PUBLIC

HUTT VALLEY DHB / Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**AGENDA** Held on Wednesday 29 July Front and Centre, 69 Tory Street, Te Aro, Wellington Zoom link: **959 8709 0348** Time: 9am
	MEETING

	Item	Action	Presenter	Min	Time	Pg
1	**PROCEDURAL BUSINESS**					
1.1	Karakia			15	9:00am	
1.2	Apologies	**ACCEPT**	Chair			
1.3	Public Participation -Te Awakairangi Birthing Centre	**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	**VERBAL**	Chair			
1.8	Chief Executive's Report	**VERBAL**	Chief Executive			
1.9	Board Work Plan	**APPROVE**	Chair			
2	**PRESENTATION**					
2.1	Patient Story	**PRESENT**	Chief Executive	30	9.15am	
3	**DHB Performance and Accountability**					
3.1	CCDHB April 2020 Financial and Operational Performance Report	**NOTE**	Chief Financial Officer Director Provider Services	10	9.45am	
3.2	HVDHB April 2020 Financial and Operational Performance Report	**NOTE**	GM Finance and Corporate Services Director Provider Services			
4	**Updates**					
4.1	New Children's Hospital Update	**NOTE**	Executive Director Corporate Services	35	9.55am	
4.2	Health System Committee Items for Approval and Update	**NOTE**	HSC Chair			
4.2.1	Quarterly Report – Te Pae Amorangi	**NOTE**	Director Māori Health			
4.2.2	Quarterly Report – Taurite Ora	**NOTE**	Executive Director Māori Health			
4.2.3	Pacific Health and Wellness Strategy for the Greater Wellington Region	**APPROVE**	Director Pacific Health			
4.3	Disability Support Advisory Committee Update -DRAFT Minutes	**NOTE**	DSAC Chair			
5	**OTHER**					
5.1	General Business	**NOTE**	Chair	5	10.30am	
5.2	Resolution to Exclude the Public	**ACCEPT**	Chair			

DATE OF NEXT FULL BOARD MEETING:
2 September, details to be confirmed

CAPITAL & COAST AND HUTT VALLEY DISTRICT HEALTH BOARDS

Interest Register

24 July 2020

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

	• Member, Harkness Fellowships Trust Board • Member of the Wesley Community Action Board • Independent Consultant • Brother-in-law is a medical doctor (anaesthetist), and niece is a medical doctor, both working in the health sector in Auckland • Son is Deputy Chief Executive (insights and Investment) of Ministry of Social Development, Wellington
Hamiora Bowkett	• Deputy Chief Executive, Te Puni Kōkiri • Former Partner, PricewaterhouseCoopers • Former Social Sector Leadership position, Ernst & Young • Personal friendship with current Minister of Health, Dr David Clark (Appointment made by Minister of Finance)
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	• Director, Dunstan Lake District Limited • Councillor, Porirua City Council • Trustee, Whitireia Foundation • Member of Capital & Coast District Health Board • Brother is Team Coach for Pathways and Real Youth Counties Manukau District Health Board • Father is Acting Director in the Office for Disability Issues, Ministry of Social Development
Yvette Grace	• General Manager, Rangitāne Tu Mai Rā Treaty Settlement Trust • Member, Hutt Valley District Health Board • Member, Wairarapa District Health Board • Member, Steering group, Wairarapa Economic Development Strategy • Husband is a Family Violence Intervention Coordinator at Wairarapa District Health Board • Sister-in-law is a Nurse at Hutt Hospital • Sister-in-law is a Private Physiotherapist in Upper Hutt
Dr Tristram Ingham	• Board Member, Health Quality and Safety Commission • Director, Foundation for Equity & Research New Zealand • Director, Miramar Enterprises Limited (Property Investment Company) • Member, Independent Monitoring Mechanism to the United Nations on the United Nations Convention on the Rights of Persons with Disabilities • Chair, Te Ao Mārama Māori Disability Advisory Group

	• Co-Chair, Wellington City Council Accessibility Advisory Group • Chairperson, Executive Committee Central Region MDA • Vice Chairperson, National Council of the Muscular Dystrophy Association • Trustee, Neuromuscular Research Foundation Trust • Professional Member, Royal Society of New Zealand • Member, Disabled Persons Organisation Coalition • Member, Scientific Advisory Board – Asthma Foundation of NZ • Member, 3DHB Sub-Regional Disability Advisory Group • Member, Institute of Directors • Member, Health Research Council College of Experts • Member, European Respiratory Society • Member, Te Ohu Rata o Aotearoa (Māori medical Practitioners Association) • Senior Research Fellow, University of Otago Wellington • Wife is a Research Fellow at University of Otago Wellington • Co-Chair, My Life My Voice Charitable Trust • Member, Capital & Coast District Health Board • Member, DSAC • Member, FRAC
Dr Chris Kalderimis	• National Clinical Lead Contractor, Advance Care Planning programme for Health Quality & Safety Commission • Locum Contractor, Karori Medical Centre • Contractor, Lychgate Funeral Home
Sue Kedgley	• Member, Capital & Coast District Health Board • Member, Consumer New Zealand Board • Stepson works in middle management of Fletcher Steel
Ken Laban	• Chairman, Hutt Valley Sports Awards • Broadcaster, numerous radio stations • Trustee, Hutt Mana Charitable Trust • Trustee, Te Awaikairangi Trust • Member, Hutt Valley District Health Board • Member, Ulalei Wellington • Member, Greater Wellington Regional Council • Member, Christmas in the Hutt Committee • Member, Computers in Homes • Commentator, Sky Television
Prue Lamason	• Councillor, Greater Wellington Regional Council • Chair, Greater Wellington Regional Council Holdings Company • Deputy Chair, Hutt Mana Charitable Trust • Member, Hutt Valley District Health Board • Daughter is a Lead Maternity Carer in the Hutt
John Ryall	• Member, Hutt Union and Community Health Service Board • Member, E tū Union

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

CAPITAL & COAST AND HUTT VALLEY DISTRICT HEALTH BOARDS

Interest Register

EXECUTIVE LEADERSHIP TEAM

29 JULY 2020

Fionnagh Dougan *Chief Executive Officer*	• Board member, Children's Hospital Foundation, Queensland • Trustee, Wellington Hospital Foundation • Adjunct Professor University of Queensland
Sandy Blake *CCDHB Executive Director, Quality Improvement & Patient Safety*	• Advisor to Patient Safety and Reportable Events programme, Health Quality Safety Commission • Adviser to ACC re adverse events • Son is Associate Director of Deloittes
Debbie Barber *2DHB Acting Director of Communications*	• None
Thomas Davis *CCDHB Executive Director, Corporate Services*	• Wife's cousin Facility & Property Manager Victoria University of Wellington
Kerry Dougall *HVDHB Director of Māori Health*	• Board Chair, Kōkiri Marae Māori Women's Refuge • Board member, Ta Kirimai te Ata Whanau Collective
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 of Provider Services*	• None
Debbie Gell *HVDHB General Manager Quality, Service Improvement and Innovation*	• Member of Consumer Council for Healthy Homes Naenae
Arawhetu Gray *CCDHB Director, Māori Health*	• Co-chair, Health Quality Safety Commission – Maternal Morbidity Working Group • Director, Gray Partners • Chair, Te Hauora Runanga o Wairarapa • Chair, Tangata Whenua Advisory Group, Te Hiringa Hauora, Health Promotion Agency
Rachel Haggerty *2DHB Director, Strategy Planning & Performance*	• Director, Haggerty & Associates • Chair, National GM Planner & Funder

12 February 2020

Emma Hickson *CCDHB Chief Nursing Officer*	• None
Nicola Holden *Director, Chief Executive's Office*	• None
Dr Sisira Jayathissa *HVDHB Chief Medical Officer*	• Member of the Medicine Adverse Reaction Committee Medsafew (MOH) • Member Standing committee on Clinical trials (HRC) • Member Editorial Advisory Board NZ Formulary • Member of Internal Medicine Society of Australia and New Zealand • Australian and New Zealand Society for Geriatric Medicine • Writer NZ Internal Medicine Research Review • Clinical Senior Lecturer and Module convenor Clinical Skills module (Hutt campus), University of Otago • Company Director of Family Company Strik's Nurseries and Garden Shop 100&1 House and Garden Plans
Christine King *HVDHB Chief Allied Health Officer* *Acting CCDHB Chief Allied Health Officer*	• Brother works for Medical Assurance Society (MAS) • Sister is a Nurse for Southern Cross
Michael McCarthy *CCDHB Chief Financial Officer*	• Director/Trustee Prime Site Properties Ltd • Director Allied Laundry • Business relationship with Teresa Wall (Chair of CCDHB MPB) in primary care consulting and the Ahuriri Health Trust. • Trustee of the Wellington Hospital Foundation • Daughter works in cervical screening programme • Son and son-in-law work for Audit NZ
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
Judith Parkinson *HVDHB General Manager, Finance and Corporate Services*	• Director of Allied Laundry
Tofa Suafole-Gush *HVDHB Director, Pacific Peoples* *Acting CCDHB Director, Pacific Peoples*	• Member of Te Awakairangi Health Board • Pacific Member, Board of Compass Health • Director, Pacific Peoples, Wairarapa DHB • Husband is an employee of Hutt Valley DHB
John Tait *CCDHB Chief Medical Officer*	• Vice President RANZCOG • Ex-offico member, National Maternity Monitoring Group • Member, ACC taskforce neonatal encephalopathy • Trustee, Wellington Hospitals Foundation

	• Board member Asia Oceanic Federation of Obstetrician and Gynaecology • Chair, PMMRC
Tracy Voice *3DHB Chief Digital Officer*	• Secretary, New Zealand Lavender Growers Association • Board member, Primary Growth Partnership with PGG Wrightsons/Grassland Seed Technology Innovation
Declan Walsh *2DHB Director People, Culture and Capability*	• None

BOARD MEETING **PUBLIC**

HUTT VALLEY DHB / Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**MINUTES** Held on Wednesday, 27 May 2020, 9am Via Zoom. Hutt Valley & CCDHB Board Room
BOARD MEETING	**PUBLIC**

IN ATTENDANCE

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

Hutt Valley and Capital & Coast DHB

Fionnagh Dougan	Chief Executive
Nicola Holden	Director, Chief Executive's Office
Rachel Haggerty	Director, Strategy, Planning and Performance
Joy Farley	Director Provider Services
Amber Igasia	Board Liaison Officer
Nigel Fairley	GM Mental Health, Addictions and Intellectual Disability Services
Declan Walsh	Director People, Culture and Capability
Tofa Suafole Gush	Director Pacific Peoples Health
Christine King	Chief Allied Health Officer
Tracy Voice	Chief Digital Officer

CCDHB

John Tait	Chief Medical Officer
Emma Hickson	Chief Nursing Officer
Debbie Barber	Communications Manager
Michael McCarthy	Chief Financial Officer
Sandy Blake	Executive Director, Quality Improvement and Patient Safety
Arawhetu Gray	Director, Maori Health Team
Thomas Davis	Executive Director, Corporate Services

HVDHB

Chris Kerr	Chief Nursing Officer
Judith Parkinson	General Manager, Finance and Corporate Services
Kerry Dougall	Director, Maori Health Group
Sisira Jayathissa	Chief Medical Officer
Debbie Gell	General Manager, Quality Service Improvement and Innovation

APOLOGIES

BOARD MEETING **PUBLIC**

1 PROCEDURAL BUSINESS

1.1 KARAKIA

Tofa Suafole-Gush opened the meeting with a karakia/tatalo in Samoan to recognize Vaiaso o le Gagana Samoa (Samoan Language week) following which the Chair welcomed everyone to the meeting.

1.2 APOLOGIES

Nil.

1.3 CONTINUOUS DISCLOSURE

1.3.1 COMBINED BOARD INTEREST REGISTER

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

1.3.2 COMBINED EXECUTIVE LEADERSHIP TEAM INTEREST REGISTER

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

1.4 CHAIR'S REPORT AND CORRESPONDENCE

The Chair had nothing to note.

1.5 CHIEF EXECUTIVE'S REPORT

The Chief Executive provided an update on the following:

1. 2DHB Executive Change Process
2. The Mental Health Addiction and Intellectual Disabilities Services (MHAIDS) Change Process

2 COVID-19

2.1 UPDATE AND RECOVERY

The Chief Executive and other Executive Leadership Team (ELT) members presented on the COVID-19 recovery tracking and reporting. This report is produced regularly for the DHBs and will be a part of the ongoing COVID-19 recovery and preparedness for the DHBs. The Boards commended the DHBs for their work responding to COVID-19 and acknowledged the importance of this data.

2DHB COVID-19 Recovery Report

2.2 ADVANCED WELLNESS AT HOME INITIATIVE (AWHI): NEW WAYS OF WORKING

The Chief of Allied Health presented on the success of AWHI during the COVID-19 response. The initiative was key in decreasing the number of days patients spend in hospital. The less time a patient spends in hospital, the better their health outcomes. AWHI was specifically focused on medical patients and older people as well as stroke patients.

3 DHB PERFORMANCE AND ACCOUNTABILITY

3.1 CCDHB JANUARY AND FEBRUARY 2020 FINANCIAL AND OPERATIONAL PERFORMANCE REPORTS

This report was taken as **READ.**

3.2 HVDHB JANUARY AND FEBRUARY 2020 FINANCIAL AND OPERATIONAL PERFORMANCE REPORTS

This report was taken as **READ.**

Moved	
HVDHB	**Second**
Yvette Grace	Wayne Guppy
CCDHB	
Sue Kedgley	Kathryn Adams

4 CAPITAL PROJECTS UPDATE

4.1 NEW CHILDREN'S HOSPITAL UPDATE

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

(a) There have been no reportable incidents.

(b) That McKee Fehl are forecasting Project Handover on 21 June 2021 – the most recent delay is due to the effects of COVID-19.

(c) The Grace Neill Block L3 Reconfiguration construction work has achieved practical completion.

(d) Wellington Regional Hospital – WBCC, Link Bridge & Raised Carpark roof Building Consents have been lodged with Wellington Council.

Moved	
HVDHB	**Second**
Yvette Grace	Wayne Guppy
CCDHB	
Sue Kedgley	Kathryn Adams

5 OTHER

5.1 GENERAL BUSINESS

No further business was raised.

5.2 RESOLUTION TO EXCLUDE THE PUBLIC

Moved	
HVDHB	**Second**
Yvette Grace	Wayne Guppy
CCDHB	
Chris Kalderimis	Kathryn Adams

BOARD MEETING **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.)

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 Board meeting 13 March 2020 (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
FRAC items for Board approval and Update	As above	As above
Annual Plan Update and Delegation	As above	As above
29 Everton Terrace Sale	As above	As above
Te Whare Ahuru Rebuild	As above	As above
Major Capital Projects Committee Establishment	As above	As above
Sustainability presentation	As above	As above
HVDHB Quality Improvement and Patient Safety Report	As above	As above
CCDHB Quality Improvement and Patient Safety Report	As above	As above
HVDHB Health and Safety Report	As above	As above
CCDHB Health and Safety Report	As above	As above

HVDHB March/April 2020 Financial and Operational Performance Report	As above	As above
CCDHB March/April 2020 Financial and Operational Performance Report	As above	As above

The Board moved to Public Excluded session at 10.40pm

6 NEXT MEETING

Wednesday, 29th July 2020 – Link details to come.

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

DATED this day of 2020

David Smol
BOARD CHAIR

Chief Executive's Report

Prepared by: Fionnagh Dougan (Chief Executive)

1 Introduction

This report covers the period from 27 May 2020 – 22 July 2020.

2 COVID-19 Update

2.1 Current Cases – 2DHB

Number of COVID-19 cases: 0

Number of days without COVID-19 cases, Hutt Valley DHB: 36 days

Number of days without COVID-19 cases, Capital & Coast DHB: 93 days

2.2 Managed Isolation Facilities (MIFs)

Capital & Coast DHB is leading the health and social wellbeing response for the COVID-19 managed isolation facilities (MIFs). This is being done in partnership with Regional Public Health (RPH) and the Ministry of Defence, supporting their work in border control.

The Regional Isolation and Quarantine Control Centre (RIQ), a multi-agency group consisting of Ministry of Defence as lead organisation, Aviation Security, and NZ Police, alongside the DHB and RPH is operating out of the emergency management office on Level 4 of the Clinical Services Block of Wellington Regional Hospital.

The RIQ oversees all operations related to the managed isolation facility at the two current locations and any additional facilities as they are stood up. The facilities are staffed by CCDHB and Tu Ora Compass PHO doctors and nurses, supplemented with some agency staff. It is expected that arrivals will continue for a significant period of time.

2.3 Testing Statistics and Coverage

Information current as at 20 July 2020.

2DHB	
Tests performed to date	36,699
People tested to date	34,691
Testing coverage	7.2%
Tests performed last week	724

HVDHB	
Tests performed to date	10,651
People tested to date	10,127
Testing coverage	6.6%
Tests performed last week	210

CCDHB	
Tests performed to date	26,048
People tested to date	24,654
Testing coverage	7.4%
Tests performed last week	514

3 Events and News

3.1 Notable visits and programmes

3.1.1 Hutt Valley Women's Health Service Review Hui

On 23 July staff, Board members and stakeholders were invited to hear about the progress in relation to the implementation of the review and improvements underway across the Women's Health Service at Hutt Valley DHB.

Attendees heard about significant changes across the service and achievements made in recruitment, resourcing, equity, environment, clinical improvements, safety and culture.

The session closed with a focus on the future direction of the service across the two DHBs and the passing of a koha stone symbolising the future and the improvement journey to date.

3.1.2 Hutt Valley Te Herenga Tangata – Multidisciplinary Team Launch

Staff and stakeholders attended a celebration launch on 23 July to acknowledge the integration of the Hutt Valley DHB Community Older Persons and Rehabilitation Service (OPRS), Community Allied Health, and the Early Supported Discharge Service (ESD) service.

The new integrated service has been named Te Herenga Tangata--meaning the binding, weaving, and collective strength of community.

The integration of these services will reduce the duplication of referrals and provide a flexible pathway and approach to supporting our population—with the right level of intervention, using the best knowledge and skill-set from each profession. The service's integration will ensure it is better positioned to develop models of working with Māori, Pasifika, Disability services, Primary health, and other community based social services.

Staff, stakeholders and primary health partners will help co-design the next phase of work to provide a holistic continuum of care—supporting patients to self-manage new health conditions in the community and avoid unnecessary hospital admissions.

3.2 Health sector partnerships

3.2.1 National Public Health Advocacy Team

DHB Chairs and Chief Executives have agreed to establish a new National Public Health Advocacy team to address the structural and commercial determinants of obesity and alcohol related harm.

The overarching aims for this work is:

> *To improve the sustainability of the health system and help eliminate health inequities.*
>
> *To establish & deploy strategic communications and advocacy capability, using DHB assets, partners and connections to secure public and cross-party support for a more assertive national policy, smart regulation and legislation to make greater impact on structural and commercial determinants of health.*

The Northern Regional Alliance is hosting the new team under the leadership of Dr Nick Chamberlain, CEO of Northland District Health Board and national lead DHB Chief Executive for Public Health. Vui Mark Gosche, Board Chair of Counties Manukau District Health Board has been appointed by the national DHB Chairs to act as the Chair sponsor for the work that the team will be undertaking.

A steering group with expert support drawn from across New Zealand is being established to help guide and advise on the priorities and work programme. Membership will include representatives from a range of DHBs and public health units as well as strong Maori and Pacific representation.

The team will complement the work of the Health Promotion Agency nationally, and the good practice that exists within District Health Boards, regional Public Health Units, and partner agencies, and provide a valuable supportive resource for policy makers and leaders. The work will include co-ordination with DHB public health leaders to ensure the relevant DHB policies are strengthened, consistent, and reflective of best practice (e.g. healthy food and drink policies).

3.3 Patients and community

3.3.1 GP Liaison Consultant Psychiatrist Service

The Mental Health, Addictions and Intellectual Disability Service (MHAIDS) has launched a GP Liaison service to provide specialist mental health and addictions advice to general practices across the Hutt Valley, Wairarapa, and Wellington regions.

From today, general practitioners and nurse practitioners will be able to contact the GP Liaison consultant psychiatrist for phone consultations, join virtual consultations via zoom, and access monthly virtual education sessions.

The new service supports the Government's Access and Choice Mental Health initiative and aligns with the recommendations of He Ara Oranga—to expand access and choice, and enhance wellbeing, promotion and prevention.

"The GP Liaison service is an important component of ensuring that primary care has access to early specialised mental health and addictions advice," said MHAIDS general manager Nigel Fairley.

"The service strengthens the ability to initiate treatment for people in the community before their condition worsens or becomes acute."

It is recognised internationally that the needs of those with mild to moderate mental health and addictions problems are best met in the primary care setting. Early specialised support strengthens the overall continuum of care and supports a collaborative whole-of-sector approach to improving outcomes for our people.

Primary health organisations across the greater Wellington region welcome the additional support and service.

"Mental health work is a large part of primary care and we are very pleased to welcome this new role," says Tu Ora Compass mental health medical director Dr Louise Poynton.

"Our general practices will now be able to rapidly access specialist advice, which will have a significant positive impact on the care we deliver to our patients."

"General practices in the Hutt Valley have been calling for this kind of service for some time, so it is wonderful that MHAIDS has enabled this position to be put in place," said Te Awakairangi chief executive Bridget Allan. "We are looking forward to working closely with the MHAIDS teams on other service improvements for our tangata whaiora."

3.3.2 Virtual solutions ensure continued care for older people

Specialist wound care nurses Alice Bourke (Kapiti), Fiona Guthrie (Kenepuru) Natalie Scott (Wound charge nurse manager) Claire Todd (Kenepuru), Sharleen Dockerty (Kapiti), and Elizabeth Frost (Wellington).

A new way of working ensured that Aged Residential Care (ARC) residents have continued to receive safe and quality wound care during COVID-19.

Prior to COVID-19, the Specialist Wound Nurse Team visited ARC facilities to treat and advise on complex non-healing wounds such as leg ulcers, diabetic foot ulcers, and pressure injuries. This stopped once the country moved into the alert level 4 lockdown.

“Under the lockdown we could no longer visit ARC facilities in person to consult and provide expert wound advice, but the nurses and residents still needed wound care support,” said community wound clinical nurse specialist Natalie Scott.

“Being able to provide this service is important for the ARC facility nurses to provide best practice, and important to residents’ health and wellbeing. Providing virtual clinics enabled continuity of care, and we contacted ARC facilities to assure them we would continue to provide our service.”

Using the virtual clinic involves a facility’s registered nurse (RN) referring a resident to the service and providing photographs of the resident’s wound. The wound care nurse and RN then clinically assess and review the case and photos by phone.

“We discuss the wound’s status with the RN, collaborate on a care plan, and then follow up by phone over the following weeks to check the resident’s progress. This enables us to support ARC nurses, and provide expert advice despite alert level restrictions.

“ARC nurses and residents have appreciated this ongoing support immensely, residents’ families have also been pleased to have wound care specialists involved in their loved ones’ care, and we’ve been able to ensure that people have not been disadvantaged during this time.”

