2016	31/08/2023	Operating
3 x Ultrasounds (Equigroup)	GE Healthcare Ltd		7,315	87,782	153,618	28/09/2020	28/06/2022	Operating
1 x Ultrasound Epiq (Equigroup)	Philips NZ Commercial Ltd		1,761	21,129	40,498	28/09/2020	28/08/2022	Operating
CT Scanner 128 Slice (Equigroup)	Toshiba Medical Systems		24,976	299,711	499,518	28/09/2020	28/05/2022	Operating
Philips Digital Diagnost C90	De Lage Landen (paid monthly in arrears)		7,265	87,186	435,930	31/01/2020	31/01/2025	Operating
Philips Digital Diagnost C90	De Lage Landen (paid monthly in arrears)		6,184	74,214	371,070	31/01/2020	31/01/2025	Operating
Philips Diagnost R2	De Lage Landen (paid monthly in arrears)		3,932	47,186	235,930	1/06/2020	1/06/2025	Operating
Philips Digital Diagnost C90 (ED)	De Lage Landen (paid monthly in arrears)		6,177	74,118	370,592	30/09/2020	30/09/2025	Operating
Philips Digital Diagnost C90 (Resus)	De Lage Landen (paid monthly in arrears)		3,877	46,520	232,601	31/08/2020	31/08/2025	Operating
		293,188	**106,251**	**1,275,040**	**5,158,543**			
Total Leases			**194,626**	**2,335,529**				

Treasury as at 31 October 2020

1) Short term funds / investment ($000)

NZHP banking activities for the month	Current month ($000)	Last month ($000)
Average balance for the month	$50,221	$9,180
Lowest balance for the month	($12,394)	($12,740)
Average interest rate	0.67%	(0.42%)
Net interest earned/(charged) for the month	$28	($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	6
Total value of transactions	$12,858 NZD
Largest transaction	$6,369 NZD

	No. of transactions	Equivalent NZD
AUD	5	$6,489
GBP	1	$6,369
SGD		
USD		
Total	**6**	$12,858

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	$4,029	$932	$2,567	$79	$135	$73	$0	$242
Capital & Coast District Health Board	$2,869	$133	$206	$109	$42	$150	$51	$2,178
Accident Compensation Corporation	$657	$603	($247)	$5	$11	$77	($50)	$258
Wairarapa District Health Board	$469	$11	$9	$40	$29	$33	$199	$148
Auckland District Health Board	$92	$81	$0	$3	$2	$0	$0	$7
Wellington Southern Community Laboratories	$67	$3	$2	$0	$0	$0	$0	$62
Abbvie Limited	$66	$66	$0	$0	$0	$0	$0	$0
Crispin Gondra	$55	$0	$0	$0	$3	$0	$0	$53
ESR Limited	$51	$51	$0	$0	$0	$0	$0	$0
Oranga Tamariki - Ministry for Children	$42	$0	$0	$0	$0	$0	$0	$42
Total Top 10 Debtors	**$8,398**	**$1,880**	**$2,538**	**$235**	**$221**	**$333**	**$200**	**$2,990**

Board Information

December 2020

Capital & Coast DHB October 2020 Financial and Operational Performance Report	
Action Required **The Capital & Coast DHB Board note:** (a) The DHB had a ($3.8m) deficit for the month of October 2020, being $708k favourable to budget before excluding COVID-19 and Holidays Act [2003] (b) The DHB year to date had a deficit of ($16.1m), being ($3.4m) unfavourable to budget before COVID-19 and Holidays Act [2003] (c) In the three months we have incurred $7.7m additional net expenditure for COVID-19 and $2.7m against provision for Holidays Act [2003] (d) This means that the DHB has an overall YTD deficit of ($5.6m) from normal operations (excluding COVID-19 and Holidays Act) being $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 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 31 October 2020 is $5.6m deficit, versus a budget deficit of $12.6m.

Additional net COVID related expenditure above funding, year to date is $7.7m.

The monthly provision for increasing Holidays Act liability is $756k and year to date the impact on the result is $2.7m

For the four months to 31 October 2020 the overall DHB year to date result, including COVID and Holidays Act costs is $16.1m deficit.

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

Capital Expenditure was $13 million year to date.

We had a negative cash Balance at month-end of $20.6 million offset by positive "Special Funds" of $12.9 million (net $7.7 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 hospital had a very busy month – going against the first quarter trends the number of ED presentations in October 2020 was higher than the number recorded in the same month in the previous financial year with record numbers of triage 1 and 2 presentations. Correspondingly the utilisation of available of adult beds in core wards in October 2020 is 94.2% which is higher than the 91.8% rate recorded in October 2019.

Addressing ESPI 2 and 5 waiting lists remains a significant challenge and risk with the numbers of patients waiting more than 120 days for treatment fluctuating month on month. We are waiting for confirmation from MoH to our submission for planned care recovery funding to secure additional outsourcing volume to meet a required reduction in ESPI2 and ESPI 5 waitlists with our system improvement project making good progress around all aspects of managing elective flow.

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 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 and the added pressure of high activity this 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 as per previous month's reports. . Notable highlights this month are the a working group established to identify space to create additional acute assessment bed and use of the transit lounge for some selected patient pathways has also been initiated to try and improve flow.

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.

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 24 FTE above our annual budget (however note lead DHB roles).
Financial	The YTD result for the DHB was ($5.6m) deficit from normal operations, against our DHB budget of ($12.6m). An additional ($7.7m) was spend on unfunded COVID-19 costs split between the provider and funder arm, and ($2.7m) was recognised for Holidays Act provisions.
Governance	The Board has a responsibility to scrutinise the financial reports alongside FRAC, and report back issues as identified.

Engagement/Consultation

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

Identified Risks

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

Attachment/s

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

Capital & Coast District Health Board

Monthly Financial and Operational Performance Report

For the period ending 31 October 2020

Presented in December 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 31 October 2020 is $5.6m deficit, versus a budget deficit of $12.6m.
- Additional net COVID related expenditure above funding, year to date is $7.7m.
- The monthly provision for increasing Holidays Act liability is $756k and year to date the impact on the result is $2.7m
- For the four months to 31 October 2020 the overall DHB year to date result, including COVID and Holidays Act costs is $16.1m deficit.
- The DHB has submitted an Annual baseline budget of $39.8 million deficit. The DHB is working with the Ministry to have the budget and Annual Plan signed off.
- Capital Expenditure was $13 million year to date.
- We had a negative cash Balance at month-end of $20.6 million offset by positive "Special Funds" of $12.9 million (net $7.7 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.

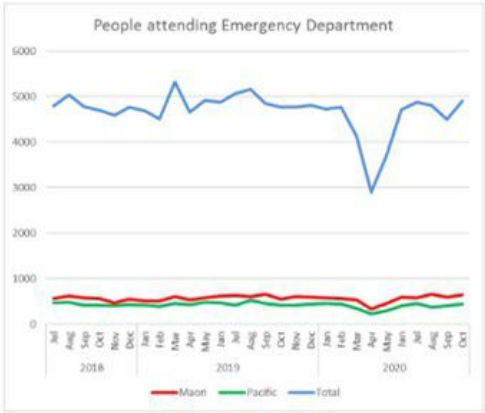
Executive Summary continued

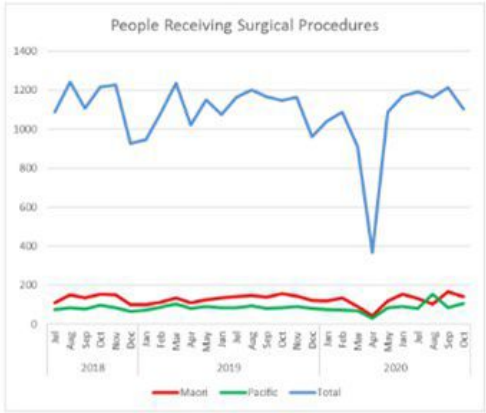
- The hospital had a very busy month – going against the first quarter trends the number of ED presentations in October 2020 was higher than the number recorded in the same month in the previous financial year with record numbers of triage 1 and 2 presentations. Correspondingly the utilisation of available of adult beds in core wards in October 2020 is 94.2% which is higher than the 91.8% rate recorded in October 2019.
- Addressing ESPI 2 and 5 waiting lists remains a significant challenge and risk with the numbers of patients waiting more than 120 days for treatment fluctuating month on month. We are waiting for confirmation from MoH to our submission for planned care recovery funding to secure additional outsourcing volume to meet a required reduction in ESPI2 and ESPI 5 waitlists with our system improvement project making good progress around all aspects of managing elective flow.
- 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 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 and the added pressure of high activity this 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 as per previous months reports. . Notable highlights this month are the a working group established to identify space to create additional acute assessment bed and use of the transit lounge for some selected patient pathways has also been initiated to try and improve flow.
- 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.

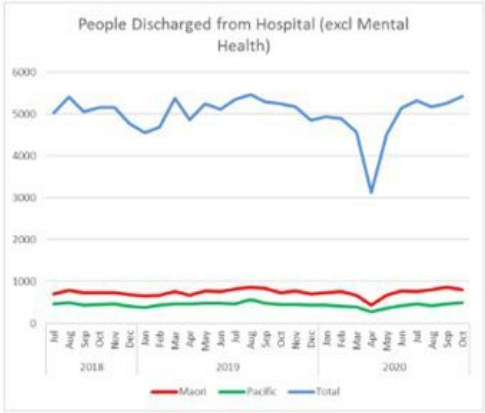
Performance Overview: Activity Context (People Served)

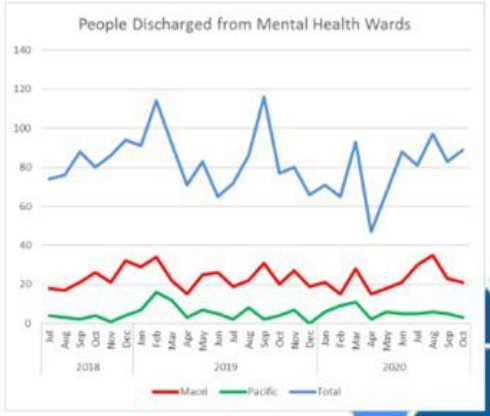
CCDHB funds services that touch thousands of people in our community every month. Unless otherwise indicated, the numbers below count individuals once and are based on CCDHB being the DHB of Service. Our services have returned to delivering services to our population without the restrictions due to COVID-19.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

People attending ED	**4,910**	645 Maori, 441 Pacific
People receiving Surgical Procedures (in main theatres)	**1,103**	140 Maori, 106 Pacific
People discharged from Kenepuru Community Hospital or Wellington Regional Hospital (excl Mental Health)	**5,414**	804 Maori, 502 Pacific
People discharged from Mental Health Wards	**89**	21 Maori, 3 Pacific



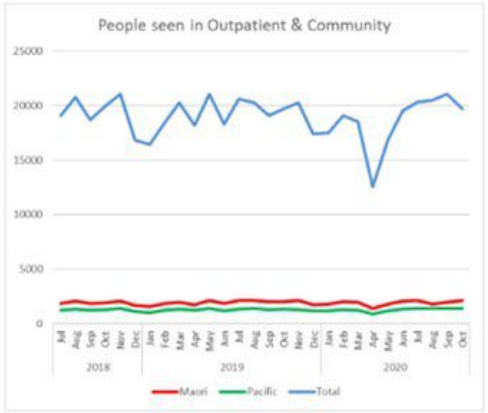


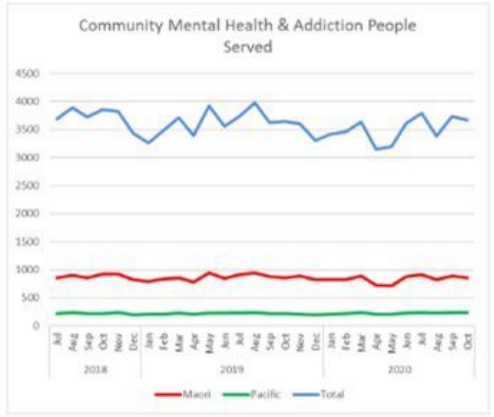


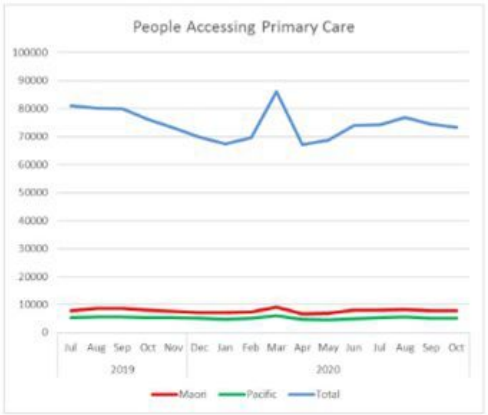


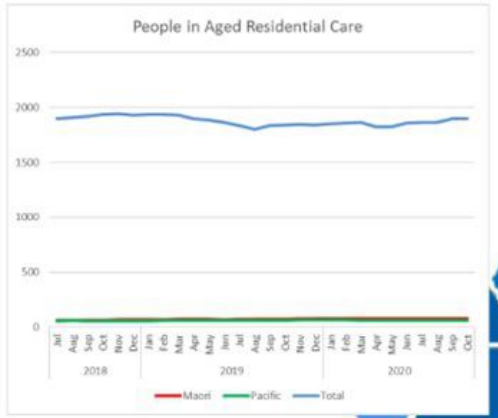
Performance Overview: Activity Context (People Served)

People seen in Outpatient & Community	**19,703**	2,133 Maori, 1,386 Pacific
Community Mental Health & Addiction People Served	**3,665**	860 Maori, 236 Pacific
People accessing primary care	**73,381**	7,715 Maori, 5,147 Pacific
People in Aged Residential Care	**1,898**	77 Maori, 63 Pacific









Financial Overview – October 2020

YTD Operating Position	YTD Provider Position	YTD Funder Position	YTD Capital Exp
$16.1m deficit Incl. $7.7m COVID-19 costs Incl. $2.7m Holidays Act	$10.9m deficit Incl. $6m COVID-19 costs Incl. $2.7m Holidays Act	$5.4m deficit Incl. $1.7m COVID-19 costs	$17.2m spend Incl. $5.0m strategic capex
Against a budgeted YTD deficit of $12.6m. BAU Month result was $1.3m favourable. YTD $7m favourable BAU variance.	Against a budgeted deficit of $8.4m. BAU Month result was $1.3m favourable. BAU YTD $6.2m favourable variance.	Against a budgeted deficit of $4.3m. BAU Month result was $32k favourable result. YTD $0.6m favourable BAU variance.	Against a KPI of a budgeted baseline (non-strategic) spend of $22m. This includes funded projects – Children's Hospital

YTD Activity vs Plan (CWDs)	YTD Paid FTE	Annual Leave Taken
0.78% behind[1]	5,473[3]	($15.9m) annualised[4]
190 CWDs below PVS plan (34 IDF CWDs ahead, of which 89 Hutt). Month result +130.5 CWDs excluding work in progress.	YTD 24 above annual budget of 5,449 FTE (budget excludes lead DHB). There is 578 FTE vacancies at end October inclusive of lead DHB transfers.	Underlying YTD annual leave taken is under by 6.8 days per FTE and Lieu leave taken for public holidays is short by 2.6 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 826 cwd outsourced (454 events) ~$4.6m 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 64 FTE worse than budgeted growth, Outsourced staff are also not counted in this metric which is currently $2.7m 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 – October 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]
65.1%	149	185	3
29.9% below the ED target of 95% Monthly -0.5%	Against a target of zero long waits a monthly movement of +146	Against a target of zero long waits, a monthly movement of -129	An expectation is for nil SSEs at any point.

YTD Activity vs Plan (CWDs)	YTD Paid FTE	YTD Cost per WEIS
0.78% behind[1]	3,613[3]	$5,840*
190 CWDs below PVS plan (34 IDF CWDs ahead, of which 89 Hutt). Month result +130.5 CWDs excluding work in progress.	YTD 51 below annual budget of 3,664 FTE. 283 FTE vacancies at month end.	Against a national case-weight price per WEIS of $5,545 (5.3% above).*to Oct 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 826 cwd outsourced (454 events) ~$4.6m 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 28 FTE worse than budgeted, Outsourced staff are also not counted in this metric which is currently $385k 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 positive variance of $400k, when adjusted for the current loss on COVID costs in our community. Revenue was $7,787k ahead of budget entirely due to COVID 19 revenue.
- CCDHB has additional COVID revenue of $6,400k and the costs are $5,700k. Of this funding $1.4m is for pharmaceutical cost pressures. Recovery 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.
- Achievement of volumes by the hospital provider arm, and under delivery of acute inter-district flows account for the most significant variations being a $614k variance which offsets the revenue and the cost to the funder.
- Funding for community services are $1,200k unfavourable 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.
- There remains risk in the loss of inter-district flow revenue, planned care for the provider arm and pharmaceutical costs in a post-covid environment. All of these elements are being closely managed.
- 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:
  - 91% of people felt they were treated with respect, and 88% kindness and understanding. 84% of respondents also indicated that their cares and concerns were adequately listened to but only 65% felt that they had been provided enough information to manage their condition and recovery. There is opportunity for improvement in this measure.
  - There have been 328 ambulance diversions in the year to September 2020. Of these, approximately 65% were aged over 65 years old and 10% have been for Māori. There has also been an overall decrease in the cumulative number of ambulances arriving to Wellington ED from Kāpiti.
  - The DNA rate for outpatient appointments is a significant focus of CCDHB to improve equity by reducing DNA rates through changes in model of care and better use of technology.