The virtual clinic has enabled Specialist Wound Nurse Team’s six specialist nurses to support more than 12 facilities in complex wound management over past six weeks.

While in-person visits to ARC facilities will resume if needed when ARC facilities relax visitation rules, the virtual clinics will continue providing virtual support for residents who have straightforward wounds and are improving.

3.3.3 Wellington Regional Children’s Hospital taking shape

The construction of the new Wellington Regional Children’s hospital is progressing and journalists took a tour this week.

Read about progress in the Dominion Post:

https://www.stuff.co.nz/national/health/122182656/wellington-childrens-hospital-midconstruction-set-to-be-perfect-space-for-kids-carers-and-staff

3.4 External Communications

3.4.1 Acknowledging 3DHB Health Pathways team

In June, a letter was sent from Streamliners acknowledging the 3DHB Health Pathways team for it's important work in the COVID-19 pathways out to our clinicians. Of particular note was the work of Justine Lancaster, Richard Mead and Antionette Ehmke. A copy of the letter can be found in Appendix One.

3.4.2 Social Media

Hutt Valley DHB

- HVDHB Facebook page impressions: 339,079 people
- Hutt Maternity Facebook page impressions: 22,688 people
- Twitter page impressions: 16,618 people
- Instagram page impressions: 11,062 people
- LinkedIn page – impressions: 9,643 people

Capital & Coast DHB

- CCDHB Facebook page impressions 149,540 people
- Twitter page impressions 9,460 people
- LinkedIn page impressions– 1,007 people

Top four posts across both DHBs

Photo: Graduate midwife Leilani Va'a (12,859 impressions)
https://www.facebook.com/CCDHB/photos/a.484743608223138/3333206526710151/?type=3&theater

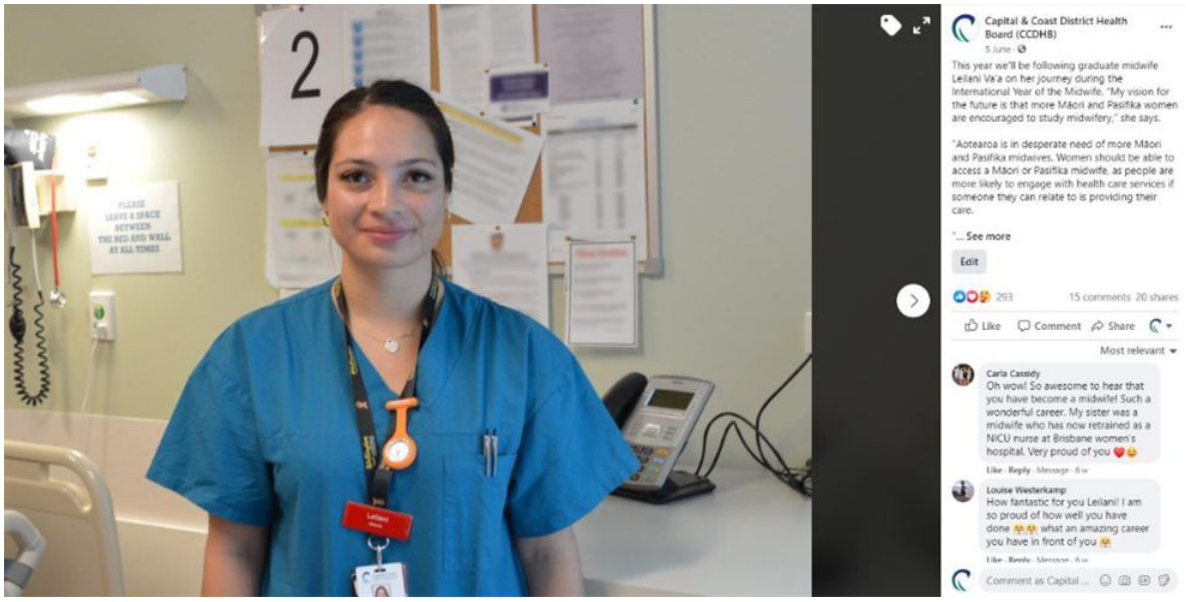
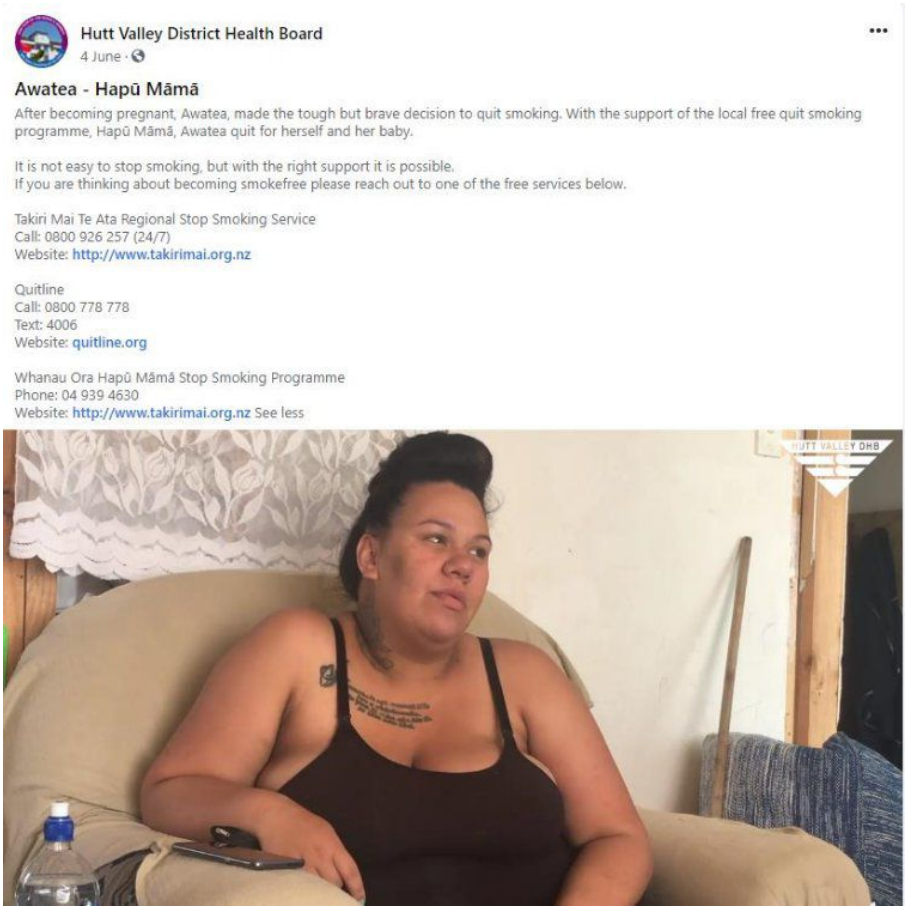


Photo: Perioperative Team (13,566 impressions)

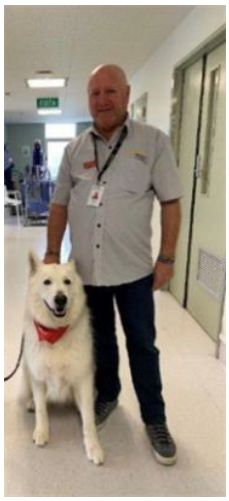
Video: Well Homes (12,967 impressions)
https://www.facebook.com/HuttValleyDHB/videos/292798502127850/

Video: Awatea's quit smoking story (29,726 impressions)
https://www.facebook.com/HuttValleyDHB/videos/1126293197751055/



3.5 Our People

3.5.1 Local Heroes



The Ward 6 rehabilitation team at Kenepuru Community Hospital recently acknowledged and thanked John, who brings Arlo the dog in as a volunteer service into the hospital.

John and Arlo have been helping with therapy practice in our rehabilitation groups recently, and it has been incredible having them support clients on their journeys. Their input has been crucial in some of the rehabilitation gains made by ward 6 clients.

Board Discussion

July 2020

Capital & Coast DHB April 2020 Financial and Operational Performance Report	
Action Required **The Board note:** (a) The DHB was ($4.3m) unfavourable to budget for the month of April 2020 (b) The DHB year to date result was ($18.7m) unfavourable to budget (c) The DHB has a revised deficit forecast for 2019-20 of ($47.5m) and takes into account an estimated impact from COVID-19 and Holidays Act provisions totalling ($18M). The original budgeted forecast was ($15.9m).	
Strategic Alignment	Financial Sustainability
Authors	Michael McCarthy, 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 on the financial performance and delivering against target performance for the DHB
Contributors	Finance Team, Mental Health and 2DHB Hospital Services, GM MHAIDS, Director Strategy Planning & Performance

Executive Summary

The delivery of services in March and April was impacted by the Civil Defence Emergency that moved New Zealand to Alert Level 3 on 22 March and Alert Level 4 on 27 March 2020. This immediately affected hospital care delivery and moved all of our services in the hospital, Mental Health, Addiction and Intellectual Disability Services (MHAIDS) and community into a state of preparation and response to COVID-19. The operational impacts were significant as services were immediately reduced, but the financial results will not be fully visible until May 2020. The MOH operating framework requires the DHB to absorb 0.1% of costs relating to a pandemic or national emergency ($879,000). All costs above that are subject to review by the MOH.

The Capital & Coast DHB has a deficit at the end of April of $29.7m year to date (YTD). This is predominantly driven by a $31.7m deficit in provider arm services. This result exceeds our planned deficit. YTD fulltime equivalents (FTE) are 38 below budget, activity is 4.82% behind PVS target and the inter district flow (IDF) revenue is unfavourable $3.9m YTD.

Included within our YTD deficit are the COVID-19 additional costs which total approximately $4.3m to the end of April.

The DHB's cash and short term liquidity is a significant issue. The DHB is solely reliant on the Crown to meet payments later in the year as they fall due. The government has provided deficit support of $16m paid in early May. Following budget announcements we anticipate a further deficit support payment. MOH have indicated they will issue a letter of support from Ministers to allow the DHB to trade as a going concern.

The latest forecast deficit submitted to MOH is ($47.5m) and the current month result is in line with the forecast. The forecast takes into account an estimated impact from COVID-19 and Holidays Act provisions.

Finally, of the 17 Ministry of Health (MOH) measures of DHB performance (confirmed Q2 results) CCDHB are delivering to target against seven, partially achieving seven and not delivering against three. The three are exclusive breastfeeding, smoking cessation and colonoscopy waiting times. Our provider arm is addressing colonoscopy waiting times with a recovery plan. The smoking cessation measure is still a work in progress however it is important to note there is a decline in smoking rates within our region.

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 38 FTE below plan.
Financial	Deficit forecast is changed to $47.5 million, recognising the original ($29.5m) forecast, an ($8m) impact of COVID-19 and a conservative ($10m) Holiday Act adjustment whilst information is clarified; currently $67million provided for. This is not part of our responsible deficit.
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	Michael McCarthy, Chief Financial Officer	Currently on track but will be impacted by current events	Major (but no payment impacts)	Major(no operational impacts)

Attachment/s

2.1.1 Capital & Coast DHB April 2020 Financial and Operational Performance Report

Capital & Coast District Health Board

Monthly Financial and Operational Performance Report

For the period ending 30 April 2020

Presented in May 2020

Capital & Coast District Health Board

Contents

Section 1

Performance Overview and Executive Summary

Executive Summary

- The delivery of services in March and April was impacted by the Civil Defence Emergency that moved New Zealand to Alert Level 3 on 22 March and Alert Level 4 on 27 March 2020. This immediately affected hospital care delivery and moved all of our services in the hospital, Mental Health, Addiction and Intellectual Disability Services (MHAIDS) and community into a state of preparation and response to COVID-19. The operational impacts were significant as services were immediately reduced, but the financial results will not be fully visible until May 2020. The MOH operating framework requires the DHB to absorb 0.1% of costs relating to a pandemic or national emergency ($879,000). All costs above that are subject to review by the MOH.
- The Capital & Coast DHB has a deficit at the end of April of $29.7m year to date (YTD). This is predominantly driven by a $31.7m deficit in provider arm services. This result exceeds our planned deficit. YTD fulltime equivalents (FTE) are 38 below budget, activity is 4.82% behind PVS target and the inter district flow (IDF) revenue is unfavourable $3.9m YTD.
- Included within our YTD deficit are the COVID-19 additional costs which total approximately $4.3m to the end of April.
- The DHB's cash and short term liquidity is a significant issue. The DHB is solely reliant on the Crown to meet payments later in the year as they fall due. The government has provided deficit support of $16m paid in early May. Following budget announcements we anticipate a further deficit support payment. MOH have indicated they will issue a letter of support from Ministers to allow the DHB to trade as a going concern.
- The latest forecast deficit submitted to MOH is ($47.5m) and the current month result is in line with the forecast. The forecast takes into account an estimated impact from COVID-19 and Holidays Act provisions totalling ($18M).
- Finally, of the 17 Ministry of Health (MOH) measures of DHB performance CCDHB are delivering to target against seven, partially achieving seven and not delivering against three. The three are exclusive breastfeeding, smoking cessation and colonoscopy waiting times. Our provider arm is addressing colonoscopy waiting times with a recovery plan. The smoking cessation measure is still a work in progress however it is important to note there is a decline in smoking rates within our region (these reflect confirmed Q2 results, preliminary Q3 results provided on page 6).

People Served – April 2020 (March 2020)

CCDHB funds services that touch thousands of people in our community every month. April is generally busy but it was impacted by the COVID-19 lockdown which led to a redesign of the operating model.

ED Attendances

3,259 (↓ 4,562)

394 Maori (↓ 602)
244 Pacific (↓ 375)

Surgical Procedures*

378 (↓ 927)

51 Maori (↓ 108)
37 Pacific (↓ 83)

* Surgical procedures completed in main theatres.

Hospital Discharges*

3,507 (↓ 5,168)

488 Maori (↓ 764)
310 Pacific (↓ 435)

* Discharges from Kenepuru Community Hospital and Wellington Regional Hospital.

Outpatient & Community Contacts

12,368 (↓ 18,466)

1,391 Maori (↓ 1,954)
892 Pacific (↓ 1,229)

Mental Health Discharges

1,066 (↓ 1,498)

241 Maori (↓ 412)
55 Pacific (↓ 66)

Mental Health & Addiction Contacts

5,445 (↓ 6,116)

1,298 Maori (↓ 1,476)
356 Pacific (↓ 391)

Primary Care Contacts

67,240 (↓ 86,066)

6,601 Maori (↓ 9,207)
4,745 Pacific (↓ 6,038)

People in Aged Residential Care

1,927 (↓ 1,965)

78 Maori (↓ 82)
69 Pacific (↓ 70)

5

Ministry Priorities (Q3 2019/20)

Ratings are preliminary. The Ministry of Health will confirm ratings on 15 May 2020.

Achieved	Not achieved
Partially Achieved	Not Assessed

Improving child wellbeing

- Children caries free at five years of age
- Mean number of decayed, missing or filled teeth at school Year 8
- Improving the number of children enrolled in and accessing the Community Oral Health Service
- Immunisation at 8 months, 2 years & 5 years

Better population health outcomes supported by a strong and equitable public health system

- Shorter stays in Emergency Departments

No deliverables this quarter

- Improving mental wellbeing
- Improving wellbeing
- Better population health outcomes supported by primary health care through prevention

Deliverables against Crown Funding Agreements and Out Year Planning

- Care Capacity Demand Management Calculation
- DHB level service component of the National SUDI Prevention Programme

This table demonstrates performance against key ministry priorities from the current performance monitoring framework. The mix of measures is determined by the Ministry of Health.

Financial Overview – April 2020

YTD Operating Position

$25.4m deficit

Exc $4.3m COVID costs

Against a budgeted YTD deficit of $11m. Month result was $4.4m deficit, breakeven in month without COVID-19.

*Includes $830k positive variance from governance arm.

YTD Provider Position

$31.7m deficit

Against a KPI of a budgeted deficit of $12.5m.
Month result was $7m deficit,[$2.5m unfavourable]

YTD Funder Position

$1.1m surplus

Against a KPI of a budgeted surplus of $1.4m.
Month result was $0.1m deficit, [$1.9m unfavourable]

YTD Capital Exp

$32.2m spend

Against a KPI of a budgeted spend of $39.2m.
This includes funded projects – Children's Hospital

YTD Activity vs Plan (CWDs)

4.82% behind[1]

2879 CWDs below PVS plan (1862 IDF CWDs behind).
Month result -1736 CWDs excluding work in progress.

YTD Paid FTE

5,190[3]

YTD 38 below annual budget of 5,228 FTE.
Month 50 favourable. 487 FTE vacancies at end Apr.

Annual Leave Taken

($6m) annualised[4]

Underlying YTD annual leave taken is short by 2.8 days per FTE. Also Lieu leave taken is short by 1.6 days out of 11 public holidays in a year.

[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 are 695 CWD more than target to Apr 20, total of 2257 outsourced ~$11.78m dollars at WEIS price.
[3] Paid FTE ignores leave balance movement which is YTD 31 FTE worse than budgeted growth, Outsourced staff are also not counted in this metric which is currently $2.9m adverse to budget.

CWD – Case weights (also known as WEIS for a year) WEIS – Weighted Inlier Equivalent Separations
4 – Only annual leave, excludes Lieu, long service and 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 – April 2020

*Surgery, Medicine, QIPS directorates

ED (SSIED) 6 Hour rule	ESPI 5 Long Waits	Specialist Outpatient Long Waits	Serious Safety Events[2]
84.8%	395	1183	5
10% below the ED target of 95% Monthly +4.9%	Against a target of zero long waits. Monthly +220	Against a target of zero long waits. Monthly +695	An expectation is for nil SSEs at any point.

YTD Activity vs Plan (CWDs)	YTD Paid FTE	YTD Cost per WEIS
4.82% behind[1]	3,345[3]	$5,972*
2879 CWDs below PVS plan (1862 IDF CWDs behind). Month result -1736 CWDs excluding work in progress.	YTD 63 below annual budget of 3,408 FTE. 182 FTE vacancies.	Against a national case-weight price per WEIS of $5,216 (14.5% above). YTD Dec $5,758 (In Jan pre-covid). *to Apr20

[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 are 695 CWD more than target to Apr 20, total of 2257 outsourced ~$11.78m dollars at WEIS price.
[2] An SSE is classified as SAC1 or SAC2 serious adverse events per HQSC
[3] Paid FTE ignores leave balance movement which is YTD 22 FTE worse than budgeted, Outsourced staff are also not counted in this metric which is currently $292k 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

Year to Date Financial Performance

- The high level financial position:
  - ($15.9m) Approved Annual Deficit Budget
  - ($29.7m) Actual Deficit (includes COVID) YTD April 2020
    - Personnel savings achieved
    - IDF revenue unachieved
    - FTE increase required in target areas
    - Clinical supply costs higher than planned
  - ($29.5m) Submitted Forecast Annual Deficit (prior to COVID-19 impacts and Holiday Act provisions)
  - ($47.5m) New Forecast Annual Deficit (after estimation of COVID-19 impact ($8M) and Holiday Act estimate ($10M))
- FRAC have previously been advised of the forecast position and the expected deficit. Controls across the organisation have held FTE levels and the individual responses in specific clinical services have improved quality and safety where essential.
- As the COVID-19 response has progressed, the overall financial impact has been negative as services ceased during preparation and implementation of Alert Levels 3 and 4. This has meant the provider arm has retained costs whilst reducing service delivery. Truly variable costs, including clinical supplies, have reduced but the greatest cost of staff was retained.
- The closure of services has not shown the underlying revenue impact, as we have been advised that IDF inflow and outflow will be paid to budget for the four months March-June and we are expecting to be fully paid for Planned Care (electives).
- Our largest cost within the month is the increase in leave liabilities; as staff usually plan leave surrounding the three public holidays in April. We have softened the blow of this impact by releasing MECA reserves in line with lower expectations derived from the state services commission's document: ‘Pay restraint in the public sector as a result of COVID-19’.
- The impact of recovery to meet critical patient need is likely to lead to a further deterioration of the financial position. This is driven by the likelihood that MOH will not provide financial support for the delivery of work where the budgeted costs for service delivery have been expended on preparedness for COVID-19.

Section 2.1

Funder Performance

Executive Summary – Funder Performance

- Overall the funder has a positive variance. When adjusted for timing differences in expenses being incurred and revenue received. The possible significant negative variance in inter-district patient flows, particularly from HVDHB, are recorded as achieved. CCDHB has recognised revenue as advised by MOH. The actual reduction is in acute and elective work and would result in a negative variance in provider payments.
- Revenue has been higher than anticipated with $3.9m being received for community pharmacy, CBAC and enhanced primary care. Additional funding was also received for Maori and Pacific responses to the COVID-19 emergency. This included investment to improve vaccination rates for Maori. Rates continue to be monitored and are improving.
- Overall community funding is tracking to normal levels of expenditure when offset from additional revenue is adjusted for. The exception to this is the community pharmacy budget. This will be offset by other positive variance.
- This also reflects that as part of the COVID-19 approach it was nationally agreed that DHBs would continue to fund community providers at existing levels regardless of whether services could be provided. It was expected that providers would re-deploy resources, and provisions were made to ensure they could not also seek funding from other Government sources. This means there is little change in expenditure patterns.
- The surveillance of COVID-19 is ongoing. Currently all CBACs and primary capacity remains available. Once advised of the MOH surveillance plan decisions will be made as to how screening and testing will continue to be provided. The Ministry has yet to indicate what funding will be available for ongoing surveillance.
- All community services are ensuring business continuity with ongoing use of telehealth and alternative models of service delivery. Monitoring is being reviewed to ensure monitoring reflects new models of care.
- The Ministry has also reprioritised essential work such as the Measles catch-up campaign.