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	Oct 2020	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year
72,885	72,885	68,138	0	4,747	Base Funding	291,540	291,540	272,552	0	18,988
7,571	4,665	5,183	2,906	2,388	Other MOH Revenue - Funder	22,852	18,660	20,657	4,192	2,195
1,120	0	0	1,120	1,120	COVID Revenue from MOH	3,172	0	0	3,172	3,172
120	45	110	75	10	Other Revenue	760	181	387	579	373
3,088	2,936	2,743	152	345	IDF Inflows PHOs	12,268	11,743	10,943	525	1,325
19,522	18,517	15,135	1,005	4,387	IDF Inflows 19/20 Wash-up Prov	73,385	74,066	67,615	(681)	5,770
104,306	**99,048**	**91,309**	**5,258**	**12,996**	**Total Revenue**	**403,977**	**396,191**	**372,154**	**7,787**	**31,824**
					Internal Provider Payments					
824	824	958	0	134	DHB Governance & Administration	3,295	3,295	3,832	0	538
54,723	53,223	44,253	(1,500)	(10,469)	DHB Provider Arm Internal Costs - HHS	218,883	218,704	197,530	(178)	(21,353)
7,767	7,752	8,815	(16)	1,048	DHB Provider Arm Internal Costs - MH	31,070	31,006	35,203	(64)	4,133
2,355	1,983	6,173	(372)	3,818	DHB Provider Arm Internal costs - Corp	6,236	5,864	7,594	(372)	1,358
65,669	**63,781**	**60,200**	**(1,888)**	**(5,469)**	**Total Internal Provider**	**259,483**	**258,869**	**244,159**	**(614)**	**(15,324)**
					External Provider Payments:					
7,200	5,703	6,018	(1,497)	(1,182)	- Pharmaceuticals	25,359	22,811	23,242	(2,548)	(2,116)
6,690	6,645	6,376	(45)	(314)	- Capitation	26,864	26,581	25,454	(283)	(1,410)
7,208	7,354	6,992	147	(216)	- Aged Care and Health of Older Persons	28,735	29,418	28,136	683	(599)
2,796	2,862	2,377	66	(419)	- Mental Health	11,389	11,448	9,532	59	(1,857)
871	807	646	(64)	(224)	- Child, Youth, Families	3,232	3,228	2,624	(3)	(608)
651	606	615	(45)	(36)	- Demand driven Primary Services	2,481	2,800	2,503	318	21
2,643	2,356	2,277	(287)	(366)	- Other services	9,887	9,425	9,297	(461)	(590)
3,725	3,725	1,689	0	(2,036)	- IDF Outflows Patients to other DHBs	14,901	14,901	12,655	0	(2,246)
5,276	5,240	4,944	(36)	(332)	- IDF Outflows Other	21,327	20,960	19,768	(367)	(1,559)
37,060	**35,299**	**31,934**	**(1,761)**	**(5,127)**	**Total External Providers**	**144,175**	**141,573**	**133,211**	**(2,602)**	**(10,963)**
712	**0**	**0**	(712)	(712)	- COVID in Community PHO, Pharms, ARC	**5,671**	**0**	**0**	(5,671)	(5,671)
103,441	**99,080**	**92,134**	**(4,361)**	**(10,596)**	**Total Expenditure**	**409,329**	**400,442**	**377,370**	**(8,887)**	**(31,958)**
864	**(33)**	**(824)**	**897**	**1,689**	**Net Result**	**(5,351)**	**(4,251)**	**(5,217)**	**(1,100)**	**(135)**

Funder Financials – Variance Explanations

Revenue

- Revenue has a positive variance YTD Oct of $7.7m. The table below outlines the drivers of this variation.
- COVID-19 community funding of $6.4m has been received from the Ministry. This includes $1.4m for Pharmaceutical cost pressures. The balance is mainly PHO GP Assessments & CBACS plus other response funding. There are cost offsets. The funding does not offset all the costs.
- There is still a shortfall of ($1.7m) YTD. This includes a provisional revenue accrual of $790k for Quarantine (MIQ) costs. Ongoing discussions with the Ministry indicate that the DHB will be fully funded for COVID community costs.
- PHO funding wash-ups and volume funding of $844k. There are increased costs of ($520k) offsetting this revenue. New funding for Mental Health of $1.02m is also offset by costs.

SIP Funder Revenue Variances	Month $000's	YTD $000's
COVID-19 community funding	3,643	6,354
PHOs wash-up & add funding	(68)	844
New Mental Health CFAs	678	1,020
Other revenue with equivalent costs	0	250
CWD IDF 2020/21 wash-up provision	1,005	(681)
Year to Date Revenue Variances	**5,258**	**7,787**

Internal Provider Payments:

- An amount of $350k was not paid to the Provider Arm due to under achievement of the IDF targets at YTD Oct 2020. Provision for payment of MIQ costs ($790k) to Provider were made in October.

External Provider Payments:

- Pharmaceuticals costs are showing the impact of COVID-19 with increasing costs unfavourable to budget by ($760k). The DHB has received additional COVID funding which offsets this cost pressure.
- PHO Capitation expenses are ($283k) unfavourable. Additional costs due to volume changes are offset by additional revenue. Effect is expected to be neutral at year end.
- Aged Residential Care and Health of Older People costs are $683k favourable. Volumes are being maintained.
- Demand driven and other services are unfavourable by ($143k). Lower costs due to the effect of COVID-19 lockdown on activity such as immunisations offset by higher youth dental volumes.
- IDF Outflows have additional costs ($367k) relates to washup for PHOs. See revenue note.
- COVID-19 costs ($5.7m) mainly due to ongoing GP assessment and CBAC claims in support of the COVID-19 response as directed by the Ministry.

Modelling CCDHB Values

Manaakitanga
Kotahitanga
Rangatiratanga

What is this measure?

- The national HQSC adult inpatient experience survey is for adults who spent at least one night in hospital.

Why is this important?

CCDHB values were developed to reflect our aspirations for patient and staff experience.

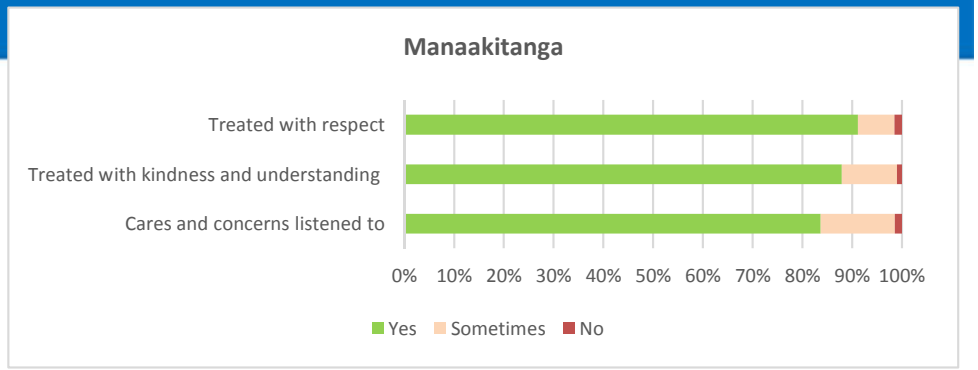
- **Manaakitanga** - respect, caring, kindness;
- **Kotahitanga** – connection, unity, equity; is the principle of togetherness, solidarity and collective action.
- **Rangatiratanga** – autonomy, integrity, excellence; captures peoples' right to participate in making decisions about their health.

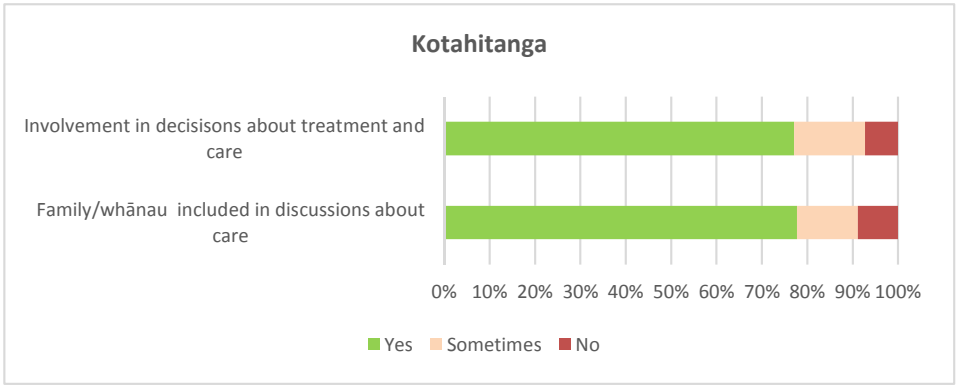
How are we performing?

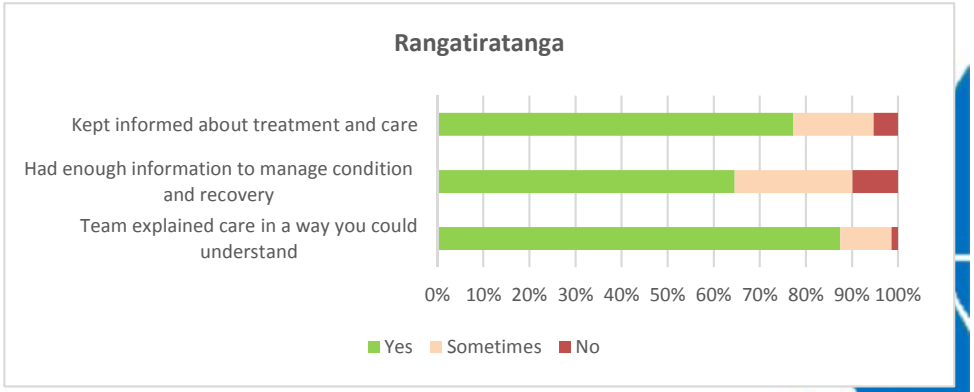
- **Manaakitanga –** 91% of people felt they were treated with respect, and 88% kindness and understanding. 84% of respondents also indicated that their cares and concerns were adequately listened to.
- **Kotahitanga -** 77% of respondents felt that both they and their family/whānau were involved in discussion and decision-making about their treatment and care.
- **Rangatiratanga** - 65% felt that they had been provided enough information to manage their condition and recovery. There is opportunity for improvement in this measure.

Management comment

- Some initiatives include: Kōrero Mai (talk to me) service implemented to help patients and their whānau get the help they need; 80% of CCDHB staff trained in speaking up for safety; engagement with Māori and Pacific Health services to understand the drivers behind lower response rates.







Kāpiti CARS

What is this measure?

- Reducing the burden of unnecessary transfers to hospital on people in Kāpiti, and the reduction of acute patients in Wellington regional Hospital.

Why is this important?

- Each year, around 1,500 Kāpiti people presented to ED by ambulance and went home on the same day.
- Kāpiti CARS was implement to reduce travel to Wellington Hospital with conditions that could be managed by our Health Care Home practice teams.

How are we performing?

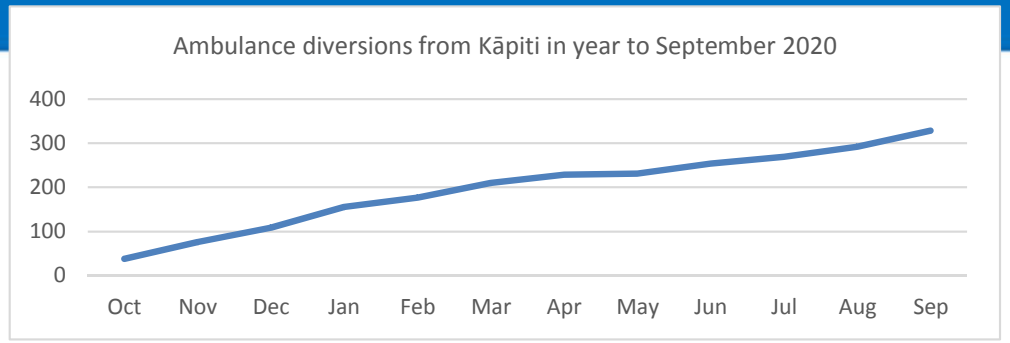
- There have been 328 ambulance diversions in the year to September 2020. Of these, approximately 65% were aged over 65 years old and 10% have been for Māori. There has also been an overall decrease in the cumulative number of ambulances arriving to Wellington ED from Kāpiti.

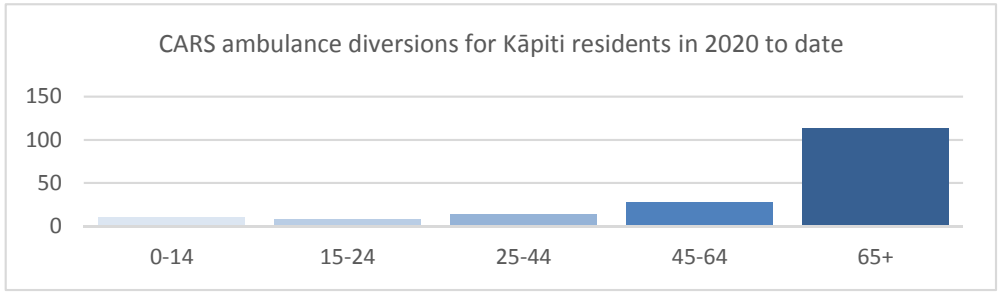
What is driving performance?

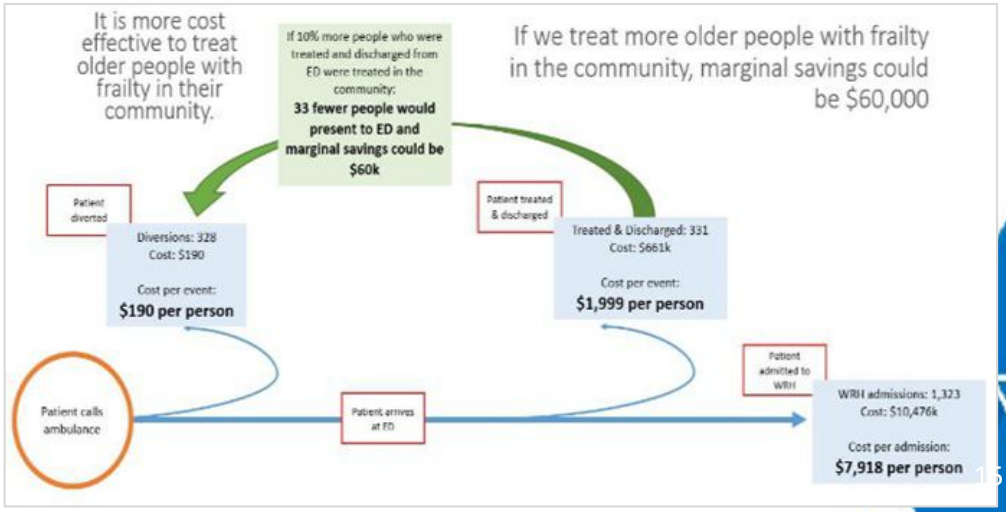
- Ambulance diversions were impacted significantly by the lockdown period, but diversion activity has begun to increase since exiting level 4. Eight of the ten Kāpiti practices continue to receive ambulance transfers.

Management comment:

- By leveraging off health care home investment and capacity, the management of people's health in the community has been improved and increased.
- Community Health Networks are CCDHBs approach to organising and delivering enhanced care locally. In July 2020, we began the design and development of the DHBs first CHN, in Kāpiti.
- It costs significantly less ($190 per person) to address and manage health concerns in the community than for the same group to present to ED.







Measles

What is this measure?

- 95% of eligible people are immunised.

Why is this important?