Funder Financial Statement of Performance

Month					Capital & Coast DHB Funder Result - $000 Apr 2020	Year to Date				
			Variance						Variance	
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year		Actual	Budget	Last year	Actual vs Budget	Actual vs Last year
68,138	68,138	63,789	0	4,349	Base Funding	681,381	681,381	637,890	0	43,491
6,253	4,872	12,400	1,381	(6,148)	Other MOH Revenue - Funder	51,126	48,721	62,483	2,405	(11,357)
3,007	0	0	3,007	3,007	Community Funding - COVID	3,924	0	0	3,924	3,924
406	263	0	143	0	Provider CCDM and MECA funding	1,663	2,625	0	(963)	0
(138)	89	76	(227)	(215)	Other Revenue	716	882	1,070	(166)	(354)
3,014	2,735	2,193	278	820	IDF Inflows PHOs	28,119	27,353	24,493	765	3,626
18,530	17,450	17,694	1,080	836	IDF Inflows 19/20 Wash-up Prov	169,790	174,505	165,264	(4,714)	4,526
99,209	**93,547**	**96,153**	**5,662**	**3,056**	**Total Revenue**	**936,718**	**935,467**	**891,201**	**1,251**	**45,518**
					Internal Provider Payments					
958	958	933	0	(25)	DHB Governance & Administration	9,581	9,581	9,327	0	(254)
46,233	44,939	44,443	(1,294)	(1,790)	DHB Provider Arm PVS - HHS	468,780	472,332	449,931	3,552	(18,849)
7,439	7,498	7,170	59	(269)	DHB Provider Arm PVS - Mental Health	74,592	74,984	71,740	392	(2,852)
3,677	3,838	7,391	161	3,714	DHB Provider Arm PVS - Corporate	39,188	38,391	21,204	(797)	(17,984)
58,308	**57,234**	**59,937**	**(1,074)**	**1,629**	**Total Internal Provider**	**592,141**	**595,288**	**552,202**	**3,147**	**(39,939)**
					External Provider Payments:					
6,861	5,790	4,773	(1,070)	(2,088)	- Pharmaceuticals	59,533	57,905	59,013	(1,628)	(520)
6,454	6,233	5,923	(221)	(531)	- Capitation	63,978	62,328	58,757	(1,649)	(5,220)
3,007	0	0	(3,007)	(3,007)	- Community COVID	3,921	0	0	(3,921)	(3,921)
6,964	7,217	7,178	253	214	- Aged Care and Health of Older Persons	69,989	72,175	69,667	2,186	(322)
2,922	2,407	2,475	(515)	(447)	- Mental Health	25,210	24,062	23,876	(1,147)	(1,333)
1,036	786	427	(250)	(609)	- Child, Youth, Families	8,395	7,862	4,264	(533)	(4,130)
1,423	1,088	851	(336)	(572)	- Demand driven Primary Services	6,431	6,327	6,247	(105)	(184)
1,972	2,240	1,728	268	(244)	- Other services	21,248	22,225	19,580	977	(1,668)
5,146	3,645	3,483	(1,501)	(1,663)	- IDF Outflows Patients to other DHBs	35,024	36,450	34,878	1,425	(146)
5,046	4,944	4,842	(102)	(204)	- IDF Outflows Other	49,695	49,437	46,785	(258)	(2,910)
40,831	**34,351**	**31,680**	**(6,480)**	**(9,151)**	**Total External Providers**	**343,423**	**338,771**	**323,069**	**(4,652)**	**(20,355)**
99,139	**91,584**	**91,617**	**(7,555)**	**(7,522)**	**Total Expenditure**	**935,564**	**934,059**	**875,271**	**(1,505)**	**(60,293)**
70	**1,963**	**4,536**	**(1,893)**	**(4,466)**	**Net Result**	**1,154**	**1,407**	**15,930**	**(254)**	**(14,776)**

Funder Financials – Revenue

Revenue

- Revenue has a positive variance YTD April $1.2m. This includes COVID-19 community funding of $3.9m. COVID-19 has a cost offset.
- IDF inflows ($4.7m) unfavourable YTD due to under-delivered patient CWD volumes from other DHBs. The IDF funding is held to target for Mar and Apr 20 due to a reduction in planned care related to COVID-19.
- PHO additional funding of $2m. This is predominantly for the reduced co-payment for Community Service Card Holders introduced by this Government and is offset by direct costs.
- CCDM expected funding for 2019/20 that MOH did not ultimately agree. YTD unfavourable ($1.4m).
- Additional funds received for MECA increases of $599k YTD offsets staff increased costs. This is transferred to the provider arm.
- Aged Care pay equity funding held back to support joint HCSS contract with Hutt was partially released in April based on a review by Hutt. YTD to still be released is ($495k). This is an offset.
- Additional other revenue is favourable YTD $1.3m. MOH specified services including child & youth and mental health, all have associated costs.
- Overall the loss of IDF revenue is a significant issue for the organisation including the impact on patient outcomes.

SIP Funder Revenue Variances	Month $000's	YTD $000's
COVID-19 community funding	3,007	3,924
IDF Inflow Revenue held back	1,079	(4,714)
PHO additional funding	402	1,992
CCDM 18/19 - over budgeted for 19/20	(138)	(1,380)
Add funds re MERAS and PSA MECA	60	599
Aged Care Pay Equity re HCSS to pay HUTT	1,387	(495)
Mental Health & other additional services	(135)	1,325
Year to Date Revenue Variances	**5,662**	**1,251**

Funder Financials – Provider Payments

Internal Provider Payments:

- Provider Arm payments are favourable to the funder $3.1m YTD mainly due to inter district inflow (both acute and planned patient activity) from other DHBs not presenting at the provider. The funder may lose some of this surplus funding in wash-up processes with MOH. The impact is not yet agreed.

External Provider Payments:

- Pharmaceutical costs are ($1.6m) unfavourable YTD, mainly due to an efficiency target built into the budget. April 20 costs increased due to additional issues in level 4 of COVID-19. Previous seasonal patterns reflect good performance. CCDHB is a high performer with regards to pharmaceutical efficiency so there is little opportunity for savings to be made but the loss will be offset against other expenditure.
- PHO Capitation expenses are ($1.6k) unfavourable YTD. Additional costs due to volumes are offset by additional revenue received from the Ministry so this will be neutral by year end.
- COVID-19 funds ($3.9m) offset by revenue passed through the DHB to PHO and Pharmacy providers as support in the COVID-19 response period.
- Aged Residential Care and Health of Older People other costs are $2m YTD favourable. Volumes are maintained. When adjusted for the transfer to Hutt for HCSS pay equity costs related to a joint contract, this budget is $0.1m favourable.
- Mental Health costs are unfavourable ($1.1m) YTD due to new funding from the Ministry into Provider contracts. This is offset by revenue from MOH for primary mental health.
- Child and Youth costs are unfavourable ($533k) YTD. This will be offset by revenue from MOH for healthy lives contracts.
- Demand driven and other services favourable $614k. Lower demand driven costs due to the start of COVID lockdown for activity such as vaccination, urgent dental and other services. Expenditure of a proportion of this saving will be incurred in recovery. The remainder will be saved to offset other unknown risks.
- IDF patient outflows are favourable $1.4m YTD, as we have not transferred patients to other DHBs, mainly Hutt Valley, Counties Manukau, Canterbury and Auckland DHBs. This offsets some of the loss in IDF inflows.

Inter District Flows (IDF)

DHB of Domicile	YTD April estimated inpatient inflow washup	March/April adjustment (set to Budget)	Caseweight IDF recognised in accounts (A+B)
Total undelivered inpatient IDF	-$10,224,750	$4,330,288	-$5,894,462

DHB of Service	YTD April estimated inpatient outflow washup	March/April set to budget	Caseweight IDF recognised in Accounts (A+B)
Canterbury	-$636,140	$143,883	-$492,257
Hutt	-$1,346,693	$900,260	-$446,433
Counties Manukau	-$536,877	$150,689	-$386,188
Auckland	-$724,323	$466,569	-$257,754
Southern	-$169,414	$48,191	-$121,223
Other under-serviced (7 DHBs)	-$242,867	$94,048	-$148,819
Other over-serviced (6 DHBs)	-$58,558	$105,398	$46,840
Waikato	$149,796	$42,176	$191,972
Grand Total	-$3,565,075	$1,951,214	-$1,613,861

Changed Recognition:

- MOH has advised that DHBs should assume that IDF revenue in March and April should be assumed at normal budgeted levels, although a loss has been recorded.

IDF Inflow (revenue):

- Overall IDF inflows are below budget by ($3.9m), however this includes additional funding for PCT drugs for IDF patients of $1.6m (less $0.4m set to budget for Mar/Apr). The funding offsets the DHB increase in pharmaceutical expenditure.
- The majority of the lower IDF inflows is caused by inpatient caseweight activity split between:
  ($2.8m) Hutt Valley, ($1.8m) MidCentral, ($1m) Taranaki
  Offset slightly by $0.9m Whanganui

IDF Outflow (expense):

- Overall IDF outflows are below budget by $1.2m. This largely relates to lower numbers of CCDHB patients treated at other DHBs as indicated on the table to the right.

Section 2.2

Hospital Performance

Executive Summary – Hospital Performance

- The COVID–19 response required the development of strategies to screen and stream patient entry to the hospital across all services and areas, with inpatient admissions limited to acutes or care that cannot be deferred, outpatient activity undertaken as telehealth, phone screening for virtual assessment and Multi Disciplinary Teams to teleconference wherever possible and diagnostic services prioritised to support assessment via ED or other acute services, inpatient care or discharge.
- The above, as well as physical distancing, impacted every aspect of service levels and delivery of service, amplifying the effect on the areas of service performance with material impact on both activity and costs. The overall financial impact has been negative as services ceased during preparation and implementation of Alert Levels 3 And 4. This has meant the provider arm has retained costs whilst reducing service delivery. Truly variable costs, including clinical supplies, have reduced but the greatest cost of staff was retained. Our largest cost within the month is the increase in leave liabilities; as staff usually plan leave surrounding the three public holidays in April.
- The DHB had targeted a large number of efficiency measures for the year ahead, which were always required to meet our deficit position of $29.5 million. Some of these such as leave management and staff vacancy rates were being largely achieved, but are now well outside that positive trajectory.
- A positive outcome of the COVID-19 response is that a number of strategies highlighted within the Acute Demand and Bed Capacity Programme were progressed as part of the planning for a surge in COVID-19 presentations and our acute response. These include the expansion of the Advancing Wellness at Home Initiative (AWHI) project that identifies potential patients needing intervention earlier in admission with the goal of reduction in the over 10 day stays for complex patients in general medicine and the increase the opening hours and resourcing of the Children's' Assessment Unit which has been relocated to the "Pink Zone" in ED as a direct result of COVID-19 response planning.
- Our recovery planning assumes that DHBs will face an extended period of risk and potential harm to our communities from the impacts of COVID-19 and therefore we are unable to return to pre-lockdown business as usual (BAU). We are now planning and delivering for new BAU that contains a COVID readiness pathway for all services, maintaining of physical distancing principles and development/implementation of new models of care.

CCDHB Activity Performance - Productivity

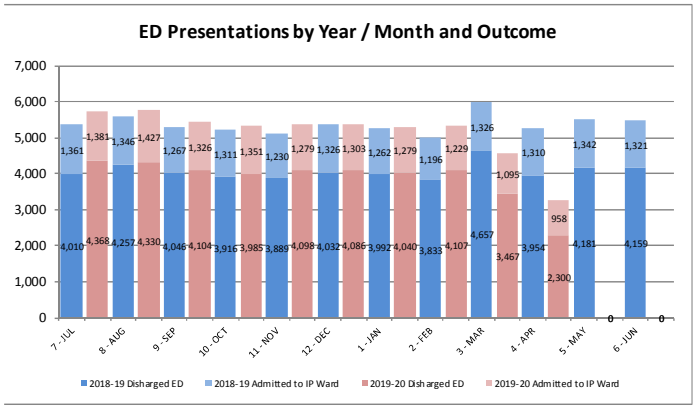
Capital and Coast DHB: April 2020

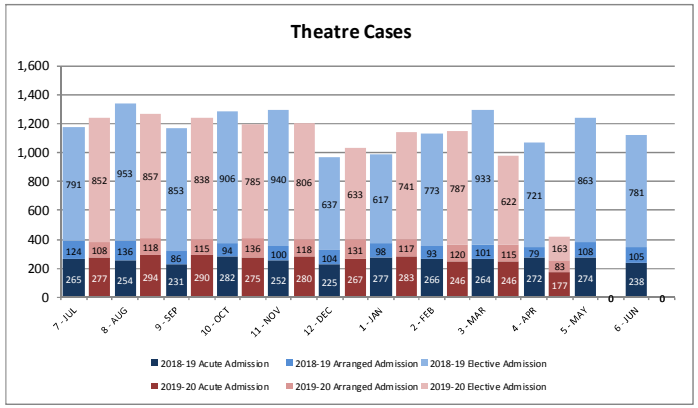
ED Presentations

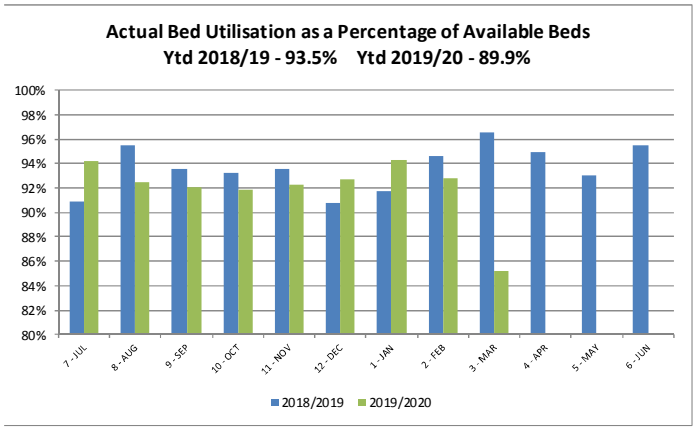
	2018/19	2019/20
YTD Totals	53,521	51,513
Change		-2,008
% Change		-4%

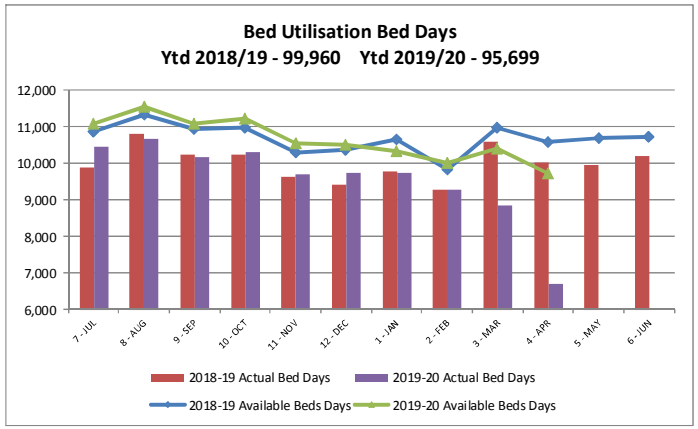
Theatre Cases

	2018/19	2019/20
YTD Totals	11,727	10,880
Change		-847
% Change		-7%









- The utilisation of available adult beds in core wards in April 2020 is 68.9% which is significantly lower than the 94.9% rate recorded in April 2019. The number of available beds in April 2020 is lower than in April 2019 with less beds open at Kenepuru and SAPU closed for a number of days.
- Elective theatre cases have significantly decreased for the month of April 2020 by 77.4% (558 cases) when compared to April 2019 and is related to COVID-19. The decrease is spread across a number of specialties with decreases evident in Ophthalmology (126), General Surgery (79), Gynaecology (76), and ENT (60)
- A recovery plan is in development which will need continued support from the private sector however DHBs consider at least a year will be required to address the backlog.

CCDHB Activity Performance

Capital and Coast DHB: April 2020

HSS Inpatient Caseweight Activity

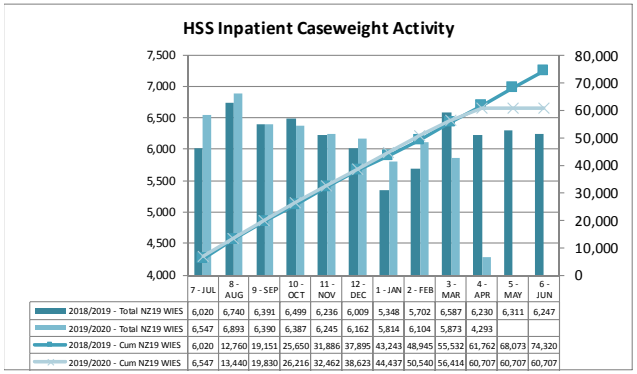
	2018/19	2019/20
YTD Totals	61,762	60,707
Change		-1,055
% Change		-1.7%

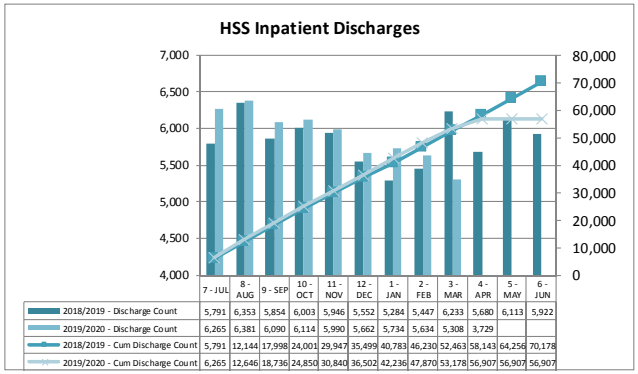
** This includes all Hospital Acitivty including ACC, Non Resident, Non-Casemix but excludes Mental Health*

HSS Inpatient Discharges

	2018/19	2019/20
YTD Totals	58,143	56,907
Change		-1,236
% Change		-2.1%

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



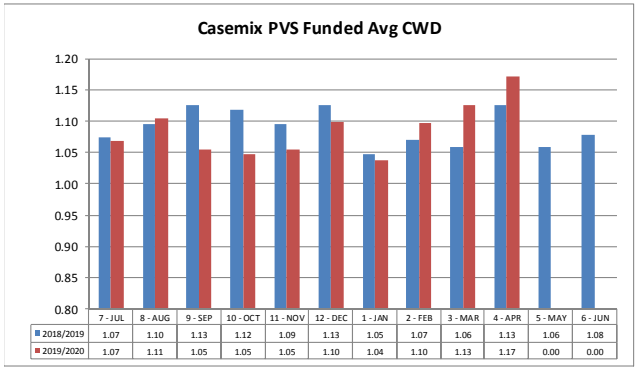


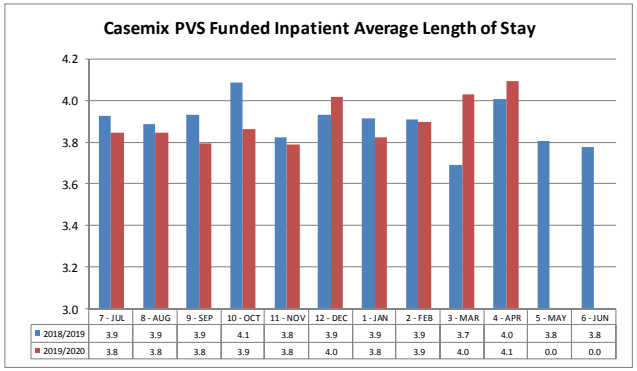
Casemix PVS Funded Avg CWD

	2018/19	2019/20
YTD Totals	1.09	1.08
Change		-0.01
% Change		-1%

Casemix PVS Funded Inpatient Average Length of Stay

	2018/19	2019/20
YTD Totals	3.89	3.89
Change		0.00
% Change		0.0%





Comparisons with same period last year:

- Local acute
  - July to Feb period: CCDHB has experienced a growth of 910 CWDs and 1,576 discharges in Local Acute activity. The increase in CWDs is driven by increased activity in General Surgery (364), Emergency Medicine (295) General Medicine (147) and Gynaecology (88).
  - March to April period: cumulative Local Acute CWDs now lower when compared to the previous financial year (240 CWDs) with a surprising small increase in discharges (138) with a slightly lower ALOS and a similar average CWD.

Local Elective

- July to Feb period: CCDHB has experienced a small reduction of 20 CWDs and 76 discharges in Local Elective activity. The decrease in CWDs is driven by increased activity in Orthopaedics (-60), ENT (-59) and General Surgery (-45) but countered by an increase in CWDs in Cardiology (93) and Ophthalmology (47)
- March to April period: cumulative Local Elective CWDs now considerably lower when compared to the previous financial year (557 CWDs) with a decrease in discharges (-744) and a slightly higher average CWD and ALOS.

IDF Acute

- July to Feb period compared to last year: CCDHB has experienced a growth of 499 CWDs and 33 discharges in IDF Acute activity. The increase in CWDs is driven by increased activity in Cardiothoracic (247), General Surgery (195) and Neonatal (160)
- March to April period: cumulative Local Acute CWDs now lower when compared to the previous financial year (34 CWDs) with a decrease in discharges (-64) with a similar ALOS and average CWD.

IDF Elective

- July to Feb period compared to last year: CCDHB has experienced a reduction of 280 CWDs with an increase of 161 discharges in IDF Elective activity. The decrease in CWDs is driven by increased activity in Cardiothoracic (-448) and General Surgery (-89). The increases in discharged is driven by increases in activity in Paediatric Surgery (64), Vascular Surgery (50) and Ophthalmology (45).
- March to April period: cumulative Local Elective CWDs now considerably lower when compared to the previous financial year (642 CWDs) with a decrease in discharges (-82) with a lower ALOS and average CWD.

HHS Operational Performance Scorecard – period Apr 19 to Apr 20

Domain	Indicator	2019/20 Target	2019-Apr	2019-May	2019-Jun	2019-Jul	2019-Aug	2019-Sep	2019-Oct	2019-Nov	2019-Dec	2020-Jan	2020-Feb	2020-Mar	2020-Apr
Care	Serious Safety Events	Zero SSEs	3	10	8	3	3	2	3	3	4	2	5	8	5
	Total Reportable Events	TBD	868	1,176	1,169	1,251	1,180	1,093	1,152	1,058	1,001	877	1,105	1,199	709
Patient and Family Centred	Complaints Resolved within 35 calendar days	TBD	74.1%	81.4%	85.7%	83.3%	83.8%	97.7%	93.3%	91.9%	87.5%	94.1%	87.1%	92.6%	100.0%
	% Discharges with an Electronic Discharge summary	TBD													
Access	Emergency Presentations		5,264	5,523	5,480	5,749	5,757	5,430	5,336	5,377	5,389	5,319	5,336	4,562	3,258
	Emergency Presentations Per Day		175	178	183	185	186	181	172	179	174	172	184	147	109
	Emergency Length of Stay (ELOS) % within 6hrs	≥95%	83.0%	83.9%	78.2%	79.8%	76.8%	76.4%	78.7%	77.2%	78.9%	81.0%	77.3%	79.9%	84.8%
	ELOS % within 6hrs - non admitted	TBD	88.9%	89.3%	84.2%	86.6%	83.6%	82.2%	85.0%	82.7%	84.6%	86.7%	82.9%	85.6%	90.8%
	ELOS % within 6hrs - admitted	TBD	65.0%	66.9%	59.4%	58.5%	55.9%	58.4%	60.0%	59.6%	61.1%	63.1%	58.6%	61.8%	70.5%
	Total Elective Surgery Long Waits	Zero Long Waits	151	116	107	68	59	64	94	107	135	167	145	175	395
	Additions to Elective Surgery Wait List		1,257	1,436	1,332	1,470	1,420	1,401	1,312	1,397	1,120	1,128	1,392	1,217	440
	% Elective Surgery treated in time	TBD	87.6%	89.7%	90.7%	88.6%	91.2%	92.7%	92.7%	92.1%	92.2%	85.8%	85.9%	89.0%	92.9%
	No. surgeries rescheduled due to specialty bed availability	TBD	5	2	8	13	23	10	5	19	3	1	8	1	1
	Total Elective and Emergency Operations in Main Theatres	TBD	1,048	1,185	1,105	1,195	1,239	1,201	1,179	1,199	997	1,067	1,101	927	378
	Faster Cancer Treatment 31 Day - Decision to Treat to Treat	85%	94.0%	93.0%	91.0%	92.0%	91.0%	93.0%	92.0%	86.0%	96.0%	90.0%	82.0%	91.0%	92.0%
	Faster Cancer Treatment 62 Day - Referral to Treatment	90%	88.0%	89.0%	89.0%	83.0%	92.0%	94.0%	97.0%	86.0%	96.0%	76.0%	86.0%	96.0%	94.0%
	Specialist Outpatient Long Waits	Zero Long Waits	138	48	49	61	0	13	43	91	165	238	324	488	1183
	% Specialist Outpatients seen in time	Zero Long Waits	89.6%	91.2%	90.3%	91.5%	91.5%	91.0%	92.8%	91.9%	94.4%	80.5%	84.2%	82.1%	87.2%
	Outpatient Failure to Attend %	TBD	7.1%	7.3%	7.2%	6.9%	7.0%	7.3%	7.1%	7.0%	7.6%	6.9%	7.3%	7.2%	4.4%
	Maori Outpatient Failure to Attend %	TBD	14.9%	14.7%	15.0%	13.8%	14.3%	14.1%	14.7%	14.3%	15.8%	14.3%	14.3%	14.4%	7.8%
	Pacific Outpatient Failure to Attend %	TBD	16.2%	16.3%	16.1%	16.7%	15.8%	17.1%	16.5%	14.5%	16.2%	15.9%	15.5%	15.0%	7.1%
Financial Efficiency	Contracted FTE (Internal labour)		4,808	4,811	4,818	4,812	4,824	4,851	4,864	4,855	4,837	4,842	4,842	4,855	4,894
	Paid FTE (Internal labour)		5,141	5,117	5,196	5,154	5,155	5,187	5,163	5,208	5,259	5,176	5,190	5,191	5,157
	% Main Theatre utilisation (Elective Sessions only)	85.0%	81.0%	80.4%	79.2%	80.4%	78.2%	79.2%	78.1%	79.0%	83.0%	82.0%	81.0%	80.0%	78.1%
Discharge and Occupancy	% Patients Discharged Before 11AM	TBD	25.0%	25.0%	23.0%	23.8%	24.4%	25.8%	25.6%	22.4%	24.0%	23.9%	24.4%	22.7%	19.4%
	Adult Long Stay Patients Not Yet Discharged (>14 days) WLG	TBD	28	32	31	37	31	22	27	32	29	26	39	29	19
	Adult Overnight Beds - Average Occupied WLG	TBD	307	297	312	315	306	314	308	305	289	294	295	275	225
	Adult Long Stay Patients Not Yet Discharged (>14 days) KEN	TBD	34	24	30	24	29	27	19	27	23	23	18	10	17
	Adult Overnight Beds - Average Occupied KEN	TBD	74	70	77	77	84	83	76	71	66	72	69	62	46
	Child Overnight Beds - Average Occupied	TBD	23	27	28	29	32	29	24	24	21	19	20	17	14
	NICU Beds - ave. beds occupied	36	37	36	31	38	31	36	37	36	33	32	28	34	38
Care	Rate of Presentations to ED within 48 hours of discharge	TBD	4.0%	3.4%	4.3%	4.0%	3.8%	3.7%	3.7%	4.2%	3.6%	3.7%	4.2%	3.7%	4.1%
	Presentations to ED within 48 hours of discharge	TBD	208	189	234	231	218	200	196	226	193	196	225	168	133
Staff Experience	Staff Reportable Events	TBD	83	114	123	123	121	125	138	127	101	111	138	137	88
	% sick Leave v standard	TBD	2.9%	3.4%	3.5%	3.7%	3.4%	3.5%	3.2%	2.9%	2.4%	2.1%	2.6%	2.9%	2.2%
	Nursing vacancy	TBD	141.0	133.0	139.0	221.0	221.4	212.2	208.9	213.9	228.0	217.6	210.3	204.4	191.5
	% overtime v standard (medical)	TBD	1.4%	2.1%	1.8%	1.9%	1.8%	1.7%	1.7%	1.7%	1.6%	1.5%	1.6%	1.9%	1.3%

Refer to later pages for more details on CCDHB performance. Highlighted where an identified target in 19/20.

CCDHB Access Performance – Shorter Stays in ED (SSIED)

Performance	FEB	MAR	APR
2018-19	83%	81%	82%
2019-20	76%	79%	85%

Breaches	FEB	MAR	APR
2018-19	805	1032	887
2019-20	1180	919	498

ED Volumes	FEB	MAR	APR
2018-19	4,725	5,456	4,939
2019-20	4,822	4,825	3,204

- The overall performance of ED admitted, treated and discharged patients for the 2019/20 financial year is presented in table 1 below. The occupancy percentage utilisation for April 2020 was 70% (maximum optimum occupancy is 92%). Occupancy was not a barrier to acute flow and achieving the SSIED target. Our performance being less than target was due to processes in place related to COVID-19. All people who screened COVID Case Definition positive were treated as having COVID until a swab result came back negative. The increased screening required and infection control processes in place for patients to be admitted to the wards added time to the patient journey.
- The Acute Demand and Bed Capacity Programme was put on hold from early March as our focus turned to planning for a surge in COVID-19 presentations and our acute response. From the end of April our focus is on the "new normal" as we look ahead to winter and the COVID vs. non-COVID parallel processes.
- The following work streams will continue to be progressed and rolled out during this time including:
  - To free up ED, the use of 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.
  - Establishment of the Acute Frailty Unit in Ward 3 from mid/late May.
  - The expansion of the Advancing Wellness at Home Initiative (AWHI) project to a wider catchment and other inpatient wards. AWHI is an early supported discharge for people whose level of function has declined on admission and has involved making changes to the patient care coordination service to identify potential patients needing intervention earlier in admission with the goal of reduction in the over 10 day stays for complex patients in general medicine.
  - Children's' Health continues to work on a project to increase the opening hours and resourcing of the Children's' Assessment Unit which has been relocated to the "Pink Zone" in ED as a direct result of COVID-19 response planning.
- Activities continue across the organisation to improve discharge processes and reduce length of stay where appropriate.

CCDHB Access Performance – Planned Care

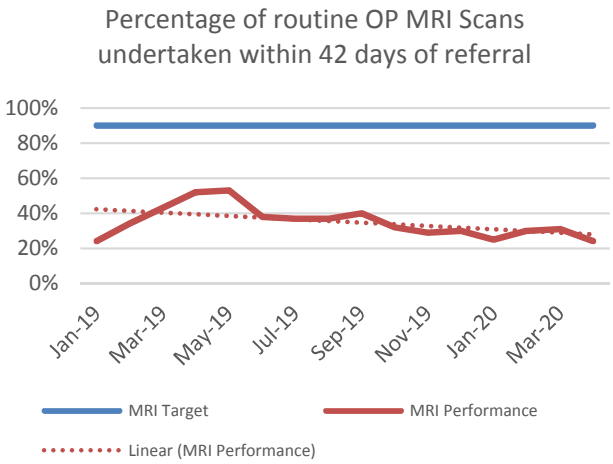
Planned Care – Inpatient Surgical Discharges/Minor Procedures

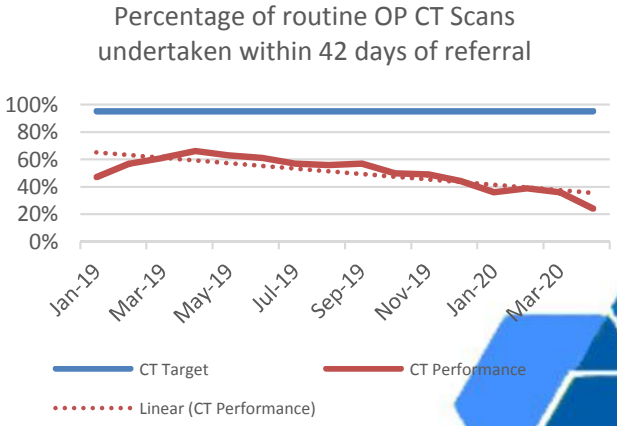
- Due to timing delays there is a six week lag in MOH reporting for inpatient volumes.
- CCDHB has achieved 96.8% of the target planned care intervention volume YTD as at March month end. This is comprised of a 744 under delivery in inpatient discharges, partially offset by a 414 over delivery in minor procedures. This result was confirmed by the Ministry as at 4 May 2020.
- As per MOH reporting, CCDHB was adverse 341.8 CWDs YTD as at end of March, this is significantly deteriorated from the previous results due to the impact of deferred procedures due to Covid-19. This equates to $1.78m YTD. March result was unfavourable -161.1 CWDs, or $840k.
- We are working to schedule surgery both in Wellington and Kenepuru and utilising private where possible. Our SMO's have been significantly involved with deferments and planning based on those with greatest clinical urgency and greatest risk of deterioration if not treated shortly.
- This under delivery has not been recognised within CCDHB financial accounts as we have been advised we will not be held back based on these washup rules due to COVID-19.

CCDHB Access Performance – Planned Care

MRI and CT Waiting Times

- Waiting times for CT and MRI remain high as a result of historical insufficient capacity to meet demand. Waiting times are now extended significantly in light of drastically reduced capacity during the pandemic response. Some level of reduced capacity will continue for the foreseeable future but is difficult to model with confidence.
- With current waiting times, there is a critical risk of patient harm, including disease progression. The likelihood of significant adverse events is extremely high and has already occurred in at least two occasions this year. 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:
  - Reprioritisation of all waiting referrals (8000+) into increase prioritisation categories in line with MOH advice
  - Working with the CCDHB Clinical directors group to align these categories with new hospital priority system in development
  - Working with SIP and HVDHB to maximise and plan best outsourcing approach moving forwards in light of new challenges (e.g. physical distancing)
  - Maximising available staffing and scanning time by running weekend elective lists where possible
  - Maximise recruitment opportunities in the Radiology workforce to extend “elective” hours – filling budgeted FTE
  - Reviewing current workflow within Radiology to maximise flexibility of bookings and acute imaging response.





CCDHB Access Performance – Planned Care

Coronary Angiography Waiting Times

- The proportion of patients waiting less than 90 days for angiography has improved (81%) compared to last month, and remains below the target of 95%.
- The service continues to be non-compliant with the elective coronary angiography target, driven by both demand and capacity (losing sessions to acute demand).
- MIT Industrial action last year has impacted capacity, as has reduced production over December and January. There are approximately 22 cases, over 90 days.
- The service has reviewed all procedures including angiography. All patients identified as urgent and non-deferrable have been treated regardless of timeframes, in conjunction with low referral rates our position has improved for April. We expect a deterioration in our position however, as our elective capacity will be reduced in order to comply with social distancing requirements.

Acute Coronary Syndrome

Key clinical quality improvement indicators

1. 70% of high-risk patients will receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0')
   - CCDHB result for March (most recent data that is available) was 91.3%. As a region we did achieve the target for March, 77.5% 93/120)
   - Hawkes Bay, Mid-Central, Wairarapa and Whanganui did not achieve the target. (59.3%, 69.2%, 50% and 60% respectively) this was primarily driven by access to labs and prioritisation.
2. The second measure relates to data quality, integrity – the target is that over 95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS-QI ACS and Cath/PCI registry data collection within 30 days.
   - CCDHB result for March was 100%. As a region we achieved target for March – 97.5%.

CCDHB Access Performance - other

FCT

- FCT treatment times for decision to treat < 31 and referral for treatment < 62 days targets were maintained
- However inflows to the service of new patients are reduced – we are anticipating a higher number over a shorter time period and planning on how to meet this and maintain our FCT targets.

NICU

- The service was characterised by high occupancies which continued over the period of the lockdown.

Colonoscopy

- We received correspondence from the National Screening team at the Ministry confirming postponement of the implementation of the national bowel screening programme. Provisional Go-Live of February 2021.
- We had a plan in place to address the waiting list backlog prior to commencement in October; we are now reviewing this taking into account the additional backlog created by COVID

Section 2.3

Mental Health Addiction & Intellectual Disability

Executive Summary – Mental Health Performance

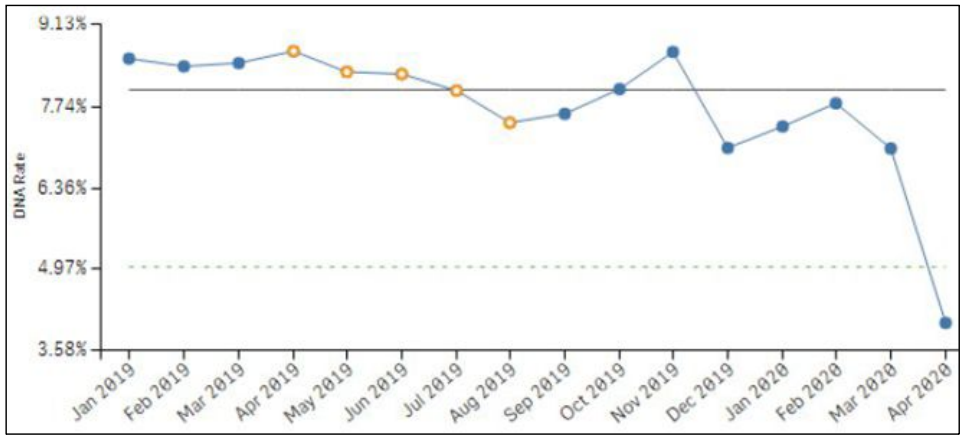
- The DHB hospital performance is under pressure in many of the key areas measured and reported on in this report. Both Acute Mental Health Inpatient Units in CCDHB and HVDHB are managing high occupancy.
- There are initiatives underway to intervene in mental health crises early and reduce pressure on 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 (MHAIDS) Operational Performance - Community

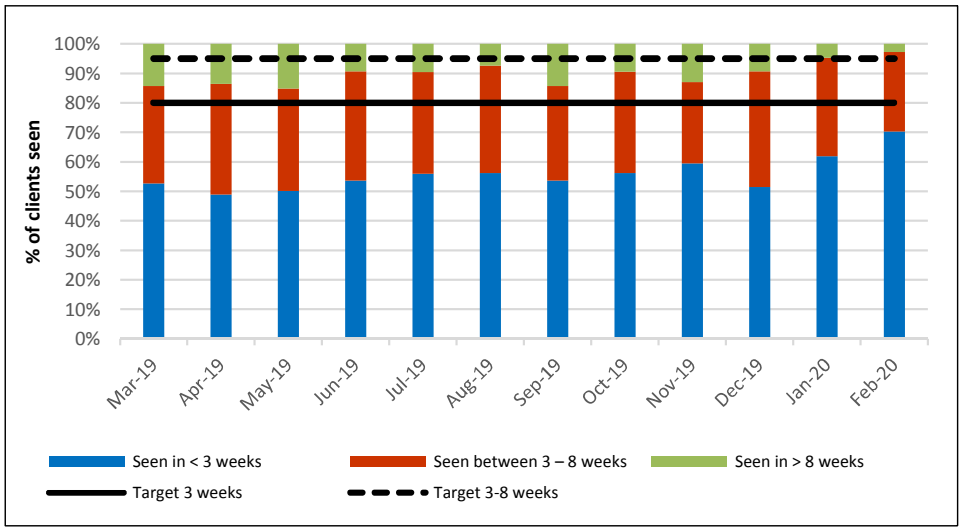
Community Engagement Key Performance Indicators

% of community service users seen in person in last 90 days	**73.2%**
% of community service users with activity recorded in last 90 days	**91.9%**

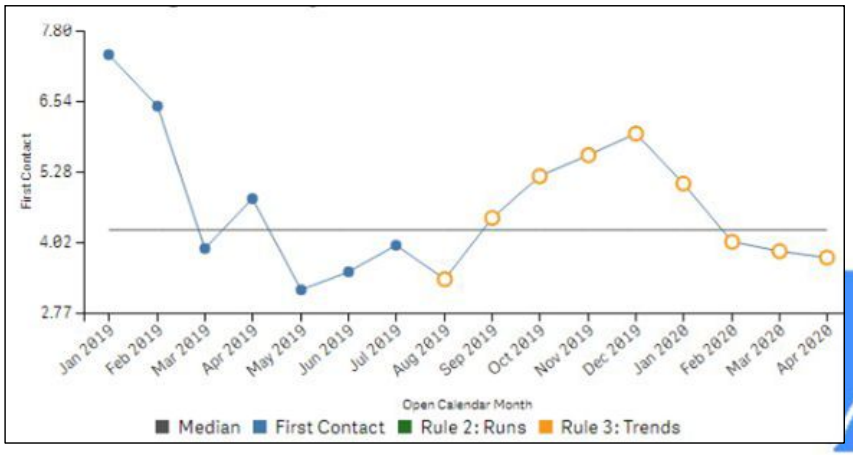
Did Not Attend Rate



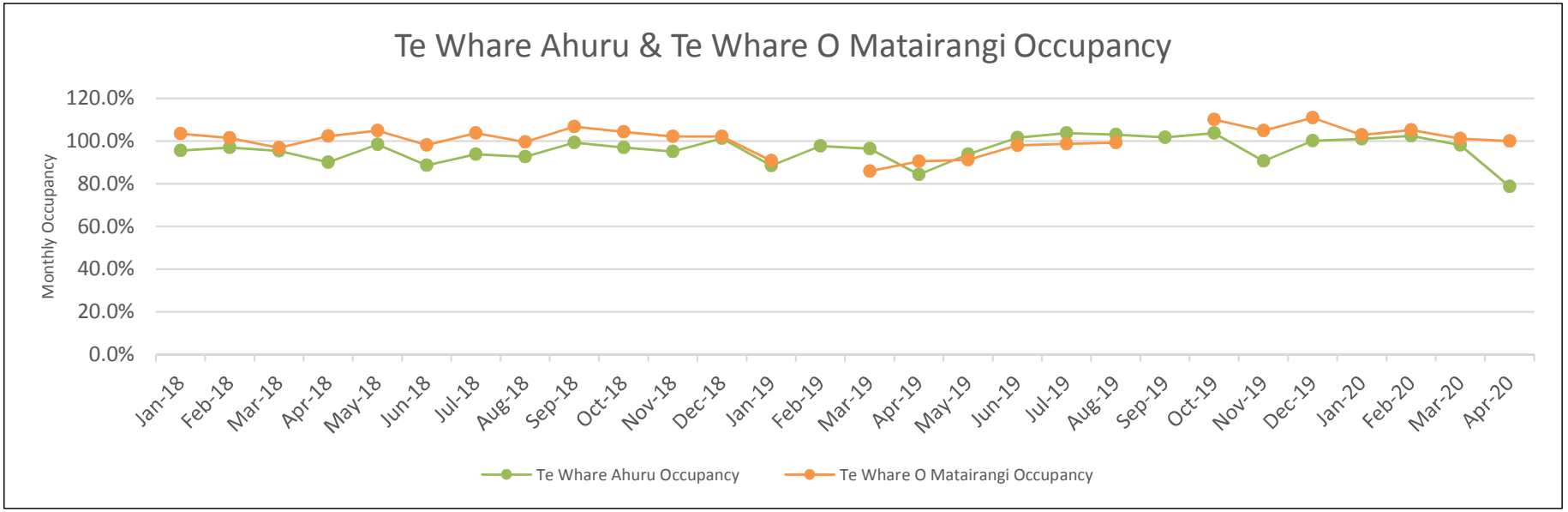
Wait Times from Referral to First In Person Contact



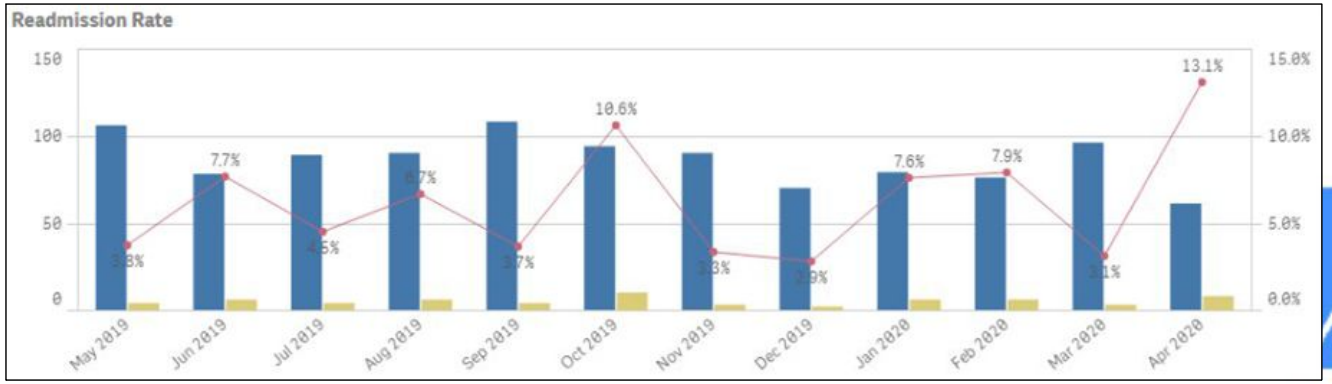
Te Haika Mean Time to First Contact



Mental Health (MHAIDS) Operational Performance – Acute Adult Inpatient Units



Readmissions Rate
(Te Whare O Matairangi and Te Whare Ahuru)

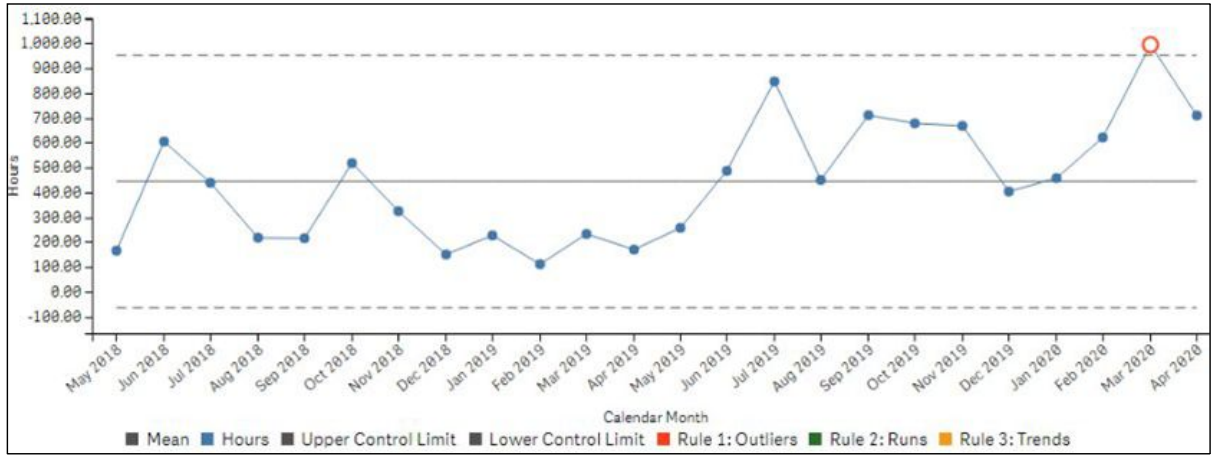


Mental Health (MHAIDS) Operational Performance – Seclusion

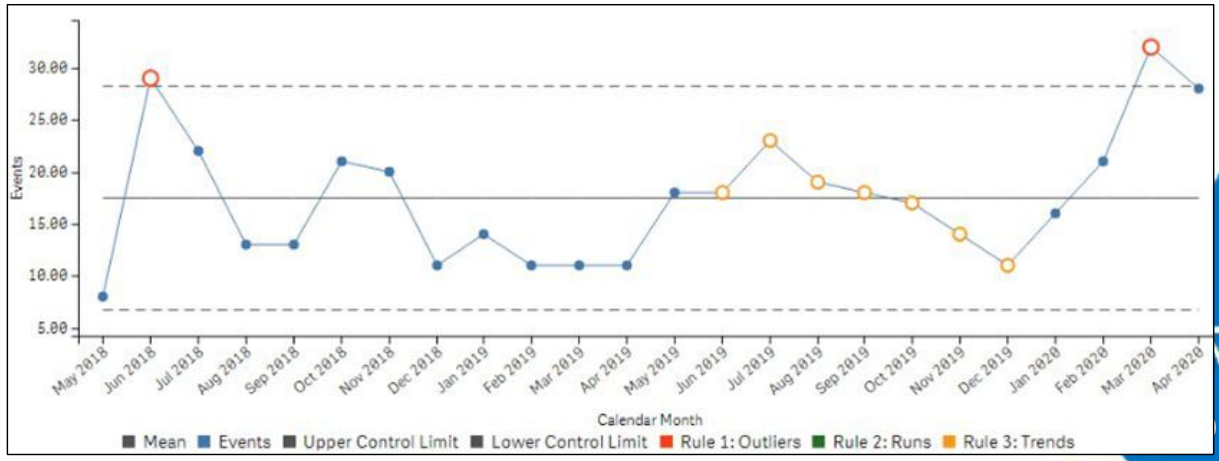
Towards Zero Seclusion Project

- Of the nine inpatient units with seclusion rooms, reports indicate four achieved zero seclusion use in April (Tāwhirimātea, Hikitia Te Wairua, Purehurehu and Rangipapa)
- MHAIDS seclusion hours and events (excluding ID) have remained stable for April.
- Unusually high seclusion hours have been noted in Haumietiketike for the past two months.
- Seclusion events have remained stable in MHAIDS for all ethnic groups.
- There has been an upwards trend in seclusion events for Te Whare o Matairangi (starting November 2019)
- Seclusion use for Māori and Pasifika has remained stable this month
- Seclusion use (hours and events) have remained stable for Te Whare Ahuru. Māori seclusion use has remained stable however, there have been an unusually high number of seclusion hours for Pasifika (two events involving one person).