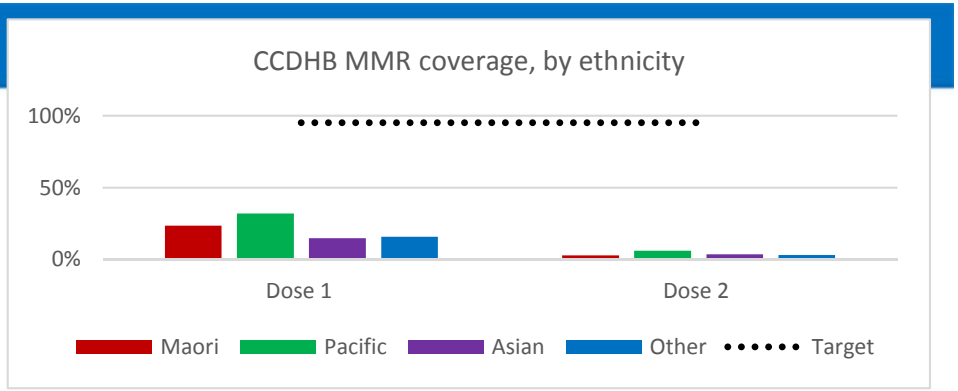
- Measles is a highly contagious virus that is easily preventable with immunisation. After one MMR dose, 95% of people are protected from measles; after two MMR doses more than 99% are protected. In 2019, New Zealand experienced its largest measles outbreak since 1997, with 1,500 confirmed cases and 30% of these hospitalised.
- In 2020, the MoH launched a national catch-up campaign targeted at 15-29 year olds who missed MMR vaccination as children, with a focus on Māori and Pacific youth.

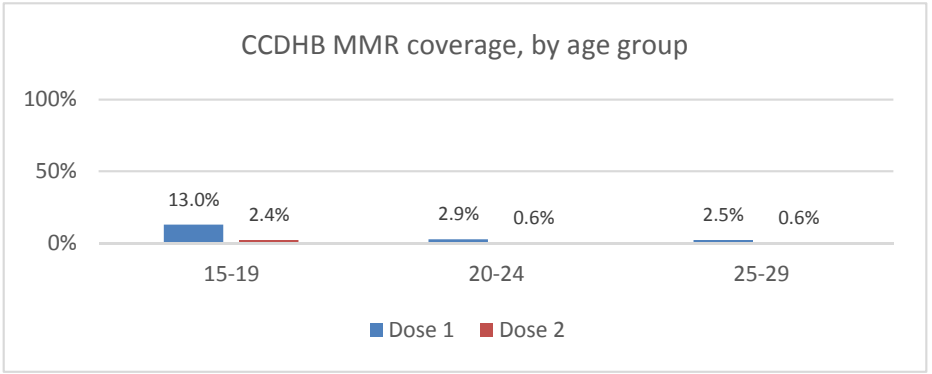
How are we performing?

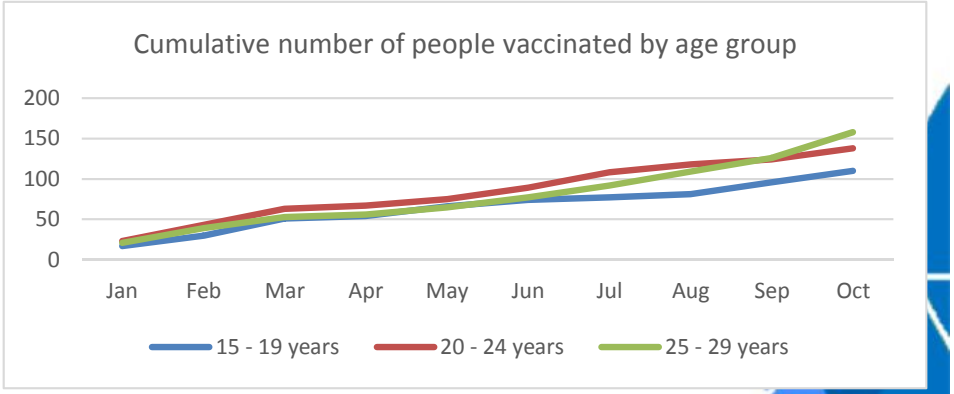
- Based on the Register, the low coverage of the second dose means there is an immunity gap for 15-29 year olds, indicating barriers to access for this group compounding the historically low coverage of childhood vaccinations.
- Single dose MMR is highest for Māori and Pacific youth. There is also a higher proportion of 15-19 year olds that vaccinated than 20-29 year olds. Since July, we have vaccinated approximately 200 youth and 406 in the year to date.

Management Comments

- The CCDHB and HVDHB Measles campaign will run from Oct 2020 to Sept 2021.
- This campaign is using novel approaches to remove barriers to access through youth-orientated communications and service delivery. In 2021, the campaign will be delivered from a Primary Care, Pharmacy, Community, events, Youth One Stop Shops, workplaces and School Based and Tertiary settings.
- Efforts continue to improve MMR data completeness, however strong campaign efforts remain a high priority.







DNA rates

What is this measure?

- DHB target: a 7% did not attend (DNA) rate for all ethnic groups

Why is this important?

- DNA rates reflect that appointments are not accessible. When health services are not accessible, there are potential delays in diagnoses and treatment, as well as system inefficiencies. This is a priority for Taurite Ora as ambulatory care services represent a significant proportion of overall DHB activity, and are the main way people access specialist advice currently not available in their communities or primary care.

How are we performing?

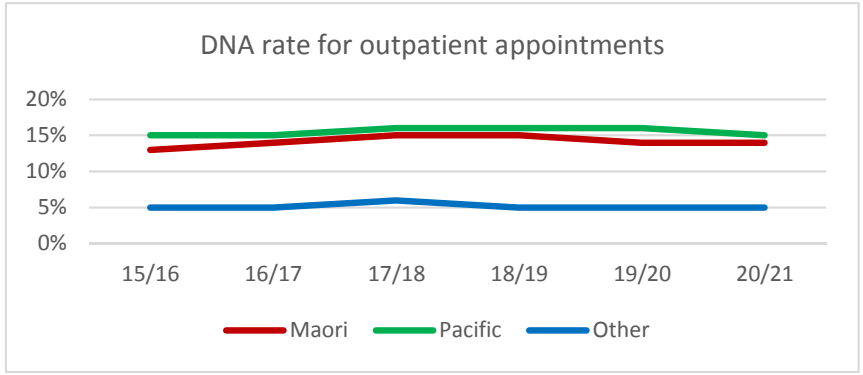
- Compared to non-Māori, non-Pacific: Māori and Pacific peoples have statistically significant higher DNA rates; they present later in disease stage; experiencing poorer health outcomes, and higher unmet health need.

What is driving performance?

- Our current service delivery models and systems do not meet the needs of Māori and Pacific peoples. Our systems do not make it easy for people to attend their appointments. We operate in a manual environment that is often not maximised for efficiency, and our IT systems are old and fragile.

Management comment:

- The implementation of a pro-equity system response is underway.
- Critical digital enablers are a high priority for development commencing with e-Referral.
- The design and implementation of new telehealth models of care across services, especially linked to planned care funding is a priority.



Ambulatory care services

Patients	• >130,000
Attended appointments	• >740,000
Appointments that could not be attended	• ~40,000
Letters sent by mail	• >720,000

Inter District Flows (IDF)

DHB of Domicile	YTD October estimated inpatient inflow wash-up
Taranaki DHB	-$559,298
Nelson Marlborough DHB	-$333,051
Hawke's Bay DHB	-$295,960
Other under-delivered (7 DHBs)	-$494,426
Other over-delivered (6 DHBs)	$524,702
Wairarapa DHB	$336,156
Hutt Valley DHB	$491,140
MidCentral DHB	$519,933
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)	$189,196

DHB of Service	YTD October estimated inpatient outflow wash-up
Other over-serviced (6 DHBs)	-$111,727
Other under-serviced (11 DHBs)	$358,984
Counties Manukau	$120,602
Auckland	$139,226
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)	$507,086

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 ($156k), a $1.2m improvement to last month.

IDF Inflow (revenue):

- Inpatient Caseweight IDF inflows are unfavourable by ($189k) which is driven by lower acute IDF flows.
- The majority of the lower IDF inflows (actuals) are caused by acute inpatient lower volumes:
  - Acute: ($781k): Cardiology ($606k), followed by Gen Med ($471k) and Oncology ($408k). Offset by Cardiothoracic $869k (with significant outsource earlier in the year)
  - Elective: $971k; Vascular $790k offset by Cardiothoracic ($283k)

IDF Outflow (expense):

- Overall IDF outflows are overall unfavourable by ($367k) and this will be reviewed as the IDFs for complex patients are revisited next month.
- In terms of IDF inpatient caseweight activity this was favourable by $507k to October; meaning less CCDHB domiciled patients were being treated at other hospitals than planned. 94% of this variance was from acute admissions (this $ number will be slightly lower as events are coded at other DHBs).
- This information is analysed and collated to provide the breakdown by DHB of Service to enable the services to understand service delivery change.

Section 2.2

Hospital Performance

Executive Summary – Hospital Performance

- The hospital had a very busy month – going against the first quarter trends the number of ED presentations in October 2020 was higher than the number recorded in the same month in the previous financial year with record numbers of triage 1 and 2 presentations. Correspondingly the utilisation of available of adult beds in core wards in October 2020 is 94.2% which is higher than the 91.8% rate recorded in October 2019.
- Addressing ESPI 2 and 5 waiting lists remains a significant challenge and risk with the numbers of patients waiting more than 120 days for treatment fluctuating month on month. We are waiting for confirmation from MoH to our submission for planned care recovery funding to secure additional outsourcing volume to meet a required reduction in ESPI2 and ESPI 5 waitlists with our system improvement project making good progress around all aspects of managing elective flow.
- 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 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 and the added pressure of high activity this 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 as per previous months reports. . Notable highlights this month are the a working group established to identify space to create additional acute assessment bed and use of the transit lounge for some selected patient pathways has also been initiated to try and improve flow.
- 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

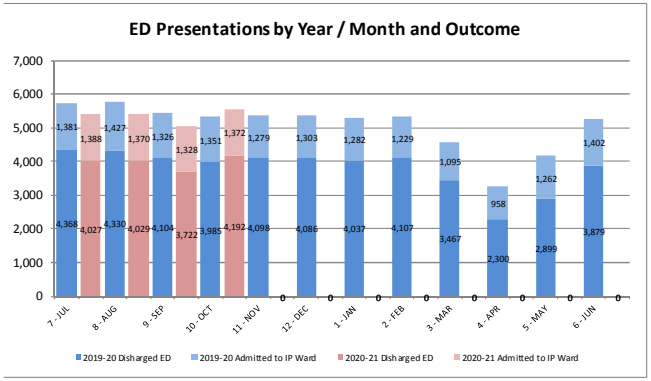
Capital and Coast DHB: October 2020

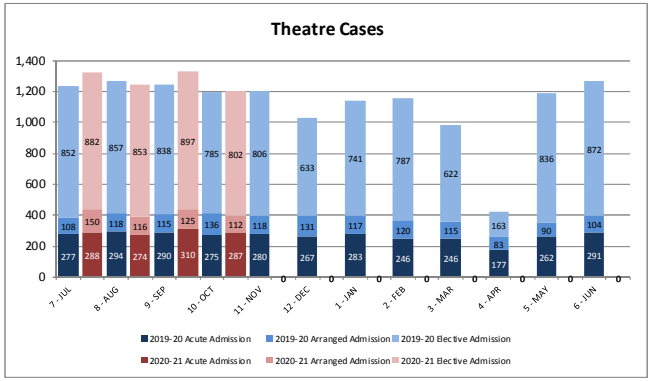
ED Presentations

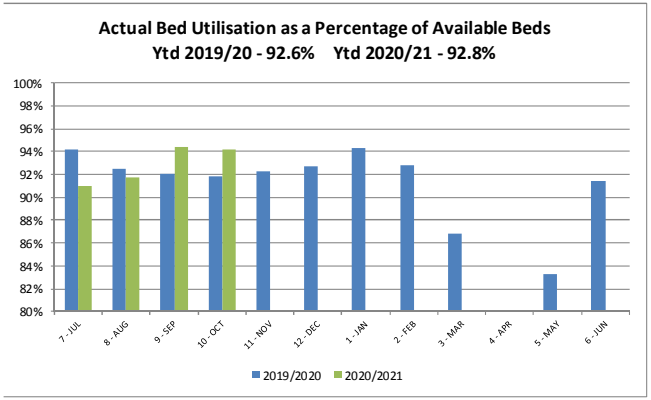
	2019/20	2020/21
YTD Totals	22,272	21,428
Change		-844
% Change		-4%

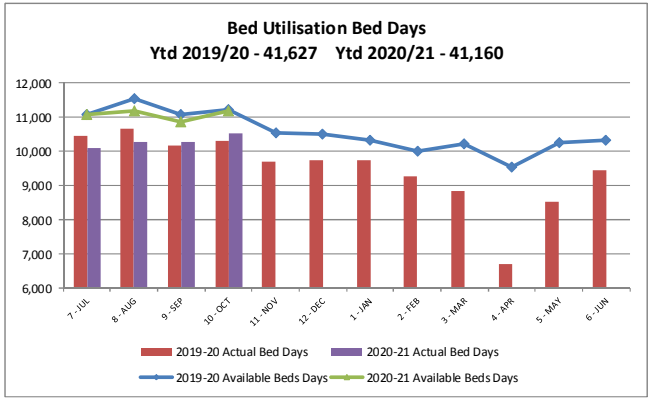
Theatre Cases

	2019/20	2020/21
YTD Totals	4,945	5,096
Change		151
% Change		3%









- The number of ED presentations in October 2020 is higher than the number recorded in the same month in the previous financial year. The emergency department October 2020 has experienced a 4.3% increase (228) in the number of presentations compared to October 2019, this equates to an approximate increase of 7.3 presentations per day.
- Through the first 3 months of 2020/21 Wellington ED has experienced a significant reduction in the number paediatric presentations compared to the previous years. However October 2020 saw only a small reduction in the number of presentations from 736 in October 2019 to 717 in October 2020 a reduction of 19 (2.68%).
- Significantly Wellington ED in October 2020 experienced the highest number of triage 1 presentations (66) in a single month ever. In addition Wellington ED in the same also experienced the third highest number of triage 2 presentations (874) recorded in a single month ever. When October 2020 is compared to October 2019 the total number of triage 1 presentation increased by 32, the number of triage 2 presentations increased by 105 and the number of triage 3 presentation increased by 137.
- The utilisation of available of adult beds in core wards in October 2020 is 94.2% which is higher than the 91.8% rate recorded in October 2019. The number of available beds in October 2020 is lower than in October 2019 with beds now transferred to ED from MAPU and less beds temporarily opened at Kenepuru in October 2020.
- The Elective theatre cases has surprisingly increased for the month of October 2020 by 2.2% (17 cases) when compared to October 2018 given the reduced the number of week days available in the month. The increases are spread across a number of specialties in particular Urology (22) and Opthalmology (33) but countered by decreases in Gynaecology (-18) and Paediatric Surgery (-14).

CCDHB Activity Performance

Capital and Coast DHB: October 2020

HSS Inpatient Caseweight Activity

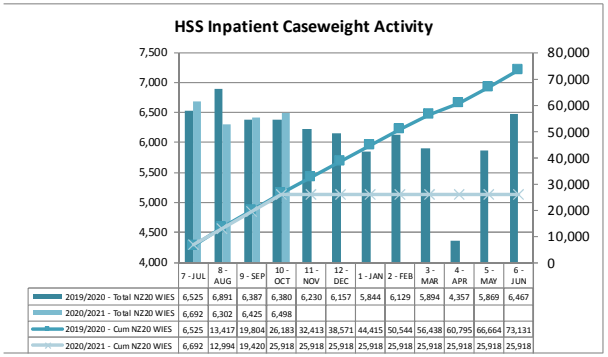
	2019/20	2020/21
YTD Totals	26,183	25,918
Change		-265
% Change		-1.0%

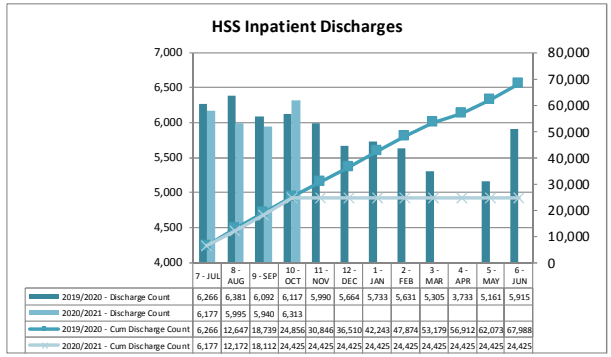
** This includes all Hospital Acitivty including ACC, Non Resident, Non-Casemix but excludes Mental Health*

HSS Inpatient Discharges

	2019/20	2020/21
YTD Totals	24,856	24,425
Change		-431
% Change		-1.7%

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



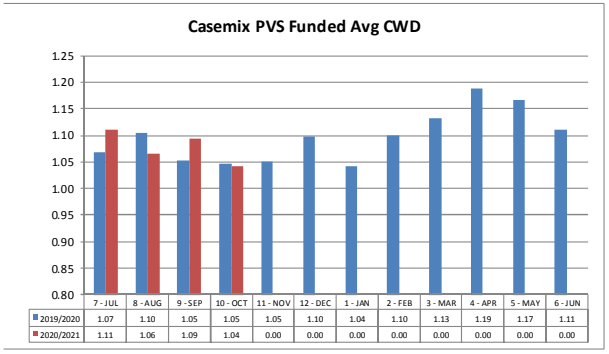


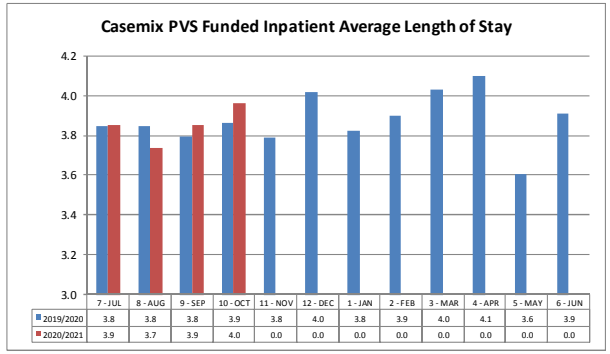
Casemix PVS Funded Avg CWD

	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	3.85
Change		-0.02
% Change		-0.4%





Comparisons with same period last year:

- Local acute CWDs are lower than previous financial year (-894 CWDs) with a decrease in discharges; a lower ALOS and a similar average CWD. The discharge decrease is driven primarily by General Medicine and Paediatric Medicine. The CWD decrease is driven primarily by General Medicine, Paediatric Medicine, Neonates and Orthopaedics.
- Local Elective CWDs are higher than the previous financial year (143 CWDs) with an increase in discharges; a similar ALOS and a slightly higher average CWD. The discharge increase is driven primarily by General Surgery and Vascular Surgery. The CWD increase is driven primarily by Cardiothoracic, Cardiology, Neurosurgery and General Surgery.
- IDF acute CWDs are lower (-114 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 Oncology, Paediatric Medicine and Cardiology. The CWD decrease is driven primarily by Cardiology, Cardiothoracic and Vascular Surgery.
- IDF Elective CWDs are higher than the previous financial year (82 CWDs) with more discharges a significantly lower ALOS and a higher average CWD. The discharge increase is driven primarily by Vascular Surgery, Opthalmology and Neurosurgery. The CWD increase is driven primarily by Cardiothoracic, Vascular Surgery, Neurosurgery and Orthopaedics.
- In combination these four admission groups equate to a decrease of 397 CWDs compared to the previous year. The services that most significantly impact this shift are General Medicine (378 CWDs) who will have also been impacted in the AHOP counting change, Paediatric Medicine (239 CWDs) and Respiratory (121 CWDs). These are four of the specialties most likely to be impacted by the reduction in the number of presentations to the Emergency department (844 Ytd).

Discharges:

- Publicly funded casemix discharges for the month of October 2020 have increased by 215
- (3.8%) in comparison to the number of discharges recorded in October 2019. The increase in discharges will be linked partly to the increase in the number of presentations to ED but at a specialty level were spread across a number of specialties with the increases most evident in Emergency Medicine (186 Acute), Vascular Surgery (13 Acute, 45 Elective), Cardiology (9 Acute, 29 Elective) and Urology (8 Acute, 26 Elective). The number of discharges was countered by decreases in General Medicine (101 Acute), Gynaecology (20 Acute, 14 Elective) and Paediatric Medicine (29 Acute).
- 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. 47 acute discharges in October 2020 and 230 discharges (246 CWDs) 2020-21 financial year to date.
- The number of outsourced discharges in private facilities decreased from 121 in October 2019 to 120 in October 2020 a decrease of 1 discharge (1% decrease).
- The October Ytd average CWD 2020/21 is lower (-0.01) than the previous year.
- The October Ytd inpatient average Length of Stay for 2020/21 (3.85) is lower (-0.02) than the previous year.

HHS Operational Performance Scorecard – period Oct 19 to Oct 20

Domain	Indicator	2020/21 Target	2019-Oct	2019-Nov	2019-Dec	2020-Jan	2020-Feb	2020-Mar	2020-Apr	2020-May	2020-Jun	2020-Jul	2020-Aug	2020-Sep	2020-Oct
Care	Serious Safety Events	Zero SSEs	6	8	8	5	11	7	8	10	5	14	6	9	3
	Total Reportable Events	TBD	1,153	1,059	1,004	881	1,108	1,207	724	905	1,082	1,165	1,264	1,363	1,326
Patient and Family Centred	Complaints Resolved within 35 calendar days	TBD	93.4%	91.9%	87.5%	94.2%	87.8%	92.4%	100.0%	93.5%	91.8%	87.5%	94.3%	94.4%	96.6%
	% Discharges with an Electronic Discharge summary	TBD													
Access	Emergency Presentations		5,336	5,377	5,389	5,319	5,336	4,562	3,258	4,161	5,281	5,415	5,399	5,050	5,564
	Emergency Presentations Per Day		172	179	174	172	184	147	109	134	176	175	174	168	179
	Emergency Length of Stay (ELOS) % within 6hrs	≥95%	77.2%	75.5%	77.4%	80.0%	75.5%	78.7%	84.7%	82.8%	74.6%	72.6%	68.5%	65.6%	65.1%
	ELOS % within 6hrs - non admitted	TBD	83.7%	81.1%	83.2%	85.8%	81.2%	84.6%	90.7%	90.4%	82.6%	79.8%	76.8%	75.2%	73.6%
	ELOS % within 6hrs - admitted	TBD	60.0%	59.6%	61.1%	63.0%	58.6%	61.8%	70.5%	66.3%	54.6%	53.5%	46.8%	41.3%	42.3%
	Total Elective Surgery Long Waits	Zero Long Waits	94	107	136	166	146	178	398	428	337	204	40	3	149
	Additions to Elective Surgery Wait List		1,312	1,399	1,120	1,129	1,411	1,271	554	1,098	1,506	1,517	1,373	1,522	1,321
	% Elective Surgery treated in time	TBD	92.7%	92.1%	92.2%	85.8%	86.0%	89.0%	92.7%	76.3%	71.3%	73.0%	84.2%	90.3%	89.0%
	No. surgeries rescheduled due to specialty bed availability	TBD	5	18	4	1	8	1	1	1	12	5	9	13	14
	Total Elective and Emergency Operations in Main Theatres	TBD	1,179	1,199	997	1,067	1,101	927	378	1,103	1,202	1,237	1,192	1,254	1,130
	Faster Cancer Treatment 31 Day - Decision to Treat to Treat	85%	92.0%	85.0%	97.0%	89.0%	82.0%	89.0%	91.0%	92.0%	91.0%	93.0%	85.0%	86.0%	84.0%
	Faster Cancer Treatment 62 Day - Referral to Treatment	90%	97.0%	86.0%	97.0%	78.0%	89.0%	97.0%	92.0%	77.0%	85.0%	94.0%	83.0%	88.0%	91.0%
	Specialist Outpatient Long Waits	Zero Long Waits	43	91	165	238	324	488	1,079	1,286	1,450	1,076	571	314	185
	% Specialist Outpatients seen in time	Zero Long Waits	92.8%	91.9%	94.4%	80.4%	83.9%	82.0%	87.1%	81.0%	74.2%	74.4%	85.2%	90.1%	88.8%
	Outpatient Failure to Attend %	TBD	7.1%	7.0%	7.6%	6.9%	7.4%	7.7%	4.4%	7.1%	6.6%	7.1%	6.7%	7.0%	7.5%
	Maori Outpatient Failure to Attend %	TBD	14.7%	14.3%	15.8%	14.6%	14.2%	15.3%	8.1%	13.9%	13.7%	14.7%	13.9%	15.3%	15.2%
	Pacific Outpatient Failure to Attend %	TBD	16.5%	14.6%	16.3%	15.9%	15.6%	16.3%	7.8%	16.6%	16.0%	16.9%	14.3%	14.4%	16.4%
Financial Efficiency	Forecast full year surplus (deficit) ($million)		($20.9m)	($26m)	($29.5m)	($29.5m)	($29.5m)	($29.5m)	($47.5m)	($47.5m)	($44.2m)	($39.8m)	($39.8m)	($62.0m)	($62.0m)
	Contracted FTE (Internal labour)		4,864	4,860	4,834	4,835	4,837	4,847	4,893	4,930	4,973	4,977	5,037	5,239	5,269
	Paid FTE (Internal labour)		5,164	5,210	5,264	5,192	5,195	5,198	5,188	5,199	5,310	5,315	5,366	5,604	5,594
	% Main Theatre utilisation (Elective Sessions only)	85.0%	78.1%	79.0%	83.0%	82.0%	81.0%	80.0%	78.1%	82.0%	81.0%	83.0%	82.0%	82.0%	82.0%
Discharge and Occupancy	% Patients Discharged Before 11AM	TBD	25.6%	22.4%	24.0%	23.9%	24.3%	22.7%	19.3%	20.4%	21.9%	24.4%	23.1%	25.4%	22.3%
	Adult Long Stay Patients Not Yet Discharged (>14 days) WLG	TBD	27	32	29	26	39	29	19	24	29	30	35	51	33
	Adult Overnight Beds - Average Occupied WLG	TBD	308	305	289	294	295	275	225	264	294	298	299	317	313
	Adult Long Stay Patients Not Yet Discharged (>14 days) KEN	TBD	19	27	23	23	18	10	17	16	17	19	19	18	23
	Adult Overnight Beds - Average Occupied KEN	TBD	76	71	66	72	69	62	46	55	63	71	72	74	76
	Child Overnight Beds - Average Occupied	TBD	24	24	21	19	21	18	15	18	23	24	23	22	23
	NICU Beds - ave. beds occupied	36	37	36	33	32	28	34	38	30	29	28	31	38	36
ALOS	Overnight Patients - Average Length of Stay (days)	TBD	3.86	3.79	4.02	3.82	3.90	4.03	4.10	3.61	3.91	3.85	3.74	3.85	3.98
Care	Rate of Presentations to ED within 48 hours of discharge	TBD	3.7%	4.2%	3.6%	3.7%	4.2%	3.7%	4.1%	3.3%	3.8%	3.7%	3.7%	4.3%	4.6%
	Presentations to ED within 48 hours of discharge	TBD	196	226	193	196	225	168	133	139	203	199	201	215	254
Staff Experience	Staff Reportable Events	TBD	138	127	102	111	138	137	90	108	161	139	154	136	174
	% sick Leave v standard	TBD	3.2%	3.0%	2.4%	2.1%	2.6%	3.5%	2.2%	2.5%	3.5%	4.0%	4.0%	3.6%	3.5%
	Nursing vacancy	TBD	208.9	213.9	228.1	219.1	211.6	206.6	193.0	171.0	157.6	248.5	266.0	252.8	248.1
	% overtime v standard (medical)	TBD	1.7%	1.7%	1.6%	1.6%	1.6%	1.9%	1.4%	1.4%	1.6%	1.7%	1.9%	2.1%	1.9%

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

Shorter Stays in ED (SSIED)

What is this measure?

- The 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 October 2020 was 65.1%. This result is a decrease on the 68.6% recorded last month (September 2020) and the 76.8% recorded in October 2019. The performance of patients who were seen, treated and discharged by ED for October 2020 was 75%. The performance of patients who were seen and admitted to hospital for September 2020 was 48%.
- A factor that affects our SSiED performance is the occupancy/bed utilisation in our wards. The average occupancy for October 2020 was 92%. 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 October 2020 was 361.

What is driving performance?

- Our performance being less than target continues to be due to the increase of elective and acute surgical work that was delayed during our COVID response. For October 2020, the average bed days utilised by acute admissions (240) increased by 6 beds per day compared to September 2020 (234). We also have in place ongoing processes related to COVID-19 screening and precautions.
- We continue to operate parallel processes in our in-patient wards to manage COVID case definition vs. non-COVID patients. Our acute flow programme of work is focusing on medical teams identifying and discharging patients earlier in the day. This then frees beds for those being admitted from ED to move to the ward in a timelier manner and thus improves our SSiED performance.

Performance	AUG	SEP	OCT
2019-20	75%	75%	77%
2020-21	68%	66%	65%

Breaches	AUG	SEP	OCT
2019-20	1315	1254	1152
2020-21	1576	1615	1762

ED Volumes	AUG	SEP	OCT
2019-20	5,284	4,940	4,973
2020-21	4,998	4,689	5,049

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. It has been agreed that this will be a permanent ward/service in Wellington Hospital.
  - 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.
  - 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 have confirmed our planned care volumes for 20/21 financial year, we are now able to report against planned targets.
- Results for October were positive, achieving 537 discharges, 45 ahead of the planned 492, 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 118 of the planned 169 in September, 89 behind for the month.
- IDF outflow results are positive for October achieving 105, 15 ahead of our planned 90.
- Minor procedures in-house are exceeding October month's plan, reporting 108 ahead of the planned 334 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 now being extended to December. This has taken around three months longer than planned so we continue to use Theatre 13 in Wellington to ensure surgery continues where possible.
- 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.

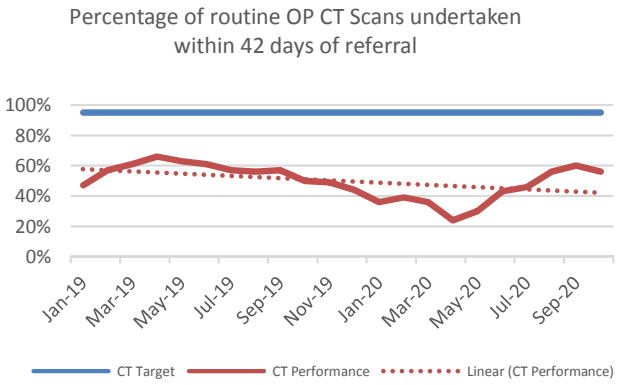
How are we performing?

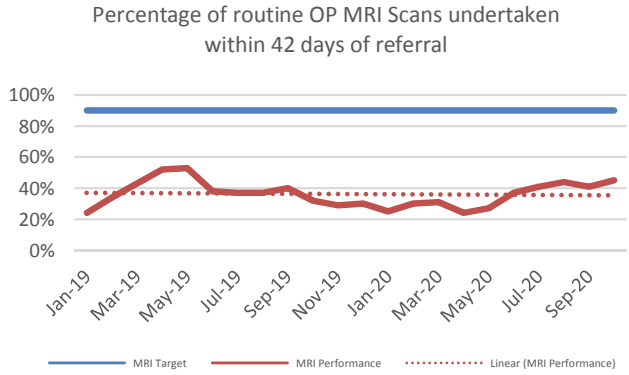
Waiting times for CT and MRI remain high as a result of historical insufficient capacity to meet demand and the pandemic response. Subsequently, the percentage measure is low.

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 serious risk of patient harm including disease progression while waiting for imaging appointments. 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:

- Upcoming planned care funding packet for CCDHB from MoH due towards the end of the year. Investment in Radiology is high on the priority list. If successful, this 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.

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 Christmas we expect slowdown of improvement over this 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 has dropped this month to 92.6%

What is driving performance?

- A drop this month is due to having to balance other non angiography procedures and availability of clinician capability to perform them, resulting in the reprioritisation of sessions. The drop below target percentage is however due to a small change in actual numbers.

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 on parental leave over the next 6 months will add to the challenge with gaps in cover arrangements until staff are available.

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 73.6%, Central Region 79.1% (129/163), CCDHB 87.1% (29/33), Hawkes Bay 56.0% (14/25), Hutt Valley 69.6% (16/23), Mid Central 87.1% (27/31)

    As a region we achieved the target. Hawkes Bay result reflects access to their local lab also. This has limited days of operation.

What is driving performance?

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

Management Comment

- 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 Ward 6 South to 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?

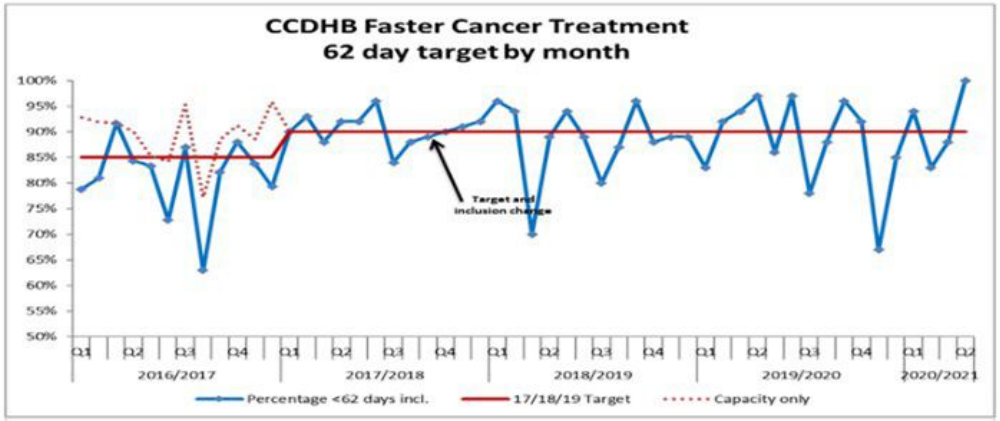
- CCDHB is compliant with the 62 day target for October 100% vs the aim of 90% of patients receiving their first cancer treatment within 62 days of being referred with a high suspicion of cancer.
- CCDHB is compliant with the 31 day indicator for October at 87% vs the aim of 85% of patients commencing treatment within 31 days from decision to treat. Note that a number of cases reported this month is lower than expected in both targets, by approximately 25%. This likely reflects the patients pending histology results for which there have been delays.