Seclusion hours by month – all MHAIDS units excluding ID



Seclusion events by month – all MHAIDS units excluding ID



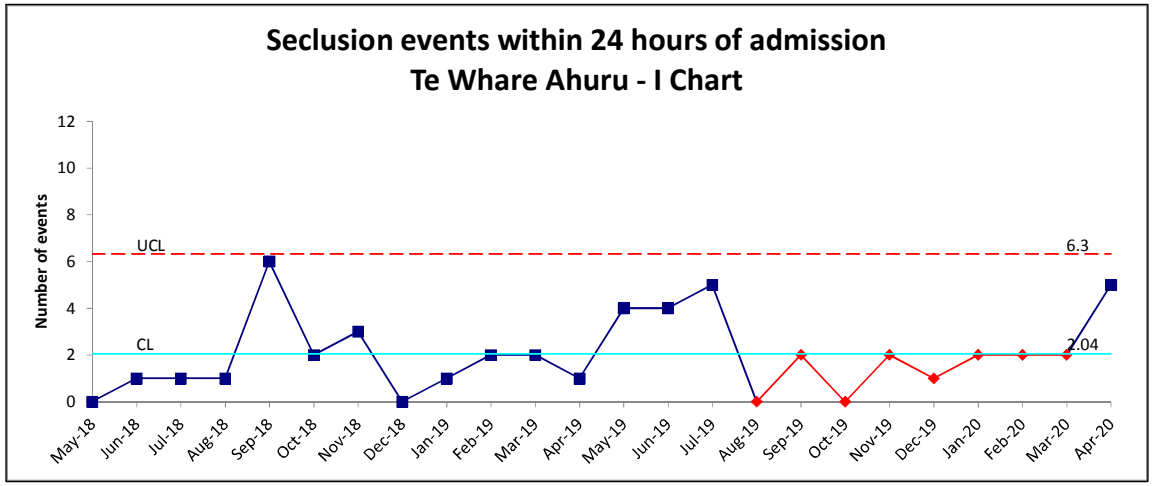
Mental Health (MHAIDS) Operational Performance – Seclusion Events within 24 Hours of Admission

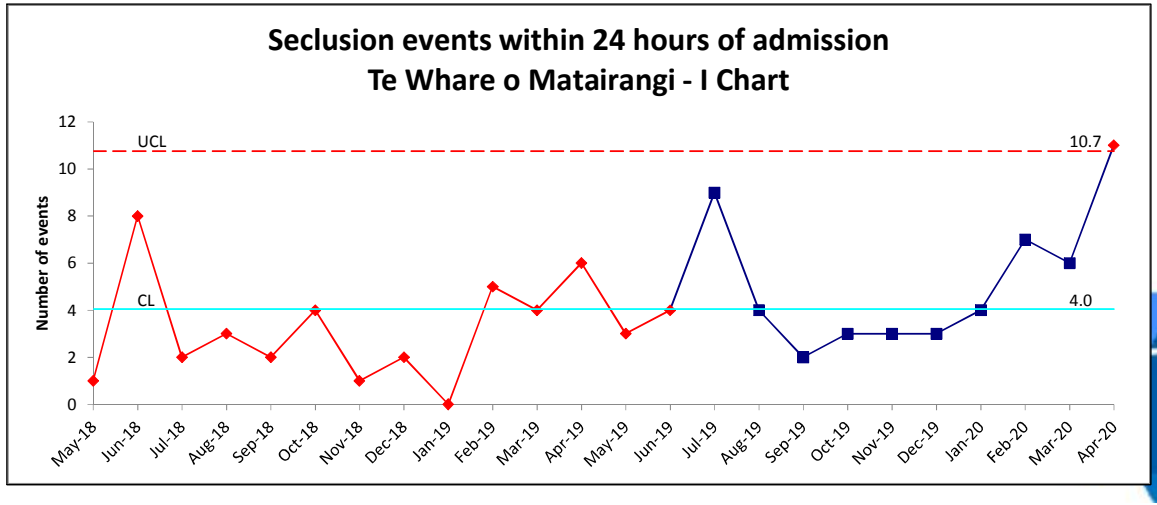
Commentary

- The I chart for Te Whare Ahuru suggests there may be an improvement in the number of seclusion events occurring within 24 hours of admission (Aug 2019 – Mar 2020) with eight months of below average seclusion events. Despite COVID precautionary measures*, admission seclusions have remained within normal limits this month. Three seclusion events were COVID related in April.

- Te Whare o Matairangi shows a spike in the number of seclusion events within 24 hours of admission. 10 of these events were COVID related in April.

* Seclusion has been initiated on admission to the two acute units as a precautionary measure against COVID-19 where a person's COVID status is unknown, they are symptomatic and there are serious concerns about the person's ability to maintain self-isolation.





Section 3

Financial Performance and Sustainability

Executive Summary Financial Performance and Position

- The DHB had an approved budget of $15.9 million against an initial submission of $29.5 million. The DHB has forecast to meet its original submission of $29.5 million and this has been accepted (not approved) by the Ministry.
- Two extraordinary items exist which will cause CCDHB to exceed this forecast, which the ministry has advised are regarded as outside the DHBs performance assessment:
  - ($8m); COVID-19: Loss of revenue, additional costs during COVID-19, and costs to catch-up on activity in the months ahead
  - ($10m); Simple extrapolation of extra Holidays Act Provisions (full calculated estimate to follow)
- New forecast of ($47.5m) when these two extraordinary items are taken into account
- The DHB had targeted a large number of efficiency measures for the year ahead, which were always required to meet our deficit position of $29.5 million. Some of these such as leave management and staff vacancy rates have been largely achieved, but will now be at risk of the impacts of COVID-19. There are a number of initiatives which were overly ambitious in being achieved in the current year. Some of these activities will take place in the 20/21 year, and others were not feasible.
- The DHB's cash is under pressure for 2020/21 as the current assets of $83m is significantly lower than the $239m of current liabilities, this is therefore resulting in the DHB being solely reliant on the Crown to meet payments as they fall due. The government has provided deficit support of $16m and following the budget announcements we expect there will be a further payment of deficit support. The Ministry has also indicated that they will issue a letter of support from ministers to allow the DHB to trade as a going concern.
- The focus of the DHB has turned to the planning and preparedness for COVID-19. This has resulted in groups being formed and staff dedicated to planning, 98000 hours of planning (not direct patient activity) has been focused on COVID-19.
- This will 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 have been shown on our COVID-19 slides.

COVID-19 Revenue and Costs

Capital & Coast DHB Operating Results - $000s	YTD COVID-19	YTD COVID-19	YTD COVID-19
YTD April 2020	Change from Trend Provider	Change from Trend Funder	Change from Trend CCDHB Total
Devolved MoH Revenue		(3,921)	(3,921)
Non-Devolved MoH Revenue			
Other Revenue	1,099		1,099
IDF Inflow	(1,948)		(1,948)
Inter DHB Provider Revenue			
Total Revenue	**(849)**	**(3,921)**	**(4,770)**
Personnel			
Medical	(2,250)		(2,250)
Nursing	(1,000)		(1,000)
Allied Health			
Support			
Management & Administration			
Total Employee Cost	**(3,250)**	**0**	**(3,250)**
Outsourced Personnel			
Medical	200		200
Total Outsourced Personnel Cost	**200**	**0**	**200**
Treatment related costs - Clinical Supp	1,500		1,500
Treatment related costs - Outsourced	(825)		(825)
Non Treatment Related Costs	(894)		(894)
IDF Outflow	(1,911)		(1,911)
Other External Provider Costs (SIP)		(3,921)	(3,921)
Interest Depreciation & Capital Charge			
Total Other Expenditure	**(2,130)**	**(3,921)**	**(6,051)**
Total Expenditure	**(5,180)**	**(3,921)**	**(9,101)**
Net result	**4,331**	**0**	**4,331**

- The April year to date financial position includes $9.1m additional costs in relation to COVID-19.
- Revenue of $3.9m has been received to fund additional costs for community providers.
- IDF revenue and Outflow expense were set to target for March & April
- The net impact year to date is $4.3m additional costs currently unfunded.

CCDHB Operating Position – April 2020

Month - April 2020				Capital & Coast DHB Operating Results - $000s	Year to Date						Annual	
			Variance					Variance	COVID-19			
Actual	Budget	Last year	Actual vs Budget	YTD April 2020	Actual	Budget	Last year	Actual vs Budget	Change from Trend	Actuals exc COVID	Annual Budget	Last year
77,803	73,273	76,189	4,531	Devolved MoH Revenue	738,094	732,727	700,374	5,367	(3,921)	734,173	879,272	840,425
3,448	3,415	3,353	33	Non-Devolved MoH Revenue	35,268	34,384	33,667	884		35,268	41,265	43,826
2,012	3,172	3,611	(1,160)	Other Revenue	31,132	32,842	35,481	(1,711)	1,099	32,231	39,404	41,074
21,544	20,186	19,888	1,358	IDF Inflow	197,909	201,858	189,757	(3,949)	(1,948)	195,961	242,229	227,680
594	618	603	(24)	Inter DHB Provider Revenue	7,032	6,360	6,807	673		7,032	7,627	8,617
105,401	**100,664**	**103,644**	**4,737**	**Total Revenue**	**1,009,435**	**1,008,171**	**966,086**	**1,264**	**(4,770)**	**1,004,665**	**1,209,799**	**1,161,622**
				Personnel								
15,667	14,787	14,516	(881)	Medical	144,172	141,762	138,772	(2,409)	(2,250)	141,922	170,050	187,670
20,950	18,628	19,275	(2,322)	Nursing	186,494	179,623	172,010	(6,870)	(1,000)	185,494	217,221	238,301
5,210	5,423	5,228	213	Allied Health	51,384	52,164	48,619	780		51,384	62,609	63,990
305	848	1,113	544	Support	8,031	8,348	7,521	317		8,031	10,138	10,930
5,973	6,592	6,439	618	Management & Administration	60,679	65,152	54,659	4,472		60,679	78,177	72,008
48,106	**46,278**	**46,571**	**(1,828)**	**Total Employee Cost**	**450,760**	**447,050**	**421,581**	**(3,710)**	**(3,250)**	**447,510**	**538,194**	**572,899**
				Outsourced Personnel								
545	420	464	(124)	Medical	5,610	4,256	5,145	(1,355)	200	5,810	5,108	6,158
16	15	15	(1)	Nursing	215	152	145	(63)		215	183	215
95	120	172	26	Allied Health	1,265	1,239	1,484	(26)		1,265	1,488	1,770
21	4	43	(17)	Support	254	44	375	(211)		254	52	461
143	55	309	(88)	Management & Administration	1,835	577	2,205	(1,258)		1,835	693	2,660
819	**614**	**1,003**	**(205)**	**Total Outsourced Personnel Cost**	**9,180**	**6,268**	**9,354**	**(2,913)**	**200**	**9,380**	**7,524**	**11,265**
8,787	10,011	10,491	1,223	Treatment related costs - Clinical Supp	103,317	101,463	101,853	(1,853)	1,500	104,817	122,344	122,929
2,477	1,741	1,467	(736)	Treatment related costs - Outsourced	19,093	18,087	16,034	(1,006)	(825)	18,268	21,794	20,314
6,750	5,081	6,766	(1,670)	Non Treatment Related Costs	64,360	55,705	57,702	(8,655)	(894)	63,466	66,360	77,600
10,192	8,589	8,325	(1,603)	IDF Outflow	84,719	85,887	81,753	1,168	(1,911)	82,808	103,064	98,083
30,656	25,762	23,356	(4,894)	Other External Provider Costs (SIP)	258,770	252,884	241,405	(5,886)	(3,921)	254,849	304,138	288,682
4,554	5,181	9,288	627	Interest Depreciation & Capital Charge	48,981	51,876	54,698	2,895		48,981	62,281	66,224
63,416	**56,364**	**59,693**	**(7,053)**	**Total Other Expenditure**	**579,239**	**565,903**	**553,445**	**(13,336)**	**(6,051)**	**573,188**	**679,981**	**673,831**
112,341	**103,256**	**107,267**	**(9,085)**	**Total Expenditure**	**1,039,178**	**1,019,220**	**984,380**	**(19,958)**	**(9,101)**	**1,030,078**	**1,225,699**	**1,257,996**
(6,940)	**(2,592)**	**(3,623)**	**(4,348)**	**Net result**	**(29,744)**	**(11,049)**	**(18,294)**	**(18,695)**	**4,331**	**(25,413)**	**(15,900)**	**(96,374)**
70	1,963	4,536	(1,893)	Funder	1,154	1,407	15,930	(254)			(0)	19,170
74	0	53	73	Governance	828	2	725	826			(1)	524
(7,083)	(4,555)	(8,213)	(2,528)	Provider	(31,726)	(12,458)	(34,949)	(19,267)			(15,899)	(116,067)
(6,940)	**(2,592)**	**(3,623)**	**(4,348)**	**Net result**	**(29,744)**	**(11,049)**	**(18,294)**	**(18,695)**			**(15,900)**	**(96,374)**

Executive Summary – Financial Variances

The overall DHB result for April 2020 is ($4.4m) unfavourable to budget and ($18.7m) unfavourable YTD. The DHB deficit year to date is ($29.7m). This variances to budget in the accounts YTD has largely been driven by the following factors:

- COVID-19 additional costs of ($4.3m) largely within the month, significant impacts within the month was due to our IDF recognition and leave liability growth.
- Revenue is favourable by ($1.3m) YTD. The largest variance is due to additional funder revenue for PHOs, GPs and CBAC setup which are passed through the DHB. We also note IDF caseweight inpatient revenue has been assumed to be paid to budget for March & April which has therefore shown an improved position compared to actual activity. We note earlier in the year we were effected by the industrial action, provision for surgical revenue in reserves (IDF Inpatient CWD). ACC related revenue is also down ($1.7m) of which a significant portion was due to COVID. This revenue was offset by increased special fund revenue, cost recovery of PCT drugs for IDF patients $1.2m (to Feb), other recoveries revenue and CCDM related revenue (shortfall borne by the funder arm) all with corresponding costs.
- Personnel costs including outsourced is ($6.6m) YTD, a significant portion relates to unallocated savings targets held in reserves ($6.8m). The remaining internal labour costs are favourable by $0.2m after a significant increase in leave liability within the month. However this also includes favourable variances due to vacancies; largely due to medical staff in surgical units earlier in the year but fully offset by outsourced staff costs across all directorates ($2.9m). Currently there are 487 FTE of internal labour vacancies some of which are backfilled which will require tight management to control costs. We have softened the blow of the leave impact and COVID costs within the month by releasing MECA reserves in line with lower expectations derived from the state services commission's document: ‘Pay restraint in the public sector as a result of COVID-19’.
- Treatment related clinical supplies ($1.9m), this partially relates to Pharmaceuticals (noting PCT IDF revenue offset above). Additional spend in treatment disposables (Blood costs - Intragam / catheters) are partially offset by implant underspend (Orthopaedic prostheses due to outsourcing and shunts/stents in our cath lab/Neurosurgery). Due to the effect of COVID-19 there is significant monthly favourable movement.
- Outsourced clinical services ($1m) largely due to outsourcing of procedures that would ordinarily be conducted in-house for the month, due to number of surgeries and procedures outsourced to meet targets, largely in Orthopaedics for the last quarter. This reduction was expected as timing variance earlier in the year, however depending on plans to catch-up on waiting lists this may be subject to increase later in the year.
- Non treatment related costs ($8.7m), a combination of savings targets yet to be realised ($6.6m), increase in trust expenditure (offset with revenue) and existing integrated services contract renewals (food & cleaning).
- These costs have been partially offset by underspend in aged care claims, $1.6m lower IDF outflow expenditure, and $2.9m saving in capital charge/depreciation.

Analysis of the Operating Position

Below is a summary of the key drivers behind the financial result by financial driver type:

Revenue	• Revenue is favourable by ($1.3m) YTD. The largest variance is due to additional funder revenue for PHOs, GPs and CBAC setup which are passed through the DHB. • We also note IDF caseweight inpatient revenue has been assumed to be paid to budget for March & April which has therefore shown an improved position compared to actual activity. We note earlier in the year we were effected by the industrial action, provision for surgical revenue in reserves (IDF Inpatient CWD). ACC related revenue is also down ($1.7m) of which a significant portion was due to COVID. • This revenue was offset by increased special fund revenue, cost recovery of PCT drugs for IDF patients $1.2m (to Feb), other recoveries revenue and CCDM related revenue (shortfall borne by the funder arm) all with corresponding costs.
Labour (including outsourced)	**Medical Personnel:** Medical Personnel labour month position is unfavourable both within the month by ($1m) and YTD ($3.8m). • The unfavourable YTD position is due to reserves savings targets totalling ($3.7m). • We note excluding reserves targets the DHB is ($34k) unfavourable on medical personnel despite an ($1.3m) overspend on outsourcing to cover vacancies (wherever possible we budget as internal labour as the efficient means of filling roles). • Within the month we have released $1.1m of MECA reserves which is offsetting the amount of unfavourable leave liability movement within the month

Analysis of the Operating Position

Labour (including outsourced)	**Nursing Personnel** Nursing Personnel labour month position is ($2.3m) unfavourable to budget and ($6.9m) YTD • The unfavourable month position is across all directorates largely due to leave liability movement ($1.2m) from the public holidays which is traditionally a time for more leave to be taken. • YTD ($2.4m) is due to unallocated reserve targets, with an additional ($2.8m) across the provider arm based on unmet savings targets including leave reduction targets. • Overall Paid FTE for Nursing staff has remained relatively stable since the start of the year however YTD 70 Paid FTE more than the same time last year ~$6.1m. Due to Multi Employer Collective Agreement (MECA) increases this hourly rate increase is costing the DHB approximately $127k extra per week equating to $6.7m annualised (Apr compared to July). We expect another salary increase is due in May increasing the top step of the Registered Nurse scale. Whilst these amounts have been budgeted by the DHB it is important to note the scale of the nationally agreed increases which are compounded by any new roles to service our population. • We have seen an increase in Paid & Contracted FTE from January onwards in line with our main new graduate intake and will expect hiring to commence shortly for winter roster intakes further increasing our FTEs. Some of which were hired early to support COVID-19 related activities such as our temporary CAMU ward and other related activities to ensure we could cope with worst case scenarios.

Analysis of the Operating Position

Labour (including outsourced)	**Allied Personnel** Allied Personnel labour month position is $238k favourable to budget and $754k YTD. • We note reserve unallocated savings targets totalling ($722k) YTD not being met within these results. • The unfavourable movement within the directorates is due to leave provision variance of ($472k) impacted by COVID, which has been offset by MECA reserves. **Support Personnel** Support Personnel labour month position is on budget $527k and ($106k) YTD. • YTD spend is largely in terms of outsourced maintenance. • The month variance is due to reserve assumptions for MECA settlement recalculation, which is offsetting YTD outsourcing and savings targets not met. **Management/Admin Personnel** This personnel category is favourable in the month by $531k, and $3.2m YTD. • Leave balances are impacted by ($432k) YTD due to leave provision variance movement due to impacted by COVID • Savings held in reserves have offset the MECA settlement recalculation which have impacted the month favourably by $740k and YTD $1m.

Analysis of the Operating Position

Non-Labour	• Outsourced clinical services ($1m), largely due to outsourcing of procedures that would ordinarily be conducted in-house. • Treatment related clinical supplies ($1.9m), earlier in the year this partially relates to Pharmaceuticals (noting PCT IDF revenue offset above). Additional spend in treatment disposables (Blood costs - Intragam / catheters) were partially offset by implant underspend (Orthopaedic prostheses due to outsourcing and shunts/stents in our cath lab/Neurosurgery); due to COVID-19 spend will be minimal in March/April due to reduced procedures. • Infrastructure savings are not currently being met in all areas, savings in insurance, capital charge, corporate training and depreciation are offsetting large increases in the integrated services contract due to MECA rises for this external provider in addition to consultants, outsourced maintenance and mobile phone spend.
Funder	• The Funder arm has external provider payments; total costs are in line with total YTD. Increased costs in PHO, other HOP and Child, youth costs are offset by additional revenue from MOH. Costs in ARC are lower than budget targets. • IDF Outpatient volumes are also lower than paid target and the DHB has made a provision of $1.6m (case weight) as an under-spend on these costs due to COVID IDF recognition to budget. • The key monthly increase in costs is related to COVID such as CBAC establishment, which we received offsetting revenue from the Ministry.

Section 4

Financial Position

Cash Management – April 2020

Month : April 2020						Capital & Coast DHB Statement of Cashflows	Year to Date				
			Variance							Variance	
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	Notes	YTD April 2020	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year
						Operating Activities					
104,464	**104,969**	**99,831**	**(505)**	**4,633**		**Receipts**	**1,071,645**	**1,049,686**	**1,005,341**	**21,959**	**66,304**
						Payments					
41,054	45,480	38,720	4,426	(2,334)		Payments to employees	447,581	454,798	421,950	7,218	(25,631)
68,480	55,247	52,562	(13,233)	(15,919)		Payments to suppliers	602,554	552,471	545,763	(50,083)	(56,791)
0	2,484	3,393	2,484	3,393		Capital Charge paid	12,297	24,838	15,061	12,541	2,764
(4,413)	187	(6,553)	4,600	(2,140)		GST (net)	(3,695)	1,870	(7,035)	5,565	(3,340)
105,121	**103,398**	**88,121**	**(1,723)**	**(17,000)**		**Payments - total**	**1,058,737**	**1,033,977**	**975,739**	**(24,760)**	**(82,998)**
(657)	**1,571**	**11,710**	**(2,228)**	**(12,367)**	**6**	**Net cash flow from operating Activities**	**12,908**	**15,709**	**29,602**	**(2,801)**	**(16,694)**
						Investing Activities					
22	104	53	82	32		Receipts - Interest	**858**	**1,040**	**1,079**	**181**	**220**
0	0	0	0	0		Receipts - Other	500	0	0	(500)	(500)
22	**104**	**53**	**82**	**32**		**Receipts - total**	**1,358**	**1,040**	**1,079**	**(319)**	**(280)**
						Payments					
0	0	61	0	61		Investment in associates	0	0	1,460	0	1,460
4,950	3,917	2,358	(1,034)	(2,592)		Purchase of fixed assets	32,236	39,167	34,868	6,931	2,632
4,950	**3,917**	**2,419**	**(1,034)**	**(2,531)**		**Payments - total**	**32,236**	**39,167**	**36,328**	**6,931**	**4,092**
(4,928)	**(3,813)**	**(2,366)**	**(951)**	**(2,499)**	**7**	**Net cash flow from investing Activities**	**(30,878)**	**(38,127)**	**(35,249)**	**6,612**	**3,813**
						Financing Activities					
16,000	0	0	16,000	16,000		**Equity - Capital**	16,000	0	0	16,000	16,000
0	0	0	0	0		**Other Equity Movement**	11,808	0	0	11,808	11,808
0	0	0	0	0		Other	0	0	(192)	0	(192)
16,000	**0**	**0**	**16,000**	**16,000**		**Receipts - total**	**27,808**	**0**	**(192)**	**27,808**	**28,000**
						Payments					
0	**0**	**0**	**0**	**0**		Interest payments	**55**	**0**	**0**	**(55)**	**(55)**
0	**0**	**0**	**0**	**0**		**Payments - total**	**55**	**0**	**0**	**(55)**	**(55)**
16,000	**0**	**0**	**16,000**	**16,000**	**8**	**Net cash flow from financing Activities**	**27,753**	**0**	**(192)**	**27,753**	**27,945**
10,415	**(2,242)**	**9,344**	**12,821**	**1,134**		**Net inflow/(outflow) of CCDHB funds**	**9,784**	**(22,418)**	**(5,839)**	**31,564**	**15,063**
7,452	(12,093)	12,114	(19,545)	4,662		**Opening cash**	8,083	8,083	27,296	(0)	19,213
120,486	105,073	99,885	15,577	20,664		Net inflow funds	1,100,811	1,050,726	1,006,228	49,448	94,024
110,071	107,315	90,540	(2,756)	(19,531)		Net (outflow) funds	1,091,028	1,073,144	1,012,067	(17,884)	(78,961)
10,415	**(2,242)**	**9,344**	**12,821**	**1,134**		**Net inflow/(outflow) of CCDHB funds**	**9,784**	**(22,418)**	**(5,839)**	**31,564**	**15,063**
17,867	**(14,335)**	**21,458**	**32,202**	**(3,591)**		**Closing cash**	**17,867**	**(14,335)**	**21,457**	**32,202**	**(3,590)**

Capital and Coast DHB
RECONCILIATION OF CASH FLOW TO OPERATING BALANCE

	Notes	YTD April 2020 Actual $000	Budget $000	Variance $000
Net Cashflow from Operating		**12,908**	**15,709**	(2,801)
Non operating financial asset items		**(581)**	**-**	(581)
Non operating non financial asset items		**(2,507)**	**(2,246)**	(261)
Non cash PPE movements				
Depreciation & Impairment on PPE		(26,408)	(28,103)	1,695
Gain/Loss on sale of PPE		0	-	0
Total Non cash PPE movements		**(26,408)**	**(28,103)**	**1,695**
Interest Expense		**-**	**-**	**0**
Working Capital Movement				
Inventory		757	351	406
Receipts and Prepayments		238	3,240	(3,002)
Payables and Accruals		(14,150)	-	(14,150)
Total Working Capital movement		**(13,156)**	**3,591**	**(16,746)**
Operating balance		**(29,743)**	**(11,049)**	(18,694)

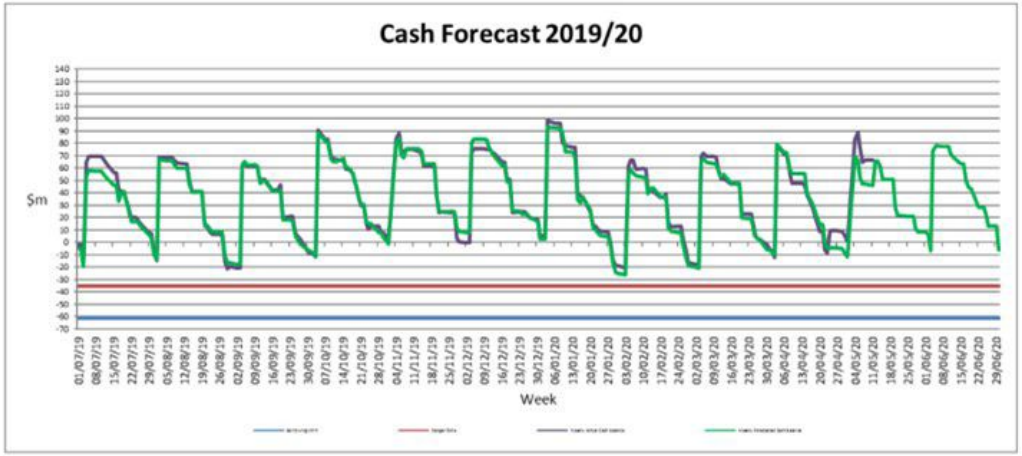
Current Ratio – This ratio determines the DHB's ability to pay back its short term liabilities.
DHB's current ratio is 0.35 (Mar 20: 0.29);

Debt to Equity Ratio - This ratio determines how the DHB has financed the asset base.
DHB's total liability to equity ratio is 37:63 (Apr 20 37:63).

Debt Management / Cash Forecast – April 2020

Accounts Receivable
30-Apr-20

Aged Debtors report ($'000)	Total	Current	1-30	31 - 60	61 - 90	91+	Previous Period
Ministry of Health	10,645	5,768	3,036	185	- 4	1,660	6,439
Other DHB's	8,444	2,643	440	397	137	4,827	6,219
Kenepuru A&M	252	18	20	27	187	-	396
ACC	78	68	- 294	210	48	46	252
Misc Other	4,087	1,227	381	448	37	1,994	7,092
Total Debtors	23,506	9,724	3,583	1,267	405	8,527	20,398
less : Provision for Doubtful Debts	(1,572)						(1,522)
Net Debtors	21,934						18,876



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 $4.7m
- **Kenepuru A&M:** Includes significant number of low value patient transactions. Provision of the overdue debts is $163k
- **Misc Other:** Includes non-resident debt of approx. $2.3m. About 59% of the non-resident debt have payment arrangements in place. The balance will be referred to collection agencies if unpaid.

Balance Sheet / Cashflow – as at 30 April 2020

Mar-20	Month : April 2020							Capital & Coast DHB Balance Sheet
					Variance			
Actual	Actual	Budget	At April 2019	At June 2019	Actual vs Budget	Actual vs April 2019	Notes	YTD April 2020
31	31	33	31	33	(2)	0	1	Bank
0	4,653	0	10,370	0	4,653	(5,717)	1	Bank NZHP
12,128	13,183	10,754	11,057	10,754	2,429	2,126	1	Trust funds
37,421	45,043	51,217	44,993	51,866	(6,174)	50	2	Accounts receivable
9,911	9,803	9,046	9,151	9,046	757	651		Inventory/Stock
9,069	9,878	4,197	5,233	4,197	5,681	4,645		Prepayments
68,559	**82,590**	**75,247**	**80,835**	**75,896**	**7,343**	**1,755**		**Total current assets**
521,607	518,199	565,559	539,428	540,558	(47,360)	(21,228)		Fixed assets
14,619	14,619	14,619	9,859	11,626	0	4,760		Work in Progress - CRISP
50,844	55,085	25,526	41,939	30,490	29,559	13,146		Work in progress
587,071	**587,903**	**605,704**	**591,226**	**582,673**	**(17,801)**	**(3,323)**	3	**Total fixed assets**
0	0	0	6,127	0	0	(6,127)		Investments in New Zealand Health Partnership
1,150	1,150	1,150	1,150	1,150	0	(0)		Investment in Allied Laundry
1,150	**1,150**	**1,150**	**7,277**	**1,150**	**0**	**(6,127)**		**Total investments**
656,780	**671,643**	**682,101**	**679,337**	**659,719**	**(10,458)**	**(7,694)**		**Total Assets**
4,707	0	25,121	0	2,704	25,121	0		Bank overdraft HBL
69,018	67,400	67,573	75,947	64,760	173	8,547	4	Accounts payable, Accruals and provisions
0	0	55	55	55	55	55	7	Loans - Current portion
5,803	7,821	0	9,830	0	(7,821)	2,009	6	Capital Charge payable
593	593	593	593	593	0	0		Insurance liability
23,997	24,174	56,248	24,708	18,577	32,074	534	5	Current Employee Provisions
119,585	122,920	53,276	50,713	120,437	(69,644)	(72,206)	5	Accrued Employee Leave
12,451	15,996	24,541	13,770	21,041	8,546	(2,225)	5	Accrued Employee salary & Wages
236,153	**238,904**	**227,408**	**175,616**	**228,167**	**(11,495)**	**(63,288)**		**Total current liabilities**
0	0	0	55	0	0	55		Crown loans
85	100	80	11,130	72	(20)	11,030		Restricted special funds
605	605	605	605	605	0	0		Insurance liability
6,297	6,297	6,353	5,642	6,353	56	(655)		Long-term employee provisions
6,987	**7,002**	**7,037**	**17,432**	**7,029**	**36**	**10,430**		**Total non-current liabilities**
243,140	**245,905**	**234,445**	**193,048**	**235,196**	**(11,460)**	**(52,857)**		**Total Liabilities**
413,640	**425,738**	**447,656**	**486,289**	**424,523**	**(21,918)**	**(60,551)**		**Net Assets**
797,172	797,172	785,356	763,878	778,200	11,816	33,294		Crown Equity
0	0	0	0	(3,484)	0	0		Capital repaid
0	19,033	0	0	0	19,033	19,033		Capital Injection
131,395	131,395	136,711	136,535	142,009	(5,316)	(5,139)		Reserves
(514,927)	(521,862)	(474,412)	(414,123)	(492,203)	(47,451)	(107,739)		Retained earnings
413,640	**425,738**	**447,655**	**486,290**	**424,522**	**(21,918)**	**(60,551)**		**Total Equity**

The DHB's overall liquidity should be of concern as the current assets of $83m is significantly lower than the $239m of current liabilities, this is therefore resulting in the DHB being solely reliant on the crown to meet payments as they fall due.

Deficit support will be needed in 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.

Fixed Assets is under-budget due to under-budgeted buildings accumulated depreciation, an over-budget variance in Work in progress for projects pending completion and asset write-downs for copper pipes and NOS.

The DHB received $16m equity funding from the Ministry and $3m relating to NHMG (National Haemophilia Management Group) from Hutt Valley DHB in April, which has temporarily solved CCDHB's exposure to overdrafts till end of this financial year in June. Further equity funding will be needed in July, to avoid the DHB going into overdraft by around $30m by the end of that month.

Payments to suppliers was higher than budgeted. This was largely affected by an increase of around $6m of sector payments made by the Ministry on behalf of the DHB. Supplier payments paid directly by the DHB was also around $4m above normal levels. Payments to suppliers have increased from last year due mainly to pay equity payments to providers, increased funder/community costs and some Covid-19 related expenditure.

Capital Expenditure and Projects Summary - April 2020

Capital Expenditure Spend		Forecast Cash Spend			
Asset Category	Actual YTD Spend	May-20	Jun-20	Total Forecast	Total FY20 Spend
Buildings	435,637	1,600,000	2,000,000	3,600,000	4,035,637
Clinical Equipment	8,891,525	5,600,000	5,500,000	11,100,000	19,991,525
ICT	971,009	454,539	757,347	1,211,885	2,182,895
Projects Approved 2019-20	**10,298,170**	**7,654,539**	**8,257,347**	**15,911,885**	**26,210,056**
Buildings	6,562,393	340,000	250,000	590,000	7,152,393
Clinical Equipment	1,434,559	-	-	-	1,434,559
ICT	4,472,730	149,000	18,500	167,500	4,640,230
Projects Approved Prior Year	**12,469,682**	**489,000**	**268,500**	**757,500**	**13,227,182**
Total	**22,767,853**	**8,143,539**	**8,525,847**	**16,669,385**	**39,437,238**
Equity Funding (MOH) & Leases					(10,000,000)
Grand Total					**29,437,238**

Note: This spend excludes our key equity funded projects: Children's Hospital, ISU

The overall Capital funding for 2019-20 is $57.4 million. Key highlights to April 2020 are:

- More than $47m in projects have been approved and are progressing.
- Cash spend to date was $22.8m ($12.5m for prior year projects and $10.3m for projects from the 2019/20 Capital Plan)
- The DHB will underspend its capital expenditure budget of $37m in 2019/20 financial year. At least $15m will be rolled over to the next financial year
- As a result of delays to capital projects from COVID-19, replacement of clinical equipment ($2.2m) flagged for FY2020/21 have been brought forward. Condition assessment and the risks of delays drove these.
- COVID-19 related Capital Expenditure totals $2.5m for mainly clinical equipment and some ICT. Facilities works completed to create isolation areas resulted in changes to ICU, PACU and Theatres in preparation for treating COVID-19 patients (costs not confirmed)

Board Discussion

July 2020

Hutt Valley DHB April 2020 Financial and Operational Performance Report

Action Required

The Board note:

(a) The Financial result for April year to date was an unfavourable variance to budget of ($5.3 million) against the agreed annual budget deficit of $8.1 million.

(b) The Funder result for April year to date was $4.4 million favourable, Governance $0.6 million favourable and the Hospital provider ($10.7 million) unfavourable to budget.

(c) Total Case weighted Discharge (CWD) activity was 2.03% ahead of plan.

(d) The current year-end financial forecast deficit of $14.6 million is adverse to budget.

Strategic Alignment	Financial Sustainability is a key priority for the DHB.
Authors	Judith Parkinson, General Manager Finance & Corporate Services Joy Farley, Director of Provider Services Rachel Haggerty, Director Strategy Planning and Performance
Endorsed by	Fionnagh Dougan, Chief Executive
Purpose	To update the Board on the financial performance and delivery against target performance for the DHBs
Contributors	Finance Team, 2DHB Hospital Services, Director Strategy Planning & Performance

Executive Summary

Activity delivered by the Hutt Valley DHB provider arm for April was severely impacted by COVID-19 lockdown.

The Ministry of Health monitor performance against key measures agreed in the Annual Plan. Hutt Valley delivered to target in 11 of the key areas; partially achieved on nine measures and two were not achieved; these being immunisation and smoking cessation targets.

Year to date the Hutt Valley DHB has a deficit of $13.0m which is $5.6m above budget, this includes $2 million of COVID-19 unfunded costs. Of this deficit $12.8m is in the hospital provider arm. Activity is 2.03% ahead of that planned. Total FTE are 11 below budget.

There is a positive financial impact on the organisation as a result of a reduction in the number of patients treated at other DHBs. The inter district flow cost reduction equates to a favourable variance of $1.6m YTD.

From an outcomes perspective inequity remains a significant challenge with Maori, and Pacific having lower rates of immunisation and breastfeeding. They also experience higher rates of avoidable hospital admissions (known as ambulatory sensitive hospitalisations (ASH)).

The forecasted financial position for Hutt Valley as advised to the Ministry of Health is a deficit of $14.6m, being $6.5m above the agreed budget deficit of $8.1m.

Strategic Considerations

Service	Financial performance and funding is a key to delivering the services for the Hutt Valley population.
People	Staff numbers are 11 below plan
Financial	Deficit forecast at $14.6 million, with no future COVID-19 impacts assessed at this stage.
Governance	The Finance Risk and Audit committee is accountable for scrutinising the financial reports 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/s

1. Hutt Valley DHB April 2020 Financial and Operational Performance Report

Monthly Financial and Operational Performance Report

For Period Ending
30 April 2020

Reported in May 2020

Contents

Section 1

Financial And Performance Overview And Executive Summary

Executive Summary

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People Served – April 2020 (March 2020)

HVDHB funds services that touch thousands of people in our community every month. April is generally much busier but it was impacted by the Covid-19 lockdown which led to a redesign of the operating model.

ED Attendances	Surgical Procedures	Hospital Discharges	Mental Health Discharges
2,188 (↓3,179)	376 (↓684)	1,574 (↓2,381)	36 (↓47)
412 Maori (↓666) 174 Pacific (↓351)	63 Maori (↓145) 22 Pacific (↓46)	251 Maori (↓378) 99 Pacific (↓164)	12 Maori (↑ 15) 3 Pacific (↓6)

Outpatient & Community Contacts	Mental Health & Addiction Contacts	Primary Care Contacts	People in Age Residential Care
5,600 (↓8,641)	1,343 (↓1,531)	51,536 (↑43,797)	1,116 (↓1,135)
842 Maori (↓1,304) 370 Pacific (↓632)	319 Maori (↓358) 97 Pacific (→97)	7,912 Maori (↑7,664) 4,073 Pacific (↓2,999) (Data Mar 20; total contacts; only available quarterly)	41 Maori (↓44) 37 Pacific (→37)

Financial Overview
April 2020

YTD Operating Position	YTD Provider Position	YTD Funder Position	YTD Capital Exp
$13.0.m deficit	$12.8m deficit	$0.5m deficit	$7.0m spend
Against the budgeted deficit of $7.3m. Month result was $2.7k deficit against budget deficit $1.1m.	Against a the prior month deficit of $6.9m. Month result was $2.0m deficit, (budget $0.1m surplus).	Budget $4.9m deficit. Month result was $1.1m surplus, budget $0.5m deficit	Against the prior month spend of $6.0m.

YTD Activity vs Plan (CWDs)	YTD Paid FTE	Annual Leave Accrual
2.03% ahead	1,960	$20.1m
423 CWDs ahead PVS plan (94 IDF CWDs behind). Month result 665 below budget CWDs due to COVID	YTD 38 below annual budget of 1,998 FTE. Month 11 below budget.	This is an increase of $1.1m on prior period.

Hospital Performance Overview
April 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
85.21%	1,015	1,363	100.0%
15% below the ED target of 95%, 5% below YTD for April 19.	Against a target of zero long waits a monthly movement of +110.	Against a target of zero long waits. Monthly movement +33	We achieved the 62 day target. The 31 day target was also achieved 100%

YTD Activity vs Plan (CWD)	YTD Standard FTE	Serious Safety Events
2.03% ahead	1,945	2
423 CWDs ahead PVS plan (94 IDF CWDs behind). Month result 665 below budget CWDs due to COVID	31 below YTD budget of 1,976 FTE. Month FTE was 5 under budget.	An expectation is for nil SSEs at any point.

Section 2

FUNDER PERFORMANCE

Executive Summary – Funder

- Overall the funder has a positive variance. Underlying this is a significant positive variance as inter-district patient flows, particularly to CCDHB are less than budgeted. This reflects the impact of the COVID-19 emergency. The reduction is in acute and elective work and results in a positive variance in provider payments.
- Revenue has been higher than anticipated with $1.03m being received for community pharmacy, Community Based Assessment Centres (CBACs) and enhanced primary care. Additional funding was also received for Māori and Pacific responses to the COVID-19 emergency. This included investment to improve vaccination rates for Māori. Rates continue to be monitored and are improving.
- Overall community funding is tracking to normal levels of expenditure. There is some underspend as services have not been commissioned in mental health. A small proportion of this underspend is being used to support the psychosocial response in our communities.
- This also reflects that as part of the COVID-19 approach it was agreed nationally that DHBs would continue to fund community providers at existing levels regardless of whether services could be provided. It was expected that providers would redeploy resources, and provisions were made to ensure they could not also seek funding from other Government sources. This means there is little change in expenditure patterns.
- The surveillance of COVID-19 is ongoing. Currently all CBACs continue to operate and primary capacity remains available. Once advised of the MOH surveillance plan, decisions will be made about how screening and testing will continue to be provided. MOH has yet to indicate what funding will be available.
- Regional Public Health has returned to ongoing business as usual, but remains ready to respond in the event of an outbreak. The ongoing funding sustainability for increased contact tracing capacity is being reviewed.
- All community services are ensuring business continuity with ongoing use of telehealth and alternative models of service delivery. Monitoring is being reviewed to ensure it reflects new models of care.
- MOH has also reprioritised essential work such as the Measles catch-up campaign.