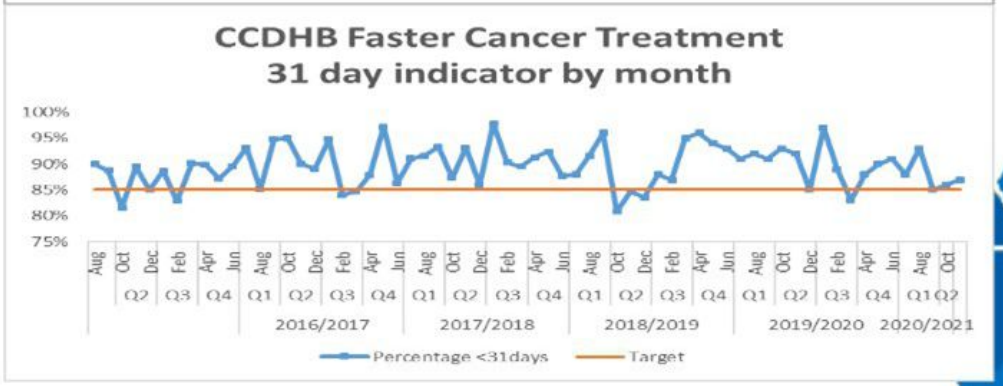
What is driving performance?

- No breaches in the 62 day target were reported at the time of this report, however some were awaiting finalising of key data elements.
- All 31 day breach patients (7) had surgery as first treatment. Capacity constraints (4 patients) related to urology and breast tumour streams in order of frequency with surgery being the first treatment. Average delay for these patients was 48 days (range 36-73 days). Substitution for an urgent case occurred on one occasion.

Management Comment

- Whilst we have begun to see an increase in the number of patients presenting with cancer the on-going challenge is access to FSA appointments and pathology reporting to inform treatment planning. That delay in pathology reporting is noticeable against all tumour streams and has been escalated to the WSCL contract holder in planning and funding. A number of MDMs were deferred due to lack of key staff cover during school holidays.





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?

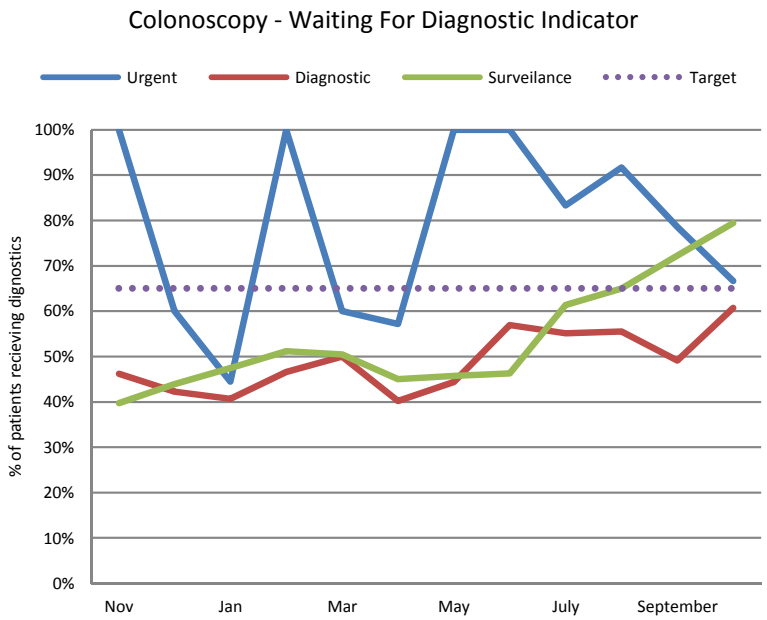
- CCDHB did not meet the Ministry of Health target for urgent and diagnostic colonoscopies achieving 67% and 61% respectively against targets of 70%. The previous month we were 79% and 49% respectively.
- We did meet the Ministry of Health target for surveillance achieving 79%.

What is driving performance?

- At the end of September there were 162 patients who had either a diagnostic or surveillance colonoscopy compared to 227 the previous month. At the end of October there were 392 patients waiting for either a diagnostic or surveillance colonoscopy compared to 308 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. The intent is to manage the increasing demand whilst waiting for two SMOs to start in 2021.



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	2019-Oct	2019-Nov	2019-Dec	2020-Jan	2020-Feb	2020-Mar	2020-Apr	2020-May	2020-Jun	2020-Jul	2020-Aug	2020-Sep	2020-Oct
Access Rate	3%	3.8%			3.6%			3.8%						
Shorter waits for non-urgent Mental Health services <= 3 weeks (Younger Persons Community & Addictions Sector)	80%	44.7%	42.3%	38.8%	51.8%	51.6%	33.3%	30.1%	44.0%	47.8%	48.0%	51.8%		
Shorter waits for non-urgent Mental Health services <= 3 weeks (Adult Community & Addictions Sector)	80%	59.1%	64.9%	55.6%	61.0%	63.8%	58.1%	47.3%	64.2%	57.4%	56.0%	52.8%		
Shorter waits for non-urgent Mental Health services <= 8 weeks (Younger Persons Community & Addictions Sector)	95%	90.0%	81.0%	90.9%	93.8%	76.9%	49.4%	74.8%	88.7%	83.7%	83.7%	88.7%		
Shorter waits for non-urgent Mental Health services <= 8 weeks (Adult Community & Addictions Sector)	95%	89.0%	87.1%	87.6%	90.3%	87.2%	72.9%	77.7%	94.4%	92.7%	91.3%	92.0%		
Community service users seen in person in last 90 days	95%	77.5%	79.1%	76.6%	77.9%	76.4%	68.8%	54.8%	56.1%	62.9%	76.7%	82.9%	83.8%	81.9%
Community DNA rate	<= 5%	8.0%	8.6%	7.4%	7.4%	7.8%	7.0%	4.0%	5.1%	6.6%	6.9%	6.6%	7.4%	7.3%
Maori under Section 29 CTO (Rate per 100,000 population) 2019/20 Target: 10% reduction of rate of previous year (405)		396	396			404			395					
Wellness Plans	95%	41.2%	41.2%			43.1%			47.3%					
Wellness Plans - Acceptable Quality	95%	68.8%	68.8%			78.9%			79.1%					
Community Services Transition (Service Exit) Plans	95%	48.7%	48.7%			47.6%			53.4%					
Community Services Transition (Service Exit) Plans - Acceptable Quality	95%	66.1%	66.1%			61.9%			71.6%					

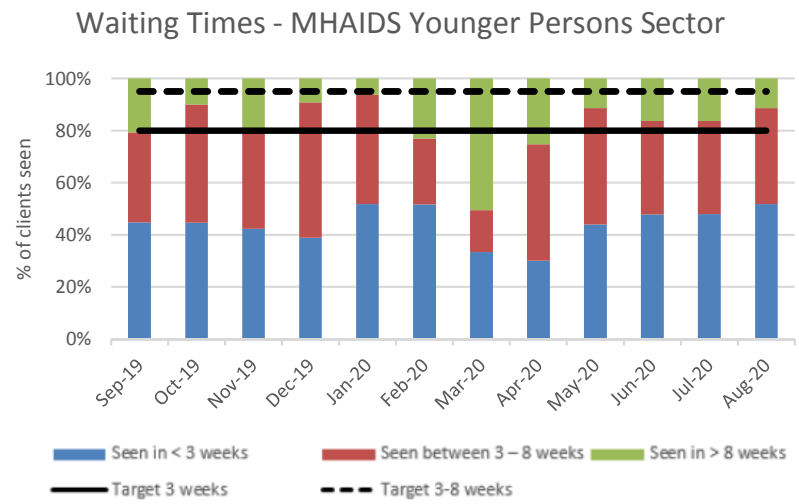
Adverse Performance requiring immediate corrective Action	Performance is below target, corrective action may be required	Performance on or better than Target / Plan

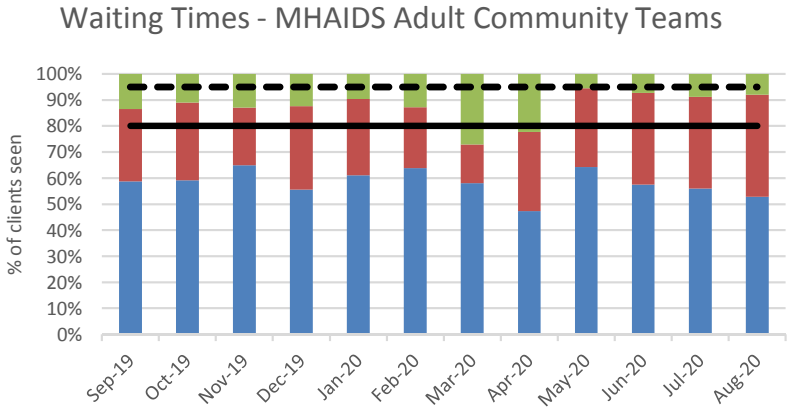
Mental Health, Addictions and Intellectual Disability Service - Monthly Performance Report (2 of 2)

Indicator	2020/21 Target	2019-Oct	2019-Nov	2019-Dec	2020-Jan	2020-Feb	2020-Mar	2020-Apr	2020-May	2020-Jun	2020-Jul	2020-Aug	2020-Sep	2020-Oct
Pre-Admission Community Care	75%	77.6%	66.1%	72.7%	62.5%	73.6%	73.5%	77.8%	69.2%	76.9%	87.3%	67.8%	80.8%	78.6%
Post-Discharge Community Care	90%	75.6%	79.5%	88.2%	77.8%	86.4%	80.0%	79.6%	87.7%	92.5%	83.3%	70.3%	86.2%	81.4%
Acute Inpatient Readmission Rate (28 Day)	<= 10%	10.6%	3.3%	2.9%	7.6%	7.9%	3.1%	11.9%	8.5%	5.1%	5.0%	4.7%	6.4%	7.5%
Inpatient Services Transition Plan	95%	71.1%	71.1%			70.5%			72.4%					
Inpatient Services Transition Plan - Acceptable Quality	95%	87.5%	87.5%			82.7%			74.4%					
Clinically Safe Acute Inpatient Occupancy Rate Te Whare Ahuru		103.8%	90.6%	100.1%	100.9%	102.4%	98.1%	78.1%	77.8%	99.7%	94.6%	97.7%	98.8%	94.0%
Clinically Safe Acute Inpatient Occupancy Rate Te Whare O Matairangi		110.0%		110.9%	102.9%	105.1%	101.1%	100.0%	93.2%	106.2%	108.2%	109.3%	105.1%	95.6%
Seclusion Hours	Aspirational goal of zero seclusion by 31 December 2020	679	668	404	458	622	995	733	632	965	590	878	272	390
Seclusion Hours - Māori		261	439	113	265	254	682	317	282	620	133	294	85	276
Seclusion Hours - Pacific Peoples		134	162	157	3	289	74	136	116	195	91	72	10	0
Seclusion Events		17	14	11	16	21	32	29	28	27	20	37	27	27
Seclusion Events - Māori		7	8	6	8	13	15	13	14	12	7	12	7	15
Seclusion Events - Pacific Peoples		4	2	2	1	4	4	3	4	9	3	3	1	0

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

KPI Spotlight - Wait Times from Referral to First In-person Contact





What is this measure?

Ministry of Health waiting times measure (MH03) - Shorter waits for non-urgent mental health and addiction services for 0-19 year olds. We replicate the measure for adult community teams internally also. This measure is calculated from the date the referral is received to the date of the first In-person contact with the client (face to face or Zoom). Referrals without a face-to-face recorded are not included. Monthly data for the past 12 months is shown (time delay required in order to allow clients to fall into the over 8 week group). The MOH has set targets that 80% of people referred for non-urgent mental health or addiction services are seen within three weeks and 95% of people are seen within 8 weeks.

Why is it important?

Mental health consumers experiencing distress should have faster access to receive therapeutic intervention.

How are we performing?

The 80% 3 week target has proved difficult to achieve, consistent with national results. Teams are managing to see around 90% of people referred within 8 weeks, close to the 95% target. CAMHS teams have struggled with this measure in recent months post COVID lockdown due to the surge in urgent referrals. Some teams have focused on this measure with successful results – the Wairarapa Adult CMHT have surpassed both targets in every month this year.

What is driving performance?

- robot technology is now being utilised to automate intake referrals. This together with associative improvements in efficiency as part of this project has yielded positive results with community teams receiving referrals quicker from Te Haika and Hutt Intake teams.
- improving processes to reduce DNA rates for initial assessments
- using the Intake Assessment document for all clients
- regular community caseload reviews to ensure clients still require secondary mental health input – this in turn creates space for new clients to be seen earlier

Barriers:

- Teams carrying vacancies struggle to meet the 3 week target especially.
- The increase in acute presentations which has impacted CAMHS teams recently means significantly less clinical time is available for non-urgent choice assessments.

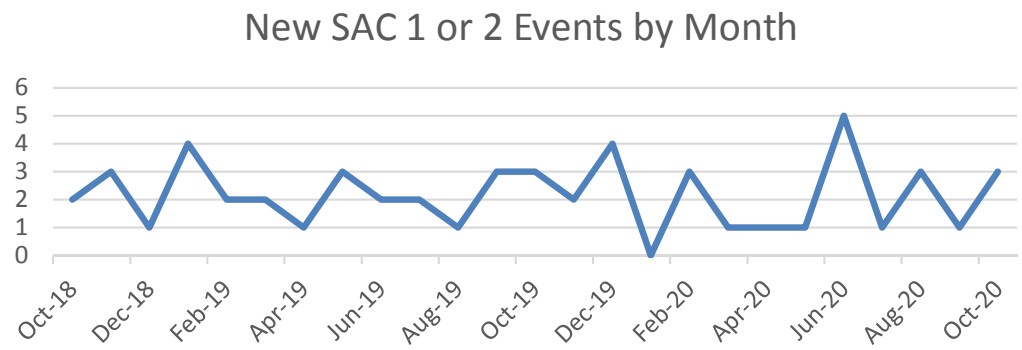
MHAIDS Quality & Safety Monthly Update

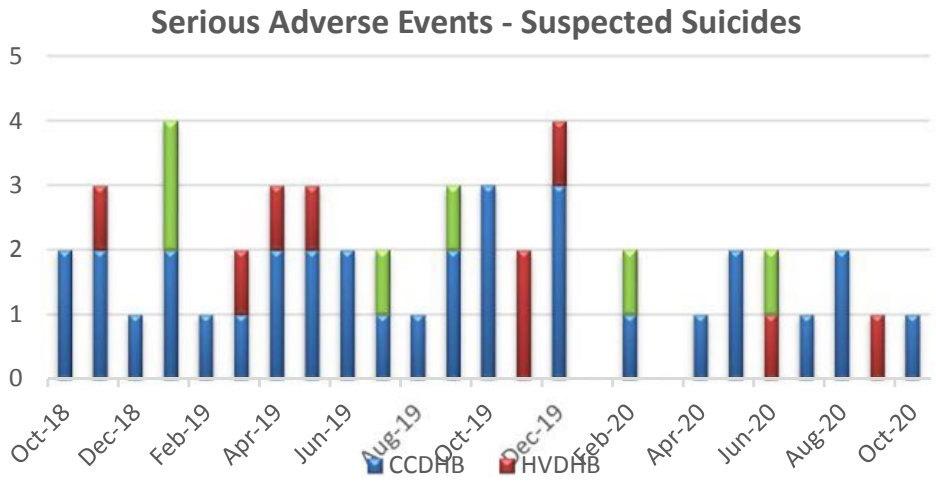
October 2020 Summary

- Serious Event Review Mentoring Programme commenced – Ten staff engaged with this. Five reviews have been allocated and a further five will be undertaken by the group in Jan 2021.
- Recruitment is underway for a new Quality Coordinator for the Operations Centre.
- Administrative support for Quality is reduced currently through resignation and sick leave. Recruitment is underway.
- Two of the national HQSC programmes – Connecting Care & Learning From Adverse Events had their final workshops in October. Local projects will continue.
- Towards Zero Seclusion will continue into 2021 and two new HQSC programmes are expected to commence.

EFFECTIVE SAFETY SYSTEMS TO RECOGNISE RISK AND REDUCE HARM

Serious Adverse Events





Key Points:

3 Events reported to HQSC:

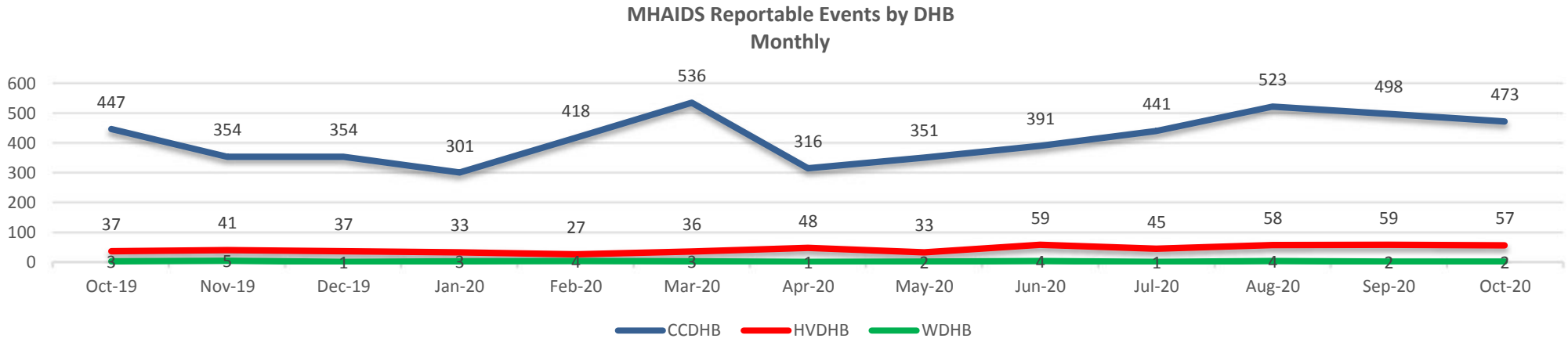
1 Suspected Suicide
2 Serious Self Harm

3 Events reported closed to HQSC

New SER Cases – October 2020		
RE Number	SAC Clarification	Event Type
93488	SAC 2	Suspected Suicide
94671	SAC 2	Serious self harm
94964	SAC 2	Serious self harm
Closed SER Cases – October 2020		
66186	Not SAC Rated	Suspected arson
71527	SAC 2	Suspected Suicide
86674	Not Sac Rated	AWOL from Seclusion
68541	SAC 2	Suspected Suicide
78977	SAC 2	Injury during medical treatment

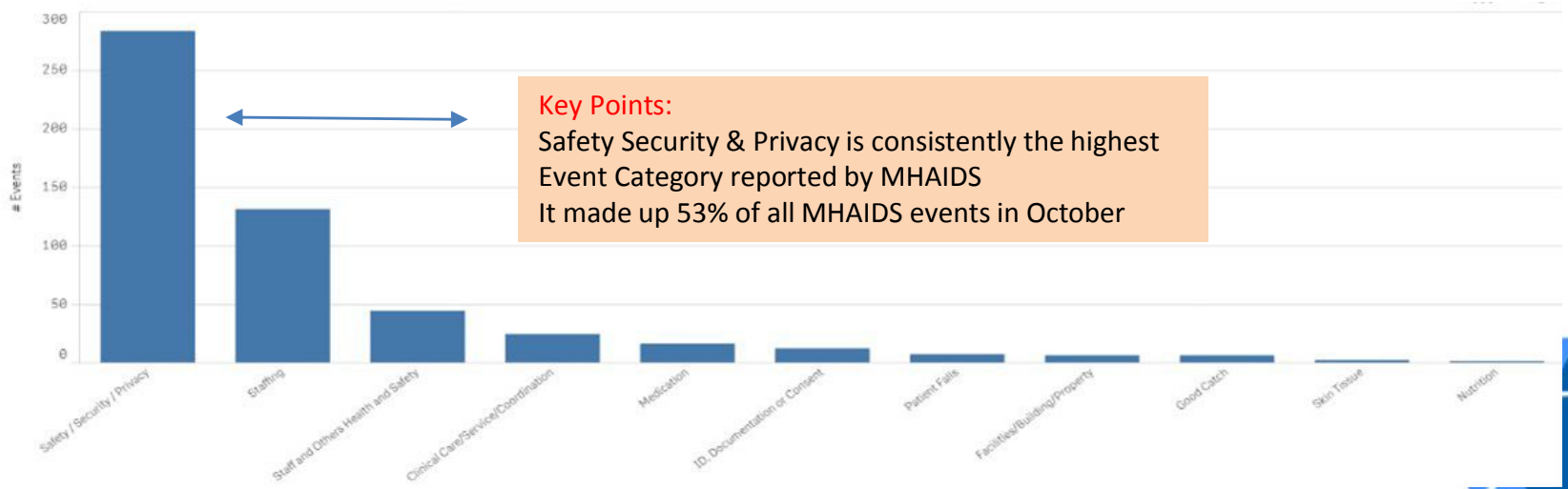
EFFECTIVE SAFETY SYSTEMS TO RECOGNISE RISK AND REDUCE HARM

Reportable Events



Key Points:

Drop in overall number of reported events from previous month.

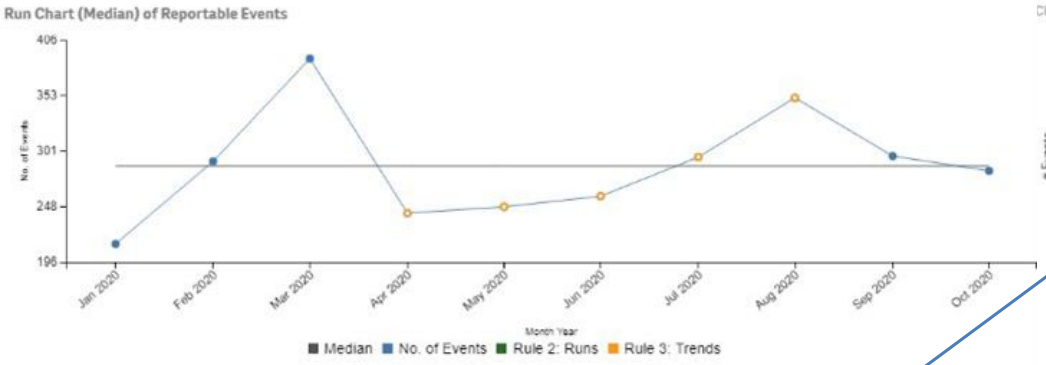


Key Points:
Safety Security & Privacy is consistently the highest Event Category reported by MHAIDS
It made up 53% of all MHAIDS events in October

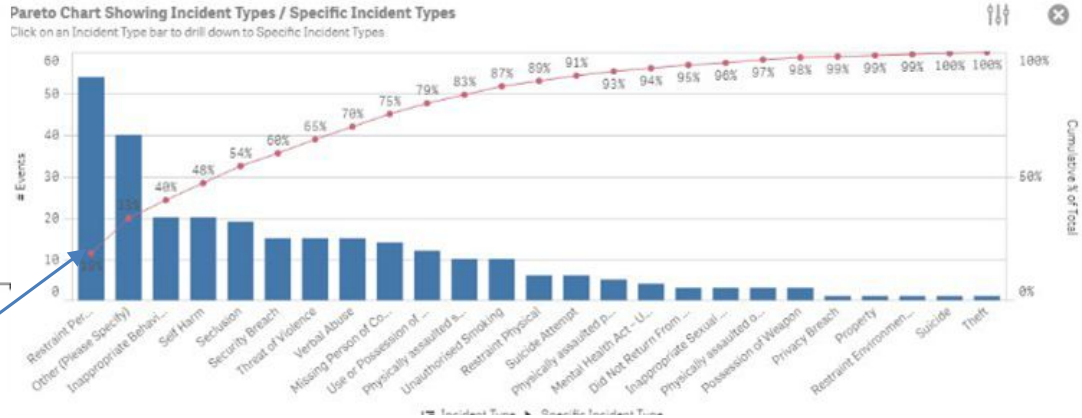
EFFECTIVE SAFETY SYSTEMS TO RECOGNISE RISK AND REDUCE HARM

Reportable Events Continued

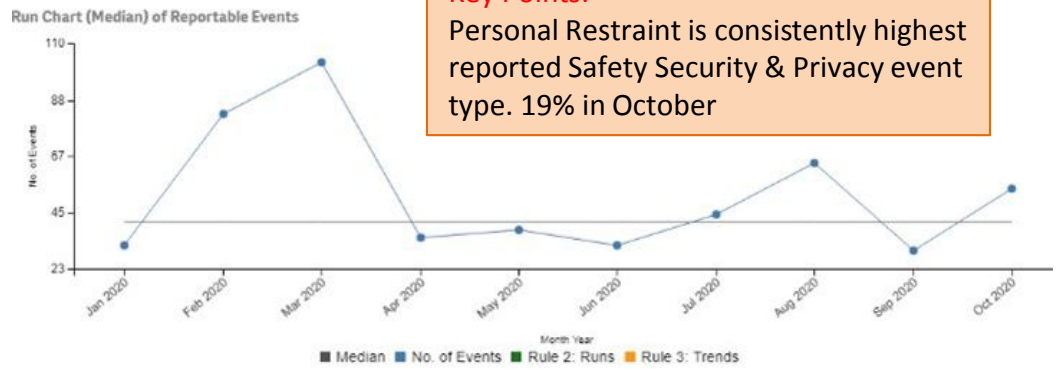
Reportable Events – Safety Security & Privacy 2020 Monthly Comparison



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

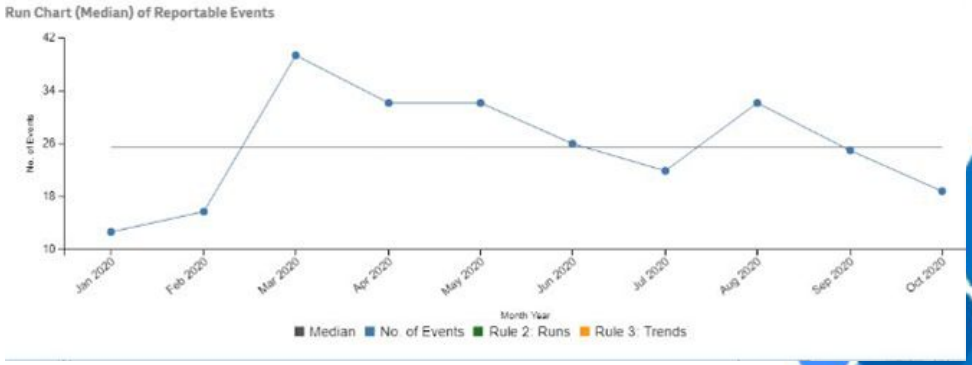


Personal Restraint Events 2020



Key Points:
Personal Restraint is consistently highest reported Safety Security & Privacy event type. 19% in October

Seclusion Events 2020 (6% of total SS&P events)

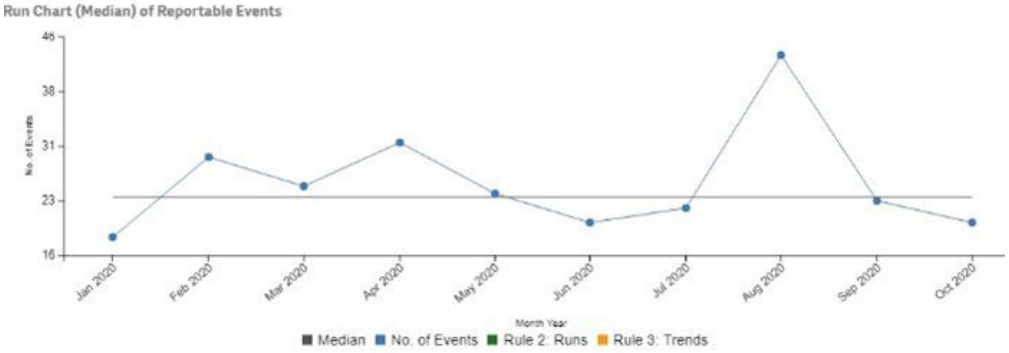


EFFECTIVE SAFETY SYSTEMS TO RECOGNISE RISK AND REDUCE HARM

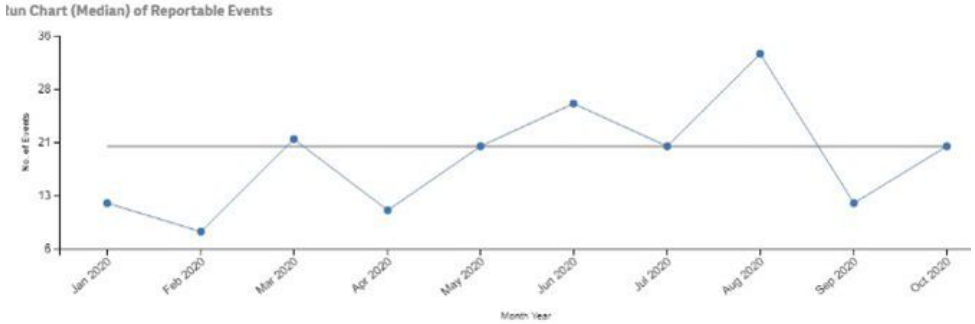
Reportable Events Continued

Key Points:
Other than Restraint (Personal) the SS&P events were at or below mean levels in October

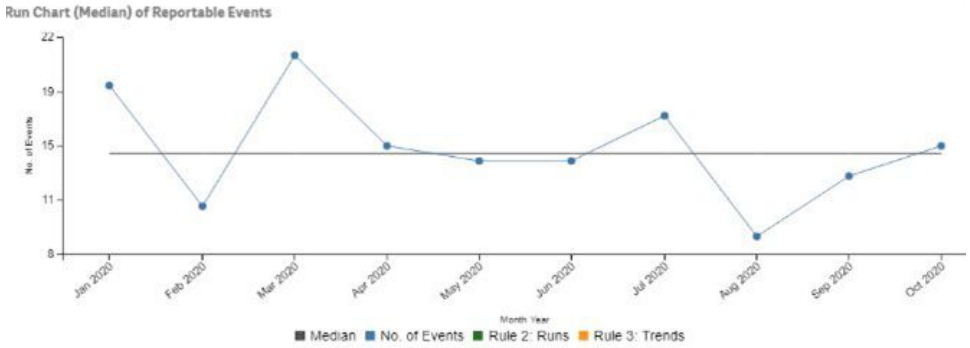
Inappropriate Behaviour Events 2020 (7% of total SS&P events)



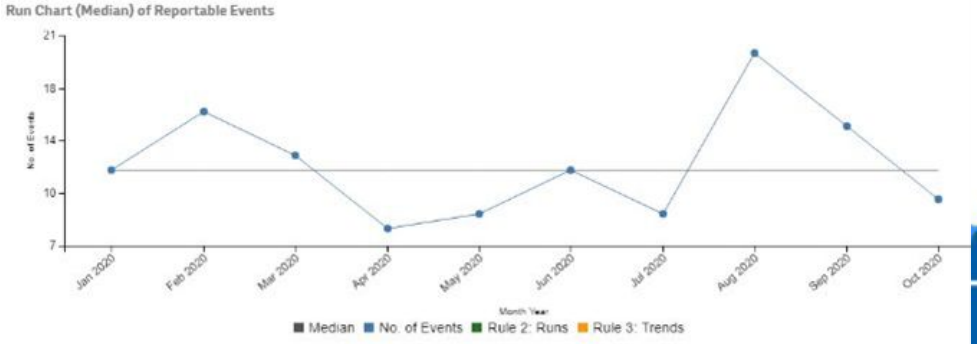
Self Harm Events 2020 (8% of total SS&P events)



Threat of Violence Events 2020 (5% of total SS&P events)



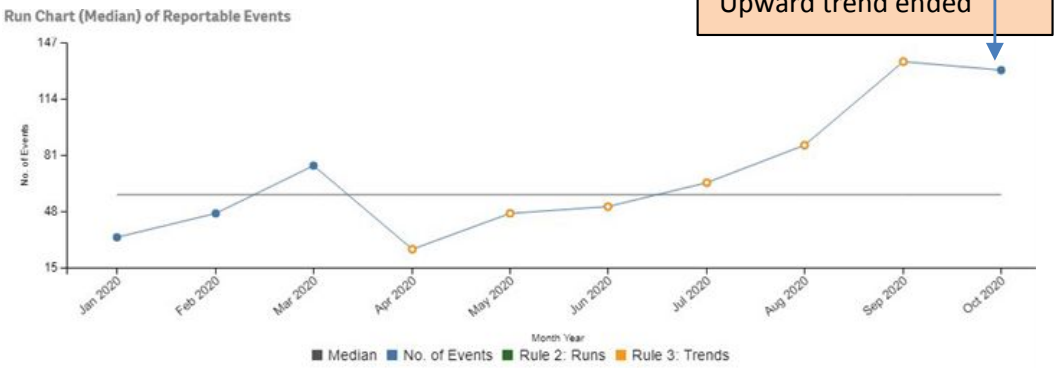
Physically Assaulted Staff Events 2020 (4% of total SS&P events)