Funder Financial Statement
March 2020

DHB Funder (Hutt Valley DHB)
Financial Summary for the month of April 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										
34,735	34,609	126	33,092	1,642	Base Funding	347,346	346,511	836	330,924	16,422	416,816	416,455	361	397,109	19,707
4,381	2,818	1,563	3,786	595	Other MOH Revenue	29,270	28,183	1,087	30,292	(1,022)	36,186	33,820	2,366	37,126	(940)
122	448	(325)	47	75	Other Revenue	407	4,476	(4,069)	552	(145)	502	5,372	(4,869)	654	(151)
7,678	8,602	(924)	8,393	(715)	IDF Inflows	85,221	86,021	(800)	85,292	(71)	102,014	103,225	(1,211)	101,806	208
46,916	**46,477**	**440**	**45,319**	**1,597**	**Total Revenue**	**462,245**	**465,192**	**(2,947)**	**447,059**	**15,185**	**555,519**	**558,872**	**(3,354)**	**536,694**	**18,824**
					Expenditure										
383	383	0	291	(92)	DHB Governance & Administration	3,831	3,831	0	2,884	(946)	4,597	4,597	0	3,467	(1,129)
19,176	20,032	856	18,494	(682)	DHB Provider Arm	199,694	200,324	630	184,762	(14,932)	239,786	240,388	602	221,939	(17,847)
					External Provider Payments										
1,301	2,811	1,509	2,266	964	Pharmaceuticals	29,300	29,364	64	30,303	1,003	34,738	35,275	537	37,728	2,990
4,287	4,329	43	4,297	10	Laboratory	42,335	43,295	960	42,681	347	50,944	51,954	1,010	51,172	229
2,428	2,479	51	2,353	(75)	Capitation	24,500	24,789	290	22,115	(2,385)	29,458	29,747	290	26,925	(2,532)
997	1,010	13	974	(23)	ARC-Rest Home Level	9,662	10,217	556	9,630	(32)	11,690	12,245	556	11,476	(214)
1,545	1,587	42	1,555	10	ARC-Hospital Level	15,720	16,046	326	15,195	(524)	18,905	19,231	326	18,224	(681)
2,883	2,757	(126)	2,959	76	Other HoP & Pay Equity	28,644	28,283	(361)	26,653	(1,991)	34,595	34,234	(361)	33,411	(1,184)
1,001	826	(176)	787	(215)	Mental Health	7,410	8,240	831	7,364	(45)	9,229	9,892	662	9,034	(195)
472	757	284	734	262	Palliative Care / Fertility / Comm Radiology	4,816	7,566	2,750	7,340	2,524	5,828	9,079	3,250	8,808	2,979
3,018	1,563	(1,455)	1,482	(1,536)	Other External Provider Payments	14,099	13,824	(275)	12,388	(1,711)	17,815	16,934	(881)	14,824	(2,991)
8,291	8,434	143	7,206	(1,084)	IDF Outflows	82,735	84,336	1,601	77,672	(5,062)	99,925	101,203	1,278	95,136	(4,789)
0	0	0	15	15	Provision for IDF Wash-ups	43	0	(43)	15	(28)	43	0	(43)	15	(28)
45,782	**46,967**	**1,185**	**43,413**	**(2,369)**	**Total Expenditure**	**462,786**	**470,115**	**7,328**	**439,003**	**(23,783)**	**557,552**	**564,778**	**7,226**	**532,160**	**(25,392)**
1,134	**(490)**	**1,625**	**1,906**	**(772)**	**Net Result**	**(541)**	**(4,923)**	**4,382**	**8,056**	**(8,598)**	**(2,034)**	**(5,906)**	**3,873**	**4,534**	**(6,568)**

There may be rounding differences in this report

Funder Financials – Revenue

Revenue:

- Revenue is made up of base funding, other MOH revenue, other revenue and inter district flows. The table shows the variance for other MOH revenue.
- Base Funding is favourable to budget for the month $126k and YTD favourable $836k.
- Other MOH revenue is favourable $1,563k for April and favourable $1,087k) YTD, driven by COVID-19 income recognised. Note: This revenue is fully offset by additional costs.
- Other revenue is unfavourable ($325k) for the month and ($4,069k) YTD, mostly driven by Hospital medicine rebates now included in expenditure ($367k).
- IDF inflows are ($924k) unfavourable for the month and ($800k) YTD driven by lower than expected volumes for March, related to COVID-19.

Other MOH Revenue Variance	MTH $000's	YTD $000's
In- Between Travel	0	(223)
Pay Equity Funding	65	686
Capitation Funding	(17)	(178)
Reduction in Capital Charge Funding	(36)	(358)
18/19 CCDM	-	365
Additional Pharmaceuticals Funding	49	495
Covid19 Funding	1,530	2,150
MECA	(182)	(1,659)
Crown funding agreements		
Maternal & Child Nutrition & Physical Activity	(32)	(321)
Tobacco Control	(23)	(294)
Alcohol & Drug	171	171
Other CFA contracts	(38)	(254)
Year to date Variance $000's	**1,563**	**1,087**

Funder Financials – Expenditure

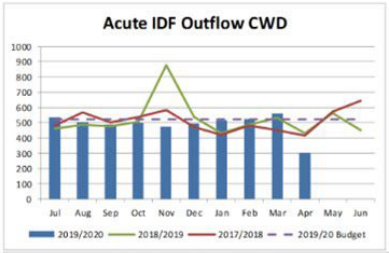
Expenditure:

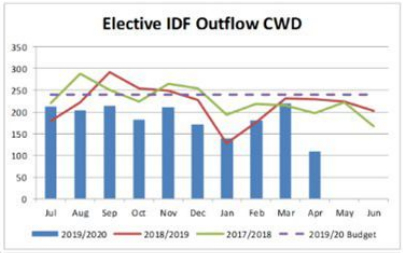
- Governance and Administration are on budget. Provider Arm payments are favourable $856k for the month, $630k YTD, mostly related to an underspend in interdistrict flows. The detail is outlined in the following page.

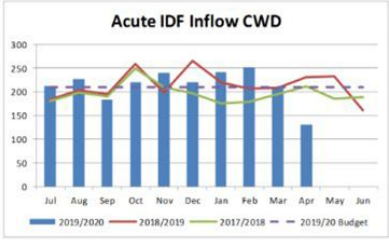
External Provider Payments:

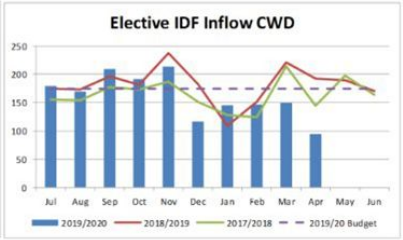
- Pharmaceutical costs are favourable $1,509k to budget for April and $64k YTD. The monthly result is driven by higher than expected Pharmac rebates. There is variability in this expenditure and it is expected to be on target at year end.
- Laboratory costs are favourable to budget by $43k for the month and favourable $960k YTD due to a reduction in the Hutt additional costs. This benefit is expected to be maintained.
- Capitation expenses are $51k favourable for the month and favourable $290k YTD offset by changes to revenue.
- Aged residential care costs are $55k favourable for the month and $882k YTD favourable. The residential care loan adjustment reported within other Health of Older People is favourable by $56k for the month and $373k YTD.
- Other Health of Older People (including Pay Equity) costs are unfavourable by ($126k) for the ($361k) YTD, mostly due to timing of contracts for Community Health & Support.
- Mental Health costs are unfavourable ($176k) for the month and favourable $831k YTD as community mental health services have been delayed. Of these resources $135k is being applied to community psychosocial support.
- Palliative Care, Fertility and Community Radiology costs are favourable by $284k for the month, $2,750k YTD. These costs are being incurred through interdistrict flows and are offset in operating budgets.
- Other external provider costs are unfavourable to budget ($1,455k) for the month, and ($275k) YTD. The Month variance is driven by COVID-19 expenditure ($1,553k) which is offset by an increase in revenue.
  - COVID-19 Community Pharmacy $ 479k
  - COVID-19 Regional Community Care $ 493k
  - COVID-19 Enhanced Primary Health Care $ 581k
- IDF Outflows are favourable $143k for the month and $1,601 YTD. The Month variance is driven by lower than expected volumes due to COVID-19.

Inter District Flows (IDF)









IDF Wash-ups and Service Changes April 2020		
IDF Outflows $000s	Variance to budget	
	Month	YTD
Current year in patient Wash-uo	1,172	2,981
Current year PCT Wash-up	(916)	(916)
Base	18	181
Personal Health various Service charges	(0)	(29)
SPO Project Charges	-	159
Washups		
FFS Washup	-	54
19/20 PHO washup	(122)	(369)
19/20 National Service Pymnt	(10)	(95)
18/19 Medical Outpatient Washups	-	994
18/19 PCT/ COMM Pharms washups	-	(1,423)
18/19 Other washups	-	64
IDF Outflow variance	**143**	**1,601**

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):

- Overall IDF inflows are under budget YTD by $800k, mainly due to inflows for inpatients being $493k under budget. This is mainly in Maternity and Orthopaedics and reflects the impact of COVID-19.

IDF Outflow (expense):

- Overall IDF outflows are under budget by $1,601k. Inpatient outflows are impacted by COVID-19. The greatest underspend is to CCDHB where we are 10% below the same time last year (725 case weighted discharges).
- Acute IDF outflows are under budget particularly in Renal, Oncology, and Haematology, with Orthopaedics and Cardiothoracic being above anticipated levels. There was one baby at CCDHB with 65 CWD and a general surgical case at 68 CWD.
- Electives are under budget particularly for Capital & Coast and this is mostly due to elective Cardiothoracic being 218 CWD or $1.1 million below budget. Results may change as data is updated.
- PCT (Cancer Pharmaceuticals) use is up and we have recognised an additional $916k in the month for the YTD position
- There was a large wash-up for 18-19 in PCTs of ($752k) which brought the final amount of ($1,092k) paid in October 19.

Section 3

Hospital Performance

Executive Summary – Hospital Performance

- The COVID–19 response required the development of strategies to screen and stream patient entry to the hospital across all services and areas, with inpatient admissions limited to acutes or care that cannot be deferred, outpatient activity undertaken as telehealth, phone screening for virtual assessment and Multi Disciplinary Teams to teleconference wherever possible and diagnostic services prioritised to support assessment via ED or other acute services, inpatient care or discharge.
- The above, as well as physical distancing, impacted every aspect of service delivery with material impact on both activity and costs. The overall financial impact has been negative as services ceased during preparation and implementation of Alert Levels 3 and 4. This has meant the provider arm has retained costs whilst reducing service delivery. Truly variable costs, including clinical supplies, have reduced, but the greatest cost of staff was retained. Our largest cost within the month is the increase in leave liabilities; as staff usually plan leave surrounding the three public holidays in April.
- Emergency department attendances were 46% lower than the same time last year and elective surgery markedly reduced. Staff were focussed on pandemic preparation including upskilling in various areas.
- A number of strategies highlighted within the Acute Demand and Bed Capacity Programme were progressed as part of the planning for a surge in COVID-19 presentations and our acute response. These included the expansion of the Advancing Wellness at Home Initiative (AWHI) project that identifies potential patients needing intervention earlier in admission with the goal of reducing the over 10 day stays for complex patients in general medicine.
- Our recovery planning assumes that DHBs will face an extended period of risk and potential harm to our communities from the impacts of COVID-19. We are now planning and delivering for new business as usual (BAU) that contains a COVID-19 readiness pathway for all services, physical distancing principles and development/roll out of new models of care.

Hospital Throughput

Month					Hutt Valley DHB Hospital Throughput YTD Apr-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							
706	1,001	295	1,081	375	Surgical	10,128	10,285	157	10,912	784	12,425	12,797
1,108	1,654	546	1,749	641	Medical	17,480	17,105	(375)	18,082	602	20,730	19,506
378	407	29	481	103	Other	4,510	4,237	(273)	4,662	152	5,052	5,474
2,192	**3,063**	**871**	**3,311**	**1,119**	**Total**	**32,118**	**31,627**	**(491)**	**33,656**	**1,538**	**38,206**	**37,777**
					CWD							
616	1,056	440	1,129	514	Surgical	11,027	11,115	88	11,532	504	13,364	12,852
618	946	329	893	276	Medical	9,359	10,228	868	9,483	124	12,277	11,991
431	442	11	549	119	Other	5,419	4,288	(1,131)	5,300	(120)	5,053	4,698
1,664	**2,444**	**780**	**2,572**	**908**	**Total**	**25,806**	**25,631**	**(175)**	**26,315**	**509**	**30,695**	**29,540**
					Other							
2,404	3,927	1,523	3,956	1,552	Total ED Attendances	39,233	40,655	1,422	41,039	1,806	49,056	47,491
681	972	291	925	244	ED Admissions	9,466	10,081	615	9,988	522	12,187	11,847
390	733	343	791	401	Theatre Visits	7,109	7,562	453	8,019	910	9,047	9,271
137	118	(19)	127	(10)	Non- theatre Proc	1,274	1,170	(104)	1,243	(31)	1,452	1,891
5,372	6,390	1,018	6,941	1,570	Bed Days	71,523	68,140	(3,383)	70,204	(1,319)	82,109	85,515
4.85	4.30	(0.55)	4.24	(0.61)	ALOS Inpatient	4.54	4.30	(0.24)	4.39	(0.15)	4.30	4.29
2.33	2.03	(0.30)	2.03	(0.31)	ALOS Total	2.22	2.03	(0.19)	2.16	(0.06)	2.03	2.20
5.15%	8.02%	2.87%	7.47%	2.32%	Acute Readmission	7.65%	8.02%	0.37%	7.95%	0.30%	7.31%	7.36%

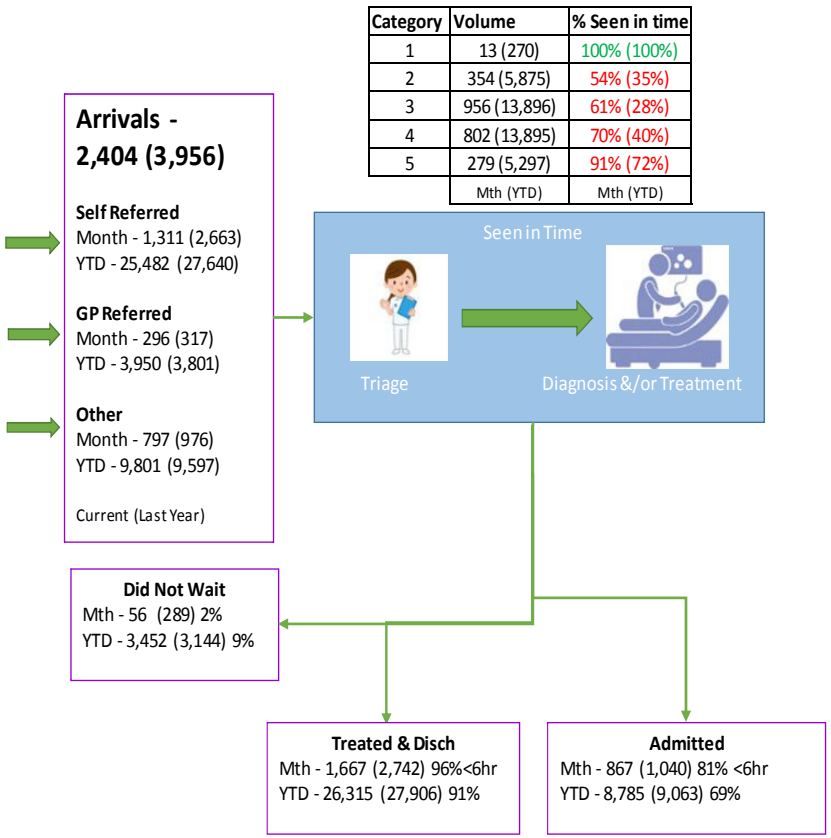
Activity in April was impacted by the COVID-19 lockdown. Elective surgery was pared back from 19 March. ED attendances reduced to just over 62% of usual attendances during April, an average of 80 per day down from 130. A higher percentage of ED attendances were admitted (28% against 23% last April) as those who presented had higher than average complexity.

Operational Performance Scorecard – Period Apr 19- Apr 20

			Performance Trend												
Domain	Indicator (MoH KPIs highlighted yellow)	2019/20 Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Safe	Serious Safety Events[1]	Zero SSEs			4	2	4	1	6	3	0	1	4	1	2
	SABSI Cases [2]	Zero	0	1	1	0	0	0	0	0	0	1	0	0	
	C. difficile infected diarrhoea cases	Zero	1	2	1	1	2	1	2	2	1	2	2	4	
	Hand Hygiene compliance	≥ 80%	N/a	N/a	86%	N/a	N/a	N/a	84%	N/a	N/a	N/a	N/a	83%	
	Seclusion Hours- average(MH Inpatient wards)[3]	≤3 hours													
Patient and Family Centred	Complaints Resolved within 35 calendar days[4]	≥90%													
	Patient reported experience measure[5] Quarterly	≥80%	85.5%			85.3%									
Timely	Emergency Presentations	49,056	3,956	4,519	4,333	4,251	4,348	4,166	4,054	4,239	4,133	4,053	4,028	3,553	2,404
	Shorter Stays in ED (SSiED) % within 6hrs	≥95%	90.5%	90.3%	85.1%	81.2%	84.4%	89.3%	88.7%	84.6%	83.7%	82.6%	83.5%	83.9%	91.4%
	SSiED % within 6hrs - non admitted	≥95%	94.4%	94.2%	91.0%	88.6%	90.4%	94.1%	92.7%	90.1%	90.9%	89.5%	90.1%	90.1%	95.7%
	SSiED % within 6hrs - admitted	≥95%	79.0%	78.3%	68.6%	61.0%	67.9%	75.2%	77.7%	71.0%	64.5%	63.1%	64.4%	66.6%	81.1%
	Total Elective Surgery Long Waits -ESPI 5	Zero Long Waits	179	151	156	227	274	303	435	536	626	737	689	834	1015
	No. Theater surgeries cancelled (OP 1-8)		157	149	131	180	143	162	169	137	116	134	98	194	50
	Total Elective & Acute Operations in MainTheatres 1-8[6]		794	828	761	770	752	744	788	769	664	784	743	704	390
	Specialist Outpatient Long Waits- ESPI 2	Zero Long Waits	271	328	355	456	486	562	583	632	889	1,130	1,189	1,233	1,363
	Outpatient Failure to Attend %	≤6.3%	7.6%	7.2%	5.7%	7.2%	6.3%	6.6%	6.8%	6.9%	7.6%	7.1%	7.6%	7.0%	6.2%
	Full Year Forecast surplus / (deficit) $m - Provider (1) (2)	($2.03)	($14.79)	($15.83)	($12.74)	($2.03)	($2.03)	($4.48)	($6.90)	($5.21)	($5.21)	($6.57)	($8.19)	($10.37)	
	Full Year Forecast surplus / (deficit) $m - DHB (1) (2)	($8.14)	($8.05)	($8.15)	($8.34)	($8.14)	($8.14)	($8.97)	($8.14)	($8.58)	($8.58)	($8.76)	($10.39)	($13.04)	
	% Theatre utilisation (Elective Sessions only)[7]	≤90%	88.9%	87.1%	90.5%	88.1%	88.5%	87.9%	87.1%	86.5%	85.5%	87.9%	89.6%	86.4%	74.5%
	Overnight Patients - Average Length of Stay (days)	≤4.3	4.74	4.25	4.25	4.46	4.38	4.36	4.82	4.52	4.37	4.34	4.35	5.31	4.90
	Long Stay Patients Not Yet Discharged (>14 days)	≤5	11	11	14	15	14	21	13	10	23	15	16	7	11
	Overnight Beds (General Occupancy) - Average Occupied	≤130	133	127	133	139	140	140	135	138	137	131	136	129	106
	Overnight Beds (General Occupancy) - % Funded Beds Occupied	≤85%	93.9%	87.0%	82.1%	86.1%	85.9%	86.2%	87.9%	89.5%	89.0%	87.2%	88.2%	90.8%	74.3%
	All Beds - ave. beds occupied[8]	≤250	231	229	241	248	253	250	242	244	232	231	244	223	179
	% sick Leave v standard	≤3.5%	3.5%	3.2%	3.7%	4.0%	3.9%	3.7%	3.5%	2.9%	2.7%	2.0%	2.5%	3.6%	
	% Nursing agency v employee	≤1.49%	2.5%	2.8%	5.2%	2.3%	2.0%	3.8%	2.6%	2.3%	1.7%	3.9%	3.02%	2.63%	
	% overtime v standard (medical)	≤9.22%	7.3%	22.8%	4.9%	7.6%	9.6%	7.4%	8.7%	11.2%	5.9%	11.6%	9.33%	7.62%	
	% overtime v standard (nursing)	≤5.47%	11.0%	13.2%	13.5%	12.9%	12.6%	12.8%	12.4%	13.8%	11.5%	17.9%	14.13%	10.57%	

Refer to later pages for more details on HVDHB performance. Highlighted where an identified target in 19/20.

Emergency Department (ED)



Category	Volume	% Seen in time
1	13 (270)	100% (100%)
2	354 (5,875)	54% (35%)
3	956 (13,896)	61% (28%)
4	802 (13,895)	70% (40%)
5	279 (5,297)	91% (72%)
	Mth (YTD)	Mth (YTD)

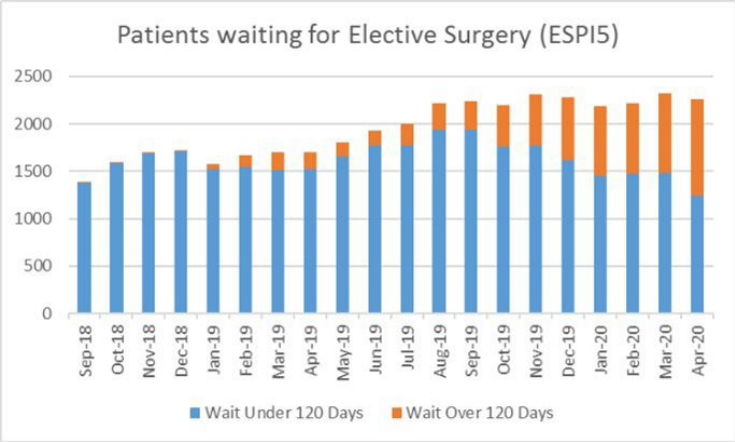
- **Presentation Volume**
  - In April 2,404 patients presented to ED, 46% below April 2019
  - 2% did not wait for treatment
  - 28% were admitted which is higher than prior months and last year (23%)
- **Shorter Stays in ED**
  - In April 91% of patients were seen and discharged or transferred within 6 hours. YTD performance is 85% against the national target of 95%
  - 81% of admitted patients in April met the National target of 95%. April is above the YTD average of 69%.
  - There was a marked improvement in Triage times during April, with 67% seen within the recommended times up from prior months 38% average

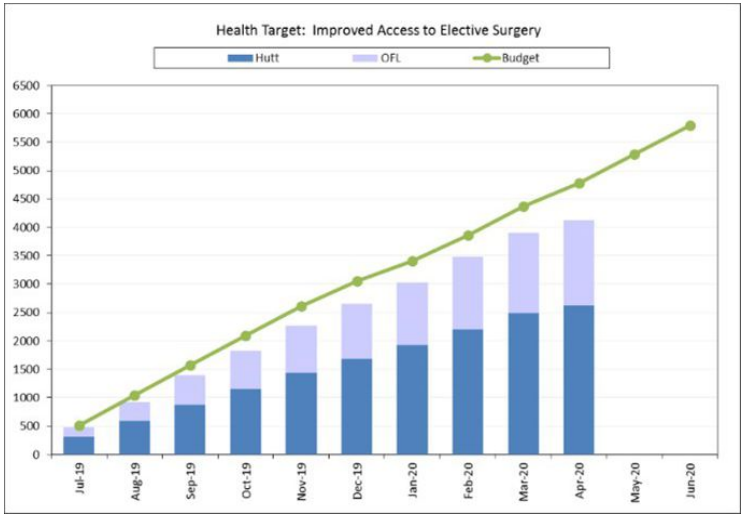
The Acute Demand and Bed Capacity Programme was put on hold from early March, as our focus turned to planning for a surge in COVID-19 presentations and our acute response. From the end of April our focus is on the "new normal" as we look ahead to winter and the COVID vs. non-COVID parallel processes.