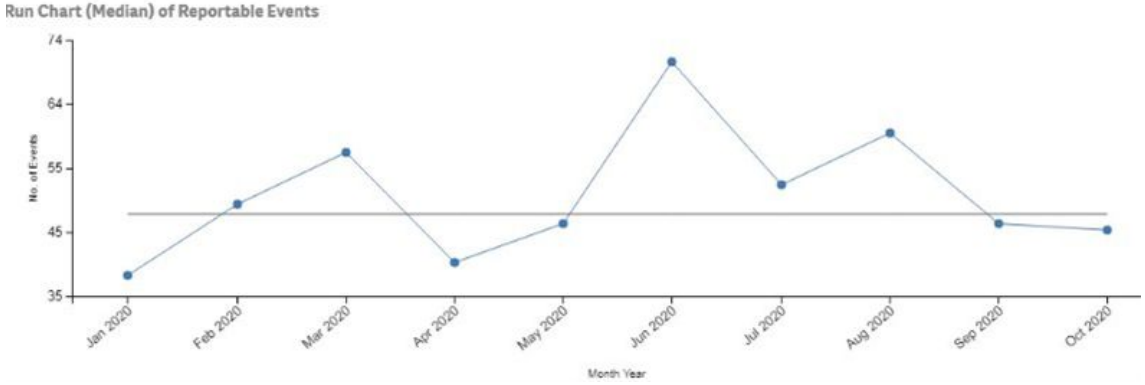
EFFECTIVE SAFETY SYSTEMS TO RECOGNISE RISK AND REDUCE HARM

Staffing Events 2020 Monthly Comparison

Key Points:
Upward trend ended

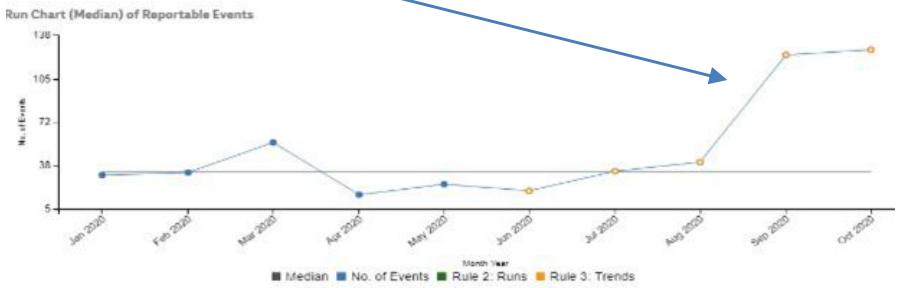


Staff & Others Health & Safety Events 2020 Monthly Comparison

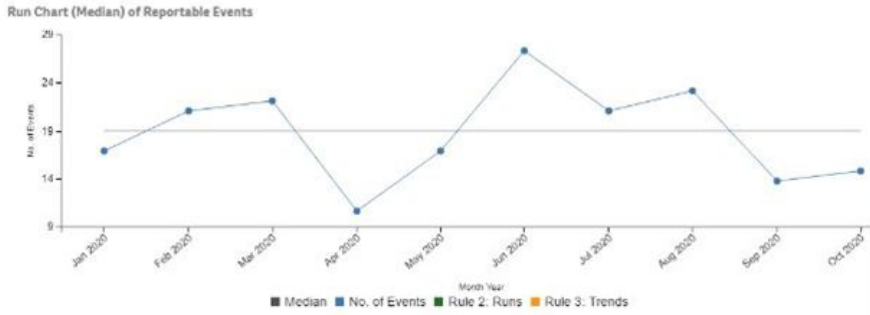


Reportable Events Continued

Key Points:
97% of Staffing events reported in October were the event type - Safe staffing
Upward trend observed-Current CCDM work has reinforced need to report.



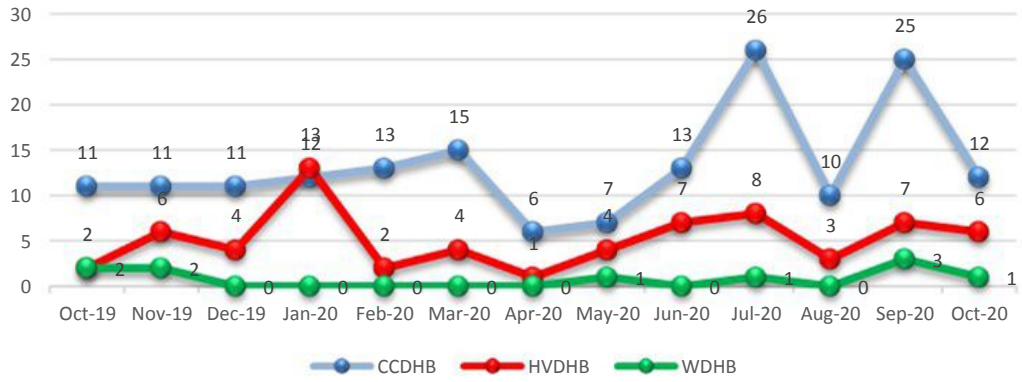
Key Points:
33% of Health & Safety events reported in October were event type – Violence Physical Assault



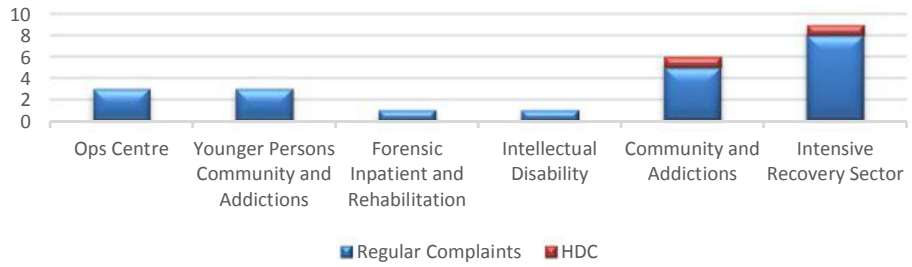
PERSON & WHĀNAU CENTRED CARE

Complaints

MHAIDS Complaints received per month

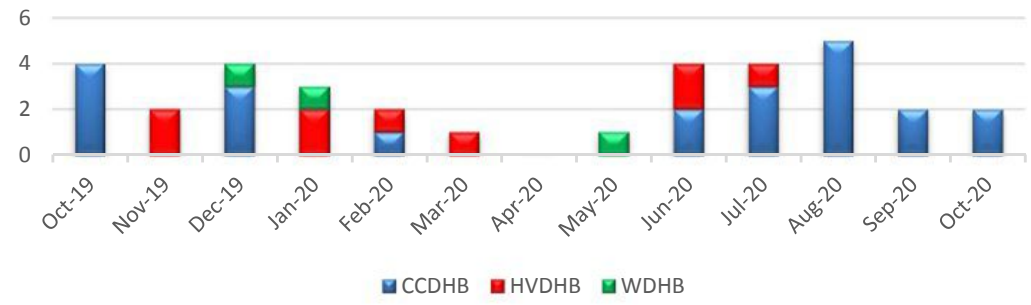


MHAIDS Complaints received per service - October 2020

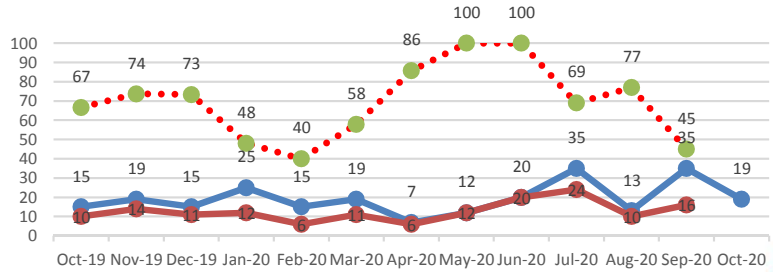


Key Points: Workload has impacted on ability of Intensive Recovery Sector to meet response times. Supports to address this have been put in place and this is being closely monitored by complaints committee

MHAIDS HDC Complaints received per month



MHAIDS Complaints Received and Closed within 20 Working Days



	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Complaints Received	15	19	15	25	15	19	7	12	20	35	13	35	19
Responded in Time	10	14	11	12	6	11	6	12	20	24	10	16	
Percentage	67	74	73	48	40	58	86	100	100	69	77	45	

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 $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:
  - ($7.7m); COVID-19: additional costs during COVID-19
  - ($2.7m); Holidays Act Provisions
- The DHB had targeted a reasonable number of efficiency measures for the year ahead totalling $38m, which are required to meet our deficit position, $12 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 ($22.4m) 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 October 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	(791)	(5,729)		(14,837)	0
			Non-Devolved MoH Revenue				0	0
2,037			Other Revenue	667			2,704	0
			IDF Inflow				0	0
			Inter DHB Provider Revenue				0	0
2,037	**(8,317)**	**0**	**Total Revenue**	**(124)**	**(5,729)**	**0**	**(12,132)**	**0**
			Personnel					
(1,610)		(2,049)	Medical	(1,790)		(801)	(3,400)	(24,939)
(1,620)		(9,145)	Nursing	(1,646)		(1,313)	(3,266)	(40,879)
		(1,370)	Allied Health			(219)	0	(6,804)
		32	Support			(59)	0	(1,826)
		168	Management & Administration			(248)	0	(7,716)
(3,230)	**0**	**(12,365)**	**Total Employee Cost**	**(3,437)**	**0**	**(2,639)**	**(6,667)**	**(82,164)**
			Outsourced Personnel					
(51)			Medical	(80)		(16)	(131)	(16)
			Nursing				0	0
			Allied Health				0	0
			Support				0	0
			Management & Administration				0	0
(51)	**0**	**0**	**Total Outsourced Personnel Cost**	**(80)**	**0**	**(16)**	**(131)**	**(16)**
2,834			Treatment related costs - Clinical Supp	(828)			2,006	0
(1,952)			Treatment related costs - Outsourced	(560)			(2,511)	0
(1,921)			Non Treatment Related Costs	(1,285)		(66)	(3,206)	(66)
			IDF Outflow				0	0
	(9,917)		Other External Provider Costs (SIP)		(7,398)		(17,315)	0
			Interest Depreciation & Capital Charge				0	0
(1,039)	**(9,917)**	**0**	**Total Other Expenditure**	**(2,672)**	**(7,398)**	**(66)**	**(21,026)**	**(66)**
(4,320)	**(9,917)**	**(12,365)**	**Total Expenditure**	**(6,189)**	**(7,398)**	**(2,721)**	**(27,824)**	**(82,246)**
6,357	**1,600**	**12,365**	**Net result**	**6,066**	**1,669**	**2,721**	**15,692**	**82,246**

- The year to date financial position includes $8m additional costs in relation to COVID-19.
- Revenue of $5.7m has been received to fund additional costs for community providers which is not sufficient for these costs
- Additional personnel costs of $2.7m have been accrued YTD for the Holidays Act
- COVID-19 costs are spread across personnel, clinical supplies, outsourced treatment and infrastructure and non-clinical costs.

CCDHB Operating Position – October 2020

Month - October 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 October 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
81,576	77,550	73,321	4,026	8,255	3,509		78,067	517	Devolved MoH Revenue	317,564	310,200	293,209	7,364	24,355	6,520		311,044	844
3,321	3,592	3,602	(271)	(280)			3,321	(271)	Non-Devolved MoH Revenue	14,831	14,322	14,012	509	819			14,831	509
17,042	2,963	3,301	14,078	13,740	(157)		17,199	14,236	Other Revenue	26,676	11,689	13,460	14,987	13,216	(667)		27,344	15,654
22,610	21,452	17,878	1,157	4,731			22,610	1,157	IDF Inflow	85,653	85,810	78,558	(156)	7,096			85,653	(156)
3,770	782	782	2,988	2,988			3,770	2,988	Inter DHB Provider Revenue	9,378	3,117	3,035	6,261	6,342			9,378	6,261
128,318	**106,340**	**98,884**	**21,978**	**29,434**	**3,352**	**0**	**124,966**	**18,626**	**Total Revenue**	**454,103**	**425,138**	**402,274**	**28,965**	**51,828**	**5,853**	**0**	**448,250**	**23,112**
									Personnel									
15,983	16,041	14,885	58	(1,098)	(106)	200	15,889	152	Medical	61,555	63,006	56,907	1,451	(4,648)	1,790	801	58,964	4,042
22,174	19,978	19,228	(2,196)	(2,946)	812	328	21,033	(1,055)	Nursing	82,489	76,961	72,751	(5,528)	(9,738)	1,646	1,313	79,530	(2,569)
6,651	5,812	5,226	(839)	(1,425)		55	6,596	(785)	Allied Health	24,523	22,800	20,536	(1,723)	(3,987)		219	24,305	(1,504)
834	931	959	97	125		15	819	112	Support	3,498	3,583	3,468	85	(30)		59	3,439	144
6,979	6,709	6,784	(271)	(195)		62	6,918	(209)	Management & Administration	27,042	25,718	25,175	(1,324)	(1,866)		248	26,794	(1,076)
52,621	**49,471**	**47,082**	**(3,151)**	**(5,540)**	**706**	**660**	**51,256**	**(1,785)**	**Total Employee Cost**	**199,107**	**192,068**	**178,838**	**(7,039)**	**(20,269)**	**3,437**	**2,639**	**193,032**	**(964)**
									Outsourced Personnel									
700	446	485	(254)	(215)	(78)	16	762	(317)	Medical	2,906	1,778	2,098	(1,129)	(808)	80	16	2,810	(1,033)
39	25	34	(14)	(5)			39	(14)	Nursing	219	100	94	(118)	(125)			219	(118)
156	114	160	(42)	4			156	(42)	Allied Health	486	455	533	(31)	47			486	(31)
22	22	38	(1)	16			22	(1)	Support	137	87	159	(50)	22			137	(50)
690	81	189	(608)	(501)			690	(608)	Management & Administration	1,732	327	988	(1,405)	(744)			1,732	(1,405)
1,606	**688**	**906**	**(918)**	**(700)**	**(78)**	**16**	**1,669**	**(981)**	**Total Outsourced Personnel Cost**	**5,480**	**2,747**	**3,871**	**(2,733)**	**(1,609)**	**80**	**16**	**5,384**	**(2,637)**
11,775	11,263	10,725	(512)	(1,050)	104		11,671	(408)	Treatment related costs - Clinical Supp	44,861	45,002	43,170	141	(1,692)	828		44,034	969
1,480	2,392	2,013	912	533	0		1,480	912	Treatment related costs - Outsourced	8,406	9,063	8,490	657	84	560		7,846	1,217
21,899	6,905	6,667	(14,994)	(15,232)	303	0	21,596	(14,691)	Non Treatment Related Costs	42,641	27,729	26,156	(14,913)	(16,485)	1,285	66	41,290	(13,561)
9,002	8,965	6,647	(36)	(2,354)			9,002	(36)	IDF Outflow	36,228	35,861	32,448	(367)	(3,780)			36,228	(367)
28,771	26,334	25,301	(2,437)	(3,470)	2,222		26,549	(215)	Other External Provider Costs (SIP)	113,618	105,711	100,788	(7,906)	(12,830)	7,398		106,219	(508)
4,949	4,815	4,331	(134)	(618)			4,949	(134)	Interest Depreciation & Capital Charge	19,826	19,596	19,649	(230)	(177)			19,826	(230)
77,876	**60,675**	**55,683**	**(17,201)**	**(22,192)**	**2,628**	**0**	**75,247**	**(14,573)**	**Total Other Expenditure**	**265,581**	**242,963**	**230,702**	**(22,618)**	**(34,879)**	**10,071**	**66**	**255,444**	**(12,481)**
132,104	**110,834**	**103,671**	**(21,270)**	**(28,433)**	**3,256**	**675**	**128,173**	**(17,339)**	**Total Expenditure**	**470,168**	**437,778**	**413,410**	**(32,390)**	**(56,758)**	**13,588**	**2,721**	**453,860**	**(16,081)**
(3,786)	**(4,494)**	**(4,787)**	**708**	**1,001**	**96**	**(675)**	**(3,206)**	**1,287**	**Net result**	**(16,066)**	**(12,640)**	**(11,136)**	**(3,425)**	**(4,930)**	**(7,735)**	**(2,721)**	**(5,610)**	**7,030**
864	(33)	(824)	897	1,689					Funder	(5,351)	(4,251)	(5,217)	(1,100)	(135)				
1	(0)	57	1	(56)					Governance	168	(0)	2	168	166				
(4,651)	(4,461)	(4,020)	(190)	(631)					Provider	(10,882)	(8,389)	(5,921)	(2,493)	(4,961)				
(3,786)	**(4,494)**	**(4,787)**	**708**	**1,001**					**Net result**	**(16,066)**	**(12,640)**	**(11,136)**	**(3,425)**	**(4,930)**				

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 ($16.07m)
- Included within this result is recognition of the adjustment to the holiday act provision ($2.7m) and an estimated impact of COVID-19 of ($7.7m).
- Excluding the two items above brings the deficit for the year into deficit of ($5.6m) being $7m favourable to budget.
- Revenue is favourable by $29m YTD, after excluding COVID-19, lead DHB changes and settlement this decreases to a $2.4m favourable variance. The variances are due to mental health national contracts, special fund/ research revenue offset by donation and interest revenue. Inpatient IDF revenue was recognised behind target by ($156k), with planned care (electives) set to target whilst the year gets underway.
- Personnel costs including outsourced is ($9.8m) YTD, excluding the Holidays Act provision ($2.7m) and the COVID-19 related costs of ($3.5m) incurred the net unfavourable variance is ($3.6m). This ($3.6m) net unfavourable variance has been more than offset by the transfer of Mental Health and ICT services to CCDHB from other DHBs ($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 $141k favourable YTD, the overspend in blood products ($476k) 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 ($657k); favourable movement in laboratory sendaway tests are offsetting increased outsourced CT scans. Surgical procedures performed in September and October were significantly delayed.
- Non treatment related costs ($14.9m) YTD unfavourable, however after excluding COVID-19, lead DHB changes and settlement this was a $1.6m favourable variance; which is due to lower spend on asset maintenance, and new investment initiatives not yet commenced.
- The funder arm is unfavourable YTD due to additional spend requirements for our community COVID-19 response. Otherwise is generally stable for the across community expenditure whilst programmes commence.

Analysis of the Operating Position – Revenue and Personnel

Revenue

- Revenue is favourable by $2.4m YTD (after lead DHB and other items indicated on previous page) despite recognising IDFs being behind target by ($156k) which is a substantial improvement on IDFs over our previous YTD result (which was $1.3m behind).
- The variance is due to revenue for special funds/research of $578k, Interest due to overdraft situations ($106k), Donations ($333k) MHAIDS non-lead DHB revenue of $641k. The funder arm is also favourable by $1.2m revenue however with offsetting community cost.

Personnel (inc outsourced)

- Medical Personnel is ($196k) unfavourable for the month, YTD favourable by $322k. The unfavourable position for the month is due to transfer of costs to CCDHB for MHAIDs services (~$474k), Holidays Act provisions ($200k) 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 ($2.2m) unfavourable to budget for the month, YTD ($5.6m) unfavourable. This is driven by overspend to budget for MHAIDs, partially driven by the transfer of staff from other DHBs to CCDHB.
- Allied Personnel labour is ($882k) unfavourable to budget for the month, YTD ($1.7m) unfavourable to budget. $1m of the YTD variance results from the transfer of staff from other DHBs to CCDHB., ($213k) Holidays Act provisions,
- Support Personnel labour month position is favourable by $97k, YTD favourable by $35k.
- Management/Admin Personnel is unfavourable in the month by ($879k), YTD unfavourable by ($2.7m). $1.3m 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 – October 2020

Month : Oct 2020						Capital & Coast DHB	Year to Date				
			Variance			Statement of Cashflows				Variance	
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	Notes	YTD Oct 2020	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year
						Operating Activities					
119,036	111,708	103,898	7,327	15,138		Receipts	452,772	446,833	428,908	5,940	23,864
						Payments					
44,267	45,974	40,603	1,707	(3,664)		Payments to employees	192,246	183,896	180,542	(8,351)	(11,705)
72,963	65,880	53,299	(7,083)	(19,664)		Payments to suppliers	260,163	256,502	237,916	(3,661)	(22,247)
0	0	0	0	0		Capital Charge paid	12,110	12,100	0	(10)	(12,110)
677	(137)	1,256	(814)	579		GST (net)	(876)	547	(1,802)	1,423	(926)
117,907	111,718	95,158	(6,189)	(22,749)		Payments - total	463,643	453,045	416,655	(10,598)	(46,988)
1,128	(9)	8,740	1,138	(7,612)	6	Net cash flow from operating Activities	(10,871)	(6,212)	12,253	(4,659)	(23,124)
						Investing Activities					
16	75	26	59	10		Receipts - Interest	116	300	385	183	268
0	0	0	0	0		Receipts - Other	0	0	0	0	0
16	75	26	59	10		Receipts - total	116	300	385	183	268
						Payments					
0	0	0	0	0		Investment in associates	0	0	0	0	0
3,841	5,511	6,972	1,669	3,131		Purchase of fixed assets	14,409	22,043	14,959	7,635	550
3,841	5,511	6,972	1,669	3,131		Payments - total	14,409	22,043	14,959	7,635	550
(3,826)	(5,436)	(6,947)	1,729	3,141	7	Net cash flow from investing Activities	(14,292)	(21,744)	(14,575)	7,818	819
						Financing Activities					
0	0	0	0	0		Equity - Capital	0	0	0	0	0
1,400	0	10,650	1,400	(9,250)		Other Equity Movement	2,074	0	10,650	2,074	(8,575)
0	0	0	0	0		Other	0	0	(55)	0	(55)
1,400	0	10,650	1,400	(9,250)		Receipts - total	2,074	0	10,594	2,074	(8,520)
						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
1,400	0	10,650	1,400	(9,250)	8	Net cash flow from financing Activities	2,074	0	10,594	2,074	(8,520)
(1,297)	(5,445)	12,443	4,267	(13,720)		Net inflow/(outflow) of CCDHB funds	(23,089)	(27,956)	8,273	5,234	(30,826)
(3,556)	(4,274)	3,914	(719)	7,469		Opening cash	18,236	18,236	8,083	0	(10,153)
120,451	111,783	114,573	8,787	5,898		Net inflow funds	454,963	447,133	439,887	8,197	15,612
121,748	117,229	102,130	(4,520)	(19,618)		Net (outflow) funds	478,052	475,088	431,614	(2,963)	(46,438)
(1,297)	(5,445)	12,443	4,267	(13,720)		Net inflow/(outflow) of CCDHB funds	(23,089)	(27,956)	8,273	5,234	(30,826)
(4,853)	(9,719)	16,357	4,867	(21,209)		Closing cash	(4,853)	(9,719)	16,356	4,867	(21,209)

Capital and Coast DHB
RECONCILIATION OF CASH FLOW TO OPERATING BALANCE

	Notes	YTD Oct 2020 Actual $000	Budget $000	Variance $000
Net Cashflow from Operating		**(10,871)**	**(6,203)**	(4,668)
Non operating financial asset items		**(44)**	-	(44)
Non operating non financial asset items		**(1,320)**	**(765)**	(555)
Non cash PPE movements				
Depreciation & Impairment on PPE		(10,934)	(8,325)	(2,608)
Gain/Loss on sale of PPE		0	-	0
Total Non cash PPE movements		**(10,934)**	**(8,325)**	**(2,608)**
Interest Expense		-	-	**0**
Working Capital Movement				
Inventory		514	-	514
Receipts and Prepayments		46,446	12,100	34,346
Payables and Accruals		(39,857)	(4,952)	(34,905)
Total Working Capital movement		**7,102**	**7,148**	**(46)**
Operating balance		**(16,066)**	**(8,145)**	(7,921)

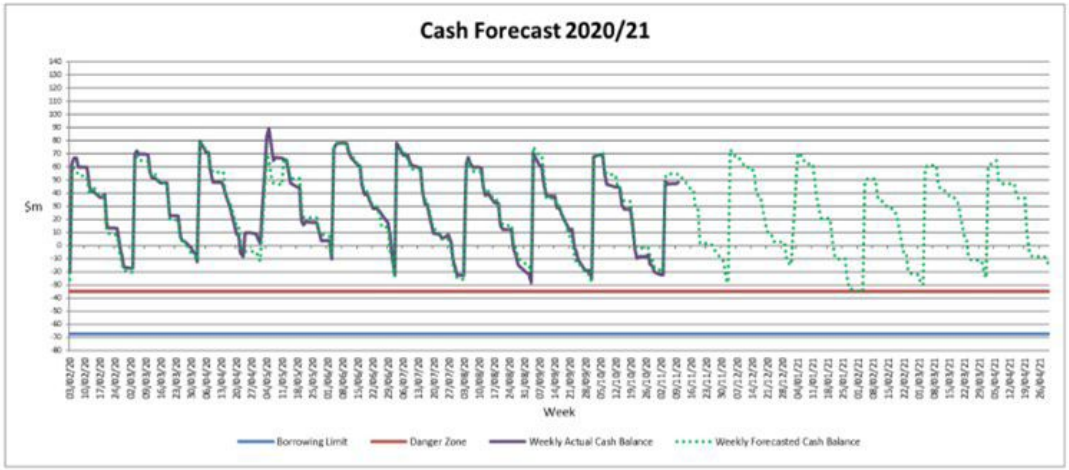
Current Ratio – This ratio determines the DHB's ability to pay back its short term liabilities.
DHB's current ratio is 0.35 (September 20: 0.32);

Debt to Equity Ratio – This ratio determines how the DHB has financed the asset base.
DHB's total liability to equity ratio is 45:55 (Sep 20: 43:57)

Debt Management / Cash Forecast – October 2020

Accounts Receivable
31-Oct-20

Aged Debtors report ($'000)	Total	Current	1-30	31 - 60	61 - 90	91+	Previous Period
Ministry of Health	9,308	5,416	215	1,733	212	1,732	10,735
Other DHB's	13,465	9,099	255	200	827	3,084	8,141
Kenepuru A&M	227	30	23	20	154	-	233
ACC	238	115	- 101	11	22	191	271
Misc Other	19,434	17,441	177	89	43	1,684	3,490
Total Debtors	42,672	32,101	569	2,053	1,258	6,691	22,870
less : Provision for Doubtful Debts	(1,549)						(1,583)
Net Debtors	41,123						21,287



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 $3.1m
- **Kenepuru A&M:** Includes significant number of low value patient transactions. Provision of the overdue debts is $134k
- **Misc Other:** Includes non-resident debt of approx. $1.96m. About 79% 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 31 October 2020

Sep-20	Month : Oct 2020				Variance			Capital & Coast DHB Balance Sheet
Actual	Actual	Budget	At Oct 2019	At Jun 2020	Actual vs Budget	Actual vs Oct 2019	Notes	YTD Oct 2020
31	31	31	33	31	0	(3)	1	Bank
10	59	(0)	5,396	6,523	59	(5,337)	1	Bank NZHP
12,783	12,874	11,683	11,427	11,683	1,192	1,448	1	Trust funds
62,851	74,222	49,375	45,502	46,342	24,847	28,721	2	Accounts receivable
10,078	9,509	8,995	9,130	8,995	514	379		Inventory/Stock
8,651	12,347	6,257	5,873	6,257	6,089	6,473		Prepayments
94,405	**109,042**	**76,341**	**77,361**	**79,831**	**32,701**	**31,681**		**Total current assets**
516,087	516,289	533,013	531,679	522,978	(16,724)	(15,390)		Fixed assets
14,847	14,847	14,847	9,859	11,626	0	4,988		Work in Progress - CRISP
68,067	68,139	54,096	44,192	57,317	14,043	23,946		Work in progress
599,002	**599,274**	**601,956**	**585,730**	**591,921**	**(2,682)**	**13,544**	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	1	0		Investment in Allied Laundry
1,150	**1,150**	**1,150**	**1,150**	**1,150**	**1**	**0**		**Total investments**
694,556	**709,467**	**679,447**	**664,242**	**672,902**	**30,020**	**45,225**		**Total Assets**
19,182	20,619	21,433	0	0	814	(20,619)		Bank overdraft HBL
82,386	89,492	64,504	67,677	76,604	(24,988)	(21,815)	4	Accounts payable, Accruals and provisions
0	0	0	0	0	0	0	7	Loans - Current portion
5,428	7,321	6,567	7,945	(252)	(754)	625	6	Capital Charge payable
593	593	593	593	593	0	0		Insurance liability
105,310	109,363	36,144	85,737	36,144	(73,218)	(23,625)	5	Current Employee Provisions
64,875	65,005	140,857	52,447	140,857	75,852	(12,558)	5	Accrued Employee Leave
15,325	19,402	7,299	19,157	7,299	(12,103)	(245)	5	Accrued Employee salary & Wages
293,098	**311,795**	**277,398**	**233,557**	**261,245**	**(34,397)**	**(78,238)**		**Total current liabilities**
0	0	0	0	0	0	0		Crown loans
104	103	95	80	95	(8)	(22)		Restricted special funds
605	605	605	605	605	0	0		Insurance liability
6,564	6,564	6,564	6,296	6,564	0	(269)		Long-term employee provisions
7,273	**7,272**	**7,264**	**6,981**	**7,264**	**(8)**	**(291)**		**Total non-current liabilities**
300,371	**319,067**	**284,662**	**240,538**	**268,510**	**(34,405)**	**(78,529)**		**Total Liabilities**
394,185	**390,400**	**394,785**	**423,704**	**404,392**	**(4,385)**	**(33,304)**		**Net Assets**
811,815	811,815	812,773	792,144	813,224	(958)	19,671		Crown Equity
0	0	0	0	(3,484)	0	0		Capital repaid
0	0	0	0	0	0	0		Capital Injection
130,659	130,659	130,660	130,944	130,659	(1)	(285)		Reserves
(548,289)	(552,074)	(548,648)	(503,256)	(536,008)	(3,427)	(48,818)		Retained earnings
394,185	**390,400**	**394,785**	**423,702**	**404,392**	**(4,386)**	**(33,303)**		**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 October was $20.6m in overdraft.

The DHB's liquidity going forward is of concern as the current assets of $109m is significantly lower than the $311m of current liabilities, this means the DHB is solely reliant on crown funding to meet payments as they fall due.

Deficit support of $39m 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 October 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	October-20 actual spend	Actual LTD Spend	To spend	Nov-20	Dec-20	Mar 21 Quarter	Jun 21 Quarter	Forecast cash spend to Jun 21*
Buildings	5,451,511	-	223,556	266,968	490,524	4,960,987	613,776	574,904	1,265,864	675,583	3,620,651
Clinical Equipment	4,636,903	-	644,782	361,228	1,006,010	3,630,893	401,271	1,095,117	938,168	764,172	4,204,738
ICT	1,093,076	-	41,960	29,751	71,710	1,021,365	122,295	122,295	701,033	76,101	1,093,433
2020-21 projects	**11,181,490**	-	**910,298**	**657,946**	**1,568,244**	**9,613,245**	**1,137,342**	**1,792,316**	**2,905,065**	**1,515,856**	**8,918,823**
Buildings	17,052,833	8,814,096	1,395,429	511,654	10,721,179	6,331,654	804,757	748,541	2,591,330	2,082,089	7,622,145
Clinical Equipment	43,693,508	21,222,465	7,018,217	706,666	28,947,347	14,746,161	1,084,945	5,196,713	2,863,718	1,445,814	17,609,406
ICT	9,563,319	6,711,200	1,266,724	239,918	8,217,842	1,345,477	363,610	283,988	693,741	271,572	2,879,634
Prior Year projects	**70,309,660**	**36,747,760**	**9,680,370**	**1,458,238**	**47,886,368**	**22,423,292**	**2,253,311**	**6,229,241**	**6,148,788**	**3,799,475**	**28,111,186**
Total	**81,491,149**	**36,747,760**	**10,590,667**	**2,116,185**	**49,454,612**	**32,036,537**	**3,390,653**	**8,021,557**	**9,053,853**	**5,315,331**	**37,030,008**

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

Key highlights to October 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. $11.1m in projects have been approved to the end of October 2020
- Total spend to the end of October 2020 was $12.70m 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
- The October actual spending was $1.8m lower than forecasted due to timing delays on clinical equipment. Forecast spend on clinical equipment for December 2020 is expected to be significantly high. This is due some high value clinical equipment projects: Linac replacement and lights and pendants replacement in Kenepuru and Wellington theatres

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
Staff Health and Safety Reports	As above	As above
HVDHB January 2021 Financial and Operational Performance Report	As above	As above
CCDHB January 2021 Financial and	As above	As above

Operational Performance Report		
Patient Story	As above	As above
Service Spotlight	As above	As above
Delivering on our Strategic Intent and Enabling System Transformation	As above	As above
2021/22 Budget	As above	As above
FIRST DRAFT Annual Plans	As above	As above
Holiday's Act Project	As above	As above
Consumer Council	As above	As above
2DHB Hospital Network	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.