The following work streams are being progressed and rolled out during this time including:

- Developing a shared model of care for Medical and surgical assessment to improve acute flow
- The expansion of the Advancing Wellness at Home Initiative (AWHI) project to a wider catchment and other inpatient wards. AWHI 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 reducing the over 10 day stays for complex patients in general medicine.

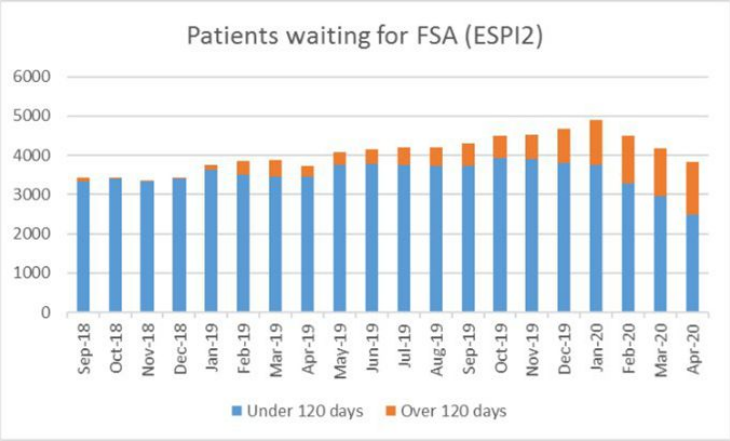
Elective Surgery

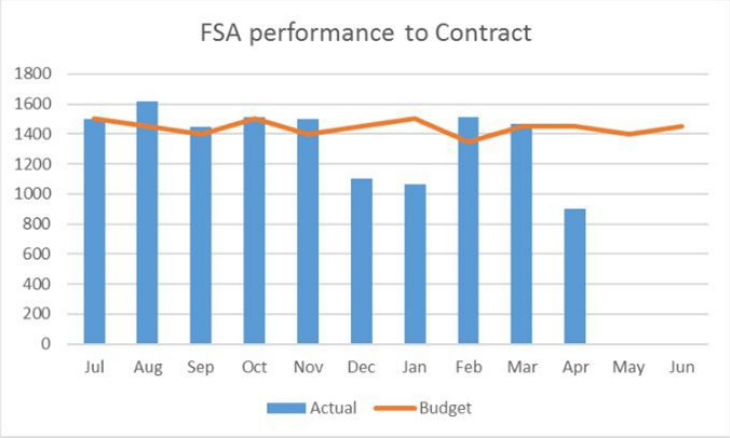




- COVID-19 measures led to the cancellation of planned care activity during April. While we continued with all acute and non-deferrable surgery care under level 3-4 and utilised private capacity where appropriate, this had a significant impact on our waiting times. Reduced outpatients meant fewer were added to the wait list.
  - Total number on the waiting list fell 2.5% to 2,260
  - The number waiting more than 120 days increased by 22% to 1,015. That is 45% of people are waiting longer than 120 days for treatment with the biggest issues are in general surgery (58%) and orthopaedics (59%)
- Accordingly we are not meeting the planned care discharges for our population (14% behind)
- By way of comparison, our population has 4,123 discharges YTD against 4,564 at the same time last year. Our minor procedures YTD are higher than the same time last year (2,638 against 2,220). (This year includes skin lesions performed in primary care - 401 YTD)
- We are currently awaiting national guidance regarding our approach to responding to the substantial and ongoing impact of COVID-19. Areas of focus are planned care and elongated timeframes for people waiting for assessment or treatment.
- We are working to schedule surgery and utilising private providers where possible. Our SMO's have been significantly involved with planning based on those with greatest clinical urgency and greatest risk of deterioration if not treated shortly.
- Continued clinical assessment and monitoring of referrals and wait lists will be key strategies for managing clinical risk.

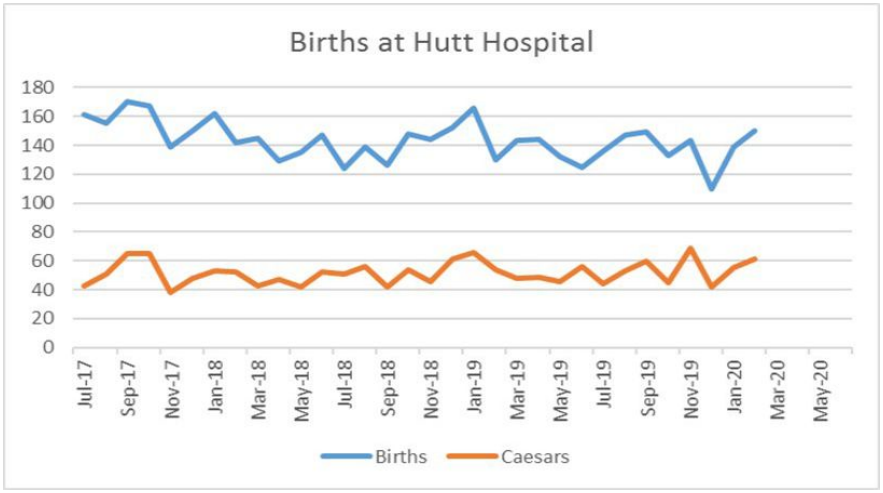
Specialist Outpatients

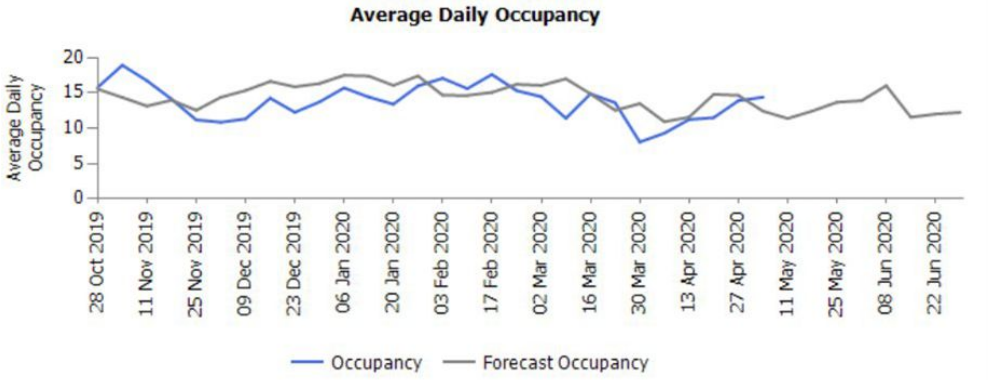




- COVID-19 measures led to significant changes in outpatient activity during April;
- The number of people waiting more than 120 days increased 10% to 1,363.
- 36% of patients have waited over 120 days for FSA; the longest waits are in General Surgery and Orthopaedics. 58 of the long wait patients are in non-surgical services.
- YTD we have seen 94% of budgeted FSAs (actual 13,629 attendances, budget 14,460 attendances)
- 6% of patients did not attend (DNA)/did not receive their FSA appointment. This was significantly higher for Maori 15% and Pacific 8% suggesting that the models of care do not work for Maori and Pacific people. The DNA rate was lower than in previous months.
- Embedding virtual and telehealth options into how we deliver outpatient and ambulatory assessments will be key strategies.

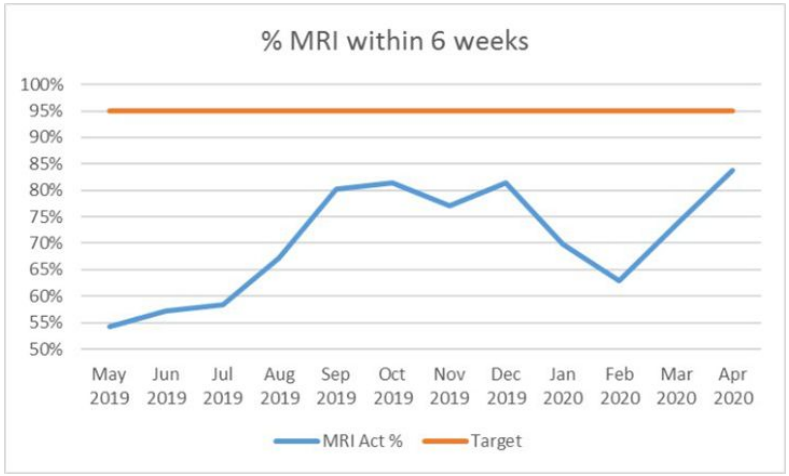
Maternity

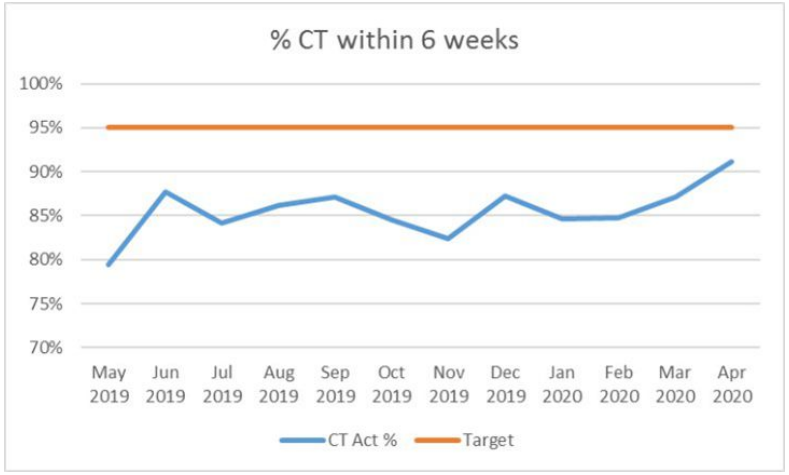




- The number of births at Hutt hospital remained relatively stable.
- The Caesarian rate for the 12 months to Jan 2020 was an average of 38% which is an increase on the previous 12 months average of 36%.
- Average bed occupancy was similar to the expectation after falling at the end of March.
- A regular system of reporting is in place via the steering committee; with good progress made against the recommended actions. Regular progress reports are provided to the MoH.

CT & MRI wait times





MRI
Apr20
84%

CT
Apr 20
91%

- The % of patients receiving their MRI within 6 weeks improved in April from 74% to 84% however volumes were down 53% due to COVID-19
- CT wait times remain close to target and volumes were only down by 15% due to COVID-19
- We are also supporting CCDHB by scanning all Hutt Valley domicile patients even if they are under care at CCDHB
- Actions currently underway:
  - Working with Strategy Planning & Performance and HVDHB to maximise and plan best outsourcing approach moving forwards in light of new challenges (e.g. physical distancing, ultra sonographer shortages)
  - Maximise recruitment opportunities in the Radiology workforce to extend “elective” hours – filling budgeted FTE
  - Reviewing current workflow within Radiology to maximise flexibility of bookings and acute imaging response.

Section 4

Financial Performance & Sustainability

Summary the financial performance for April 2020

Month					Hutt Valley DHB Operating Report for the month of April 2020	Year end Result					Annual	Annual				
Actual	Budget	Variance	Last Year	Variance	$000s	Actual	Budget	Variance	Last Year	Variance	Forecast	Budget	Variance	Last Year	Variance	
					Revenue											
39,116	37,476	1,640	36,879	2,237	Devolved MoH Revenue	376,616	375,188	1,428	361,216	15,401	453,101	450,868	2,233	434,235	18,866	
1,383	1,533	(150)	1,378	6	Non Devolved MoH Revenue	15,780	16,076	(296)	16,040	(260)	19,150	19,446	(296)	19,742	(592)	
473	639	(166)	610	(137)	ACC Revenue	5,333	6,206	(873)	6,390	(1,057)	6,491	7,341	(850)	7,539	(1,048)	
255	902	(647)	463	(208)	Other Revenue	5,076	9,087	(4,011)	4,853	223	6,081	10,891	(4,811)	6,987	(906)	
7,657	8,602	(945)	8,393	(736)	IDF Inflow	85,221	86,021	(800)	85,292	(71)	102,014	103,225	(1,211)	101,806	208	
471	326	145	323	149	Inter DHB Provider Revenue	3,529	3,262	267	3,468	61	4,196	3,915	281	4,577	(381)	
49,355	**49,479**	**(124)**	**48,045**	**1,310**	**Total Revenue**	**491,556**	**495,840**	**(4,284)**	**477,259**	**14,297**	**591,033**	**595,687**	**(4,654)**	**574,886**	**16,147**	1
					Expenditure											
					Employee Expenses											
5,212	5,037	(175)	4,784	(428)	Medical Employees	49,920	49,974	55	46,000	(3,920)	59,707	59,826	119	56,594	(3,113)	
6,950	5,883	(1,067)	5,730	(1,220)	Nursing Employees	62,404	58,384	(4,020)	57,054	(5,350)	74,503	69,893	(4,611)	69,463	(5,041)	
2,963	2,707	(257)	2,636	(327)	Allied Health Employees	26,506	26,717	211	24,818	(1,689)	31,971	32,008	37	29,882	(2,089)	
824	656	(168)	726	(98)	Support Employees	7,184	6,360	(824)	6,154	(1,030)	8,467	7,642	(824)	7,392	(1,075)	
2,559	2,475	(84)	2,426	(133)	Management and Admin Employees	23,354	24,642	1,288	22,560	(794)	28,052	29,481	1,428	27,228	(824)	
18,508	**16,758**	**(1,750)**	**16,302**	**(2,206)**	**Total Employee Expenses**	**169,369**	**166,078**	**(3,291)**	**156,586**	**(12,783)**	**202,700**	**198,850**	**(3,850)**	**190,558**	**(12,142)**	2
					Outsourced Personnel Expenses											
171	221	50	320	150	Medical Personnel	2,856	2,207	(649)	2,757	(99)	3,356	2,649	(707)	3,600	244	
158	87	(71)	143	(15)	Nursing Personnel	1,661	866	(795)	1,790	129	1,933	1,039	(894)	2,268	334	
77	29	(49)	48	(29)	Allied Health Personnel	416	286	(130)	371	(45)	473	344	(130)	502	29	
39	20	(19)	61	22	Support Personnel	428	203	(224)	260	(167)	468	244	(224)	323	(145)	
332	42	(290)	87	(246)	Management and Admin Personnel	1,458	419	(1,040)	1,002	(456)	1,566	502	(1,063)	1,299	(267)	
777	**398**	**(379)**	**659**	**(118)**	**Total Outsourced Personnel Expenses**	**6,819**	**3,981**	**(2,837)**	**6,180**	**(639)**	**7,796**	**4,778**	**(3,019)**	**7,991**	**195**	2
868	615	(253)	711	(158)	Outsourced Other Expenses	7,605	6,266	(1,340)	7,773	167	8,989	7,498	(1,492)	8,486	(503)	3
1,999	2,374	375	2,341	342	Treatment Related Costs	24,412	21,859	(2,553)	20,789	(3,623)	28,702	26,099	(2,603)	24,879	(3,823)	4
1,592	1,506	(86)	1,583	(9)	Non Treatment Related Costs	16,116	15,352	(764)	15,610	(506)	19,367	18,458	(909)	29,932	10,565	5
8,291	8,434	143	7,206	(1,084)	IDF Outflow	82,735	84,336	1,601	77,672	(5,062)	99,925	101,203	1,278	95,136	(4,789)	6
17,933	18,118	185	17,422	(511)	Other External Provider Costs	176,527	181,625	5,098	173,682	(2,845)	213,244	218,591	5,347	211,615	(1,629)	7
2,080	2,347	267	2,148	67	Interest, Depreciation & Capital Charge	20,925	23,657	2,732	21,916	990	25,233	28,352	3,120	26,163	931	8
52,050	**50,551**	**(1,499)**	**48,372**	**(3,678)**	**Total Expenditure**	**504,508**	**503,154**	**(1,354)**	**480,207**	**(24,301)**	**605,957**	**603,828**	**(2,128)**	**594,761**	**(11,195)**	
(2,694)	**(1,071)**	**(1,623)**	**(327)**	**(2,367)**	**Net Result**	**(12,952)**	**(7,314)**	**(5,638)**	**(2,947)**	**(10,004)**	**(14,924)**	**(8,141)**	**(6,783)**	**(19,876)**	**4,952**	
					Result by Output Class											
1,134	(490)	1,625	1,906	(772)	Funder	(541)	(4,923)	4,382	8,056	(8,598)	(2,034)	(5,906)	3,873	4,534	(6,568)	
45	(5)	50	(168)	214	Governance	430	(212)	642	(212)	642	432	(210)	642	(134)	566	
(3,874)	(576)	(3,298)	(2,065)	(1,809)	Provider	(12,840)	(2,179)	(10,662)	(10,792)	(2,049)	(13,322)	(2,025)	(11,297)	(24,276)	10,954	
(2,694)	**(1,071)**	**(1,623)**	**(327)**	**(2,367)**	**Net Result**	**(12,952)**	**(7,314)**	**(5,638)**	**(2,947)**	**(10,004)**	**(14,924)**	**(8,141)**	**(6,783)**	**(19,876)**	**4,952**	

There may be rounding differences in this report

Executive Summary – Financial Position

Financial performance year to date

- Total Revenue unfavourable ($4,284k)
- Personnel and outsourced Personnel unfavourable ($6,128k):
  - Medical unfavourable ($594k); Nursing unfavourable ($4,815k); Allied Health favourable $81k, Support Staff unfavourable ($1,049k); Management and Admin; favourable $248k; Annual leave Liability cost has increased $1,907k since April 2019
- Outsourced other expenses unfavourable ($1,340k)
- Treatment related Costs unfavourable ($2,553)
- Non Treatment Related Costs unfavourable ($764k)
- IDF Outflow favourable $1,609k
- Other External Provider Costs favourable $5,098k
- Interest depreciation and capital charge favourable $2,732k
- Net additional costs relating to COVID-19 of $2m are included in the April year to date result

Analysis of operating position - revenue

- **Revenue:** Total revenue unfavourable ($488k) for the month.
  - Devolved MOH revenue $1,640k favourable, driven by the recognition of MoH COVID-19 Funding $1,530k, offset by an increase in expenditure.
  - Non Devolved revenue ($150k) unfavourable driven largely MoH side contracts ($55k) and HWNZ ($92k) .
  - ACC Revenue ($166k) unfavourable this month driven by Plastics ($152k), largely reflecting the reduction of service as a result of COVID-19.
  - Other revenue ($647k) unfavourable for the month reflecting lower than expected revenue for MECA settlements being recognised.
  - IDF inflows unfavourable ($945k) for the month.
  - Inter DHB Revenue unfavourable ($145k), mostly timing differences.

COVID-19 Revenue and Costs

YTD Result - April 2020	Funder [1]	Provider (excl. Regional Public Health)	Provider - Regional Public Health (RPH)	Total
$000s	Actual	Actual	Actual	Actual
Revenue				
Devolved MoH Revenue Recognised - COVID19	1,943	(0)	207	2,150
Expenditure				
Employee Expenses				
Medical Employees		204	19	223
Nursing Employees		564	52	616
Allied Health Employees		478	51	529
Support Employees		68	0	68
Management and Admin Employees		132	17	149
Total Employee Expenses	**0**	**1,446**	**139**	**1,585**
Expenses				
Outsoruced - Provider	0	269	38	307
External Providers - Funder	1,943	0		1,943
Clinical Expenses - Provider	0	82	29	111
Non-clinical Expenses- Provider	0	224	0	224
Total Non Employee Expenses	**1,943**	**575**	**67**	**2,586**
Total Expenditure	**1,943**	**2,021**	**207**	**4,171**
Net Impact	**(0)**	**(2,021)**	**(0)**	**(2,021)**

(1) Net of RPH tagged funding

- The April year to date financial position includes $4.2m additional costs in relation to COVID-19.
- Revenue of $2.2m has been received to fund additional costs for community providers and Regional Public Health.
- The net impact year to date is $2m additional costs currently unfunded.

Analysis of operating position - Personnel

- **Total Personnel** including outsourced unfavourable ($2,129k) for the month.
  - Medical personnel incl. outsourced unfavourable ($125k). Outsourced costs are ($50k) unfavourable Medical Staff Internal are ($175k) unfavourable driven by RMO's ($340k).
  - Nursing incl. outsourced ($1,138k) unfavourable. Employee costs are ($1,067k) unfavourable, driven by Internal Registered Nurses ($488k), Internal Bureau Nurses ($93k), Senior Nurses ($125k) and other minor variances. COVID-19 related costs for Nurses including casuals and COVID-19 Leave was estimated at ($563k)
  - Allied Health incl. outsourced ($305k) unfavourable, with outsourced unfavourable ($49k), internal employees unfavourable ($257k) driven Radiology (105k) and Other Leave which is predominately related to COVID-19 Special Leave ($358k), offset by other variances.
  - Support incl. outsourced unfavourable ($186k), with Outsourced ($19k) unfavourable, and employee costs ($168k) unfavourable, reflecting larger than expected increases in the Multi Union Collective Agreement (MUCA) rates for employees. COVID-19 related costs including Special Leave are estimated at ($68k).
  - Management & Admin incl. outsourced unfavourable ($374k); internal staff unfavourable ($84k), Outsourced unfavourable ($290k), the later includes savings targets. COVID-19 relates costs including Special Leave area estimates at ($131k).
  - Sick leave for April was 7.5%, which is higher than the same time last year, which was 3.5%. This includes staff on COVID-19 Leave.

FTE Analysis

Month					FTE Report	Year To Date					Annual	
Actual	Budget	Variance	Last Year	Variance	Apr-20	Actual	Budget	Variance	Last Year	Variance	Budget	Last Year
					FTE							
281	280	(1)	269	(11)	Medical	274	280	6	271	(2)	280	273
803	792	(11)	791	(13)	Nursing	800	792	(8)	773	(27)	792	776
402	408	6	392	(9)	Allied Health	391	408	17	386	(5)	408	387
143	135	(8)	136	(7)	Support	140	135	(5)	134	(5)	135	135
357	383	26	359	2	Management & Administration	355	383	28	351	(5)	383	353
1,986	**1,998**	**11**	**1,948**	**(39)**	**Total FTE**	**1,960**	**1,998**	**38**	**1,916**	**(44)**	**1,998**	**1,923**
					$ per FTE							
16,979	18,000	1,021	17,758	779	Medical	180,559	178,742	(1,817)	169,432	(11,127)	211,916	219,529
8,651	7,428	(1,223)	7,246	(1,405)	Nursing	78,030	73,713	(4,317)	73,789	(4,241)	94,065	90,022
7,376	6,640	(736)	6,716	(660)	Allied Health	67,737	65,434	(2,303)	64,310	(3,426)	78,323	82,741
5,708	4,857	(851)	5,342	(366)	Support	51,365	47,082	(4,283)	45,761	(5,604)	62,636	56,760
7,164	6,464	(700)	6,759	(405)	Management & Administration	65,695	64,297	(1,397)	64,314	(1,381)	73,206	83,574
9,090	**8,390**	**(700)**	**8,371**	**(719)**	**Average Cost per FTE all Staff**	**86,168**	**83,111**	**(3,057)**	**81,731**	**(4,437)**	**101,217**	**103,398**

Medical over budget for the month by (1); SMOs under budget by 11 FTE, MOSS under budget by 2 FTE, offset by RMO's & House Officers combined.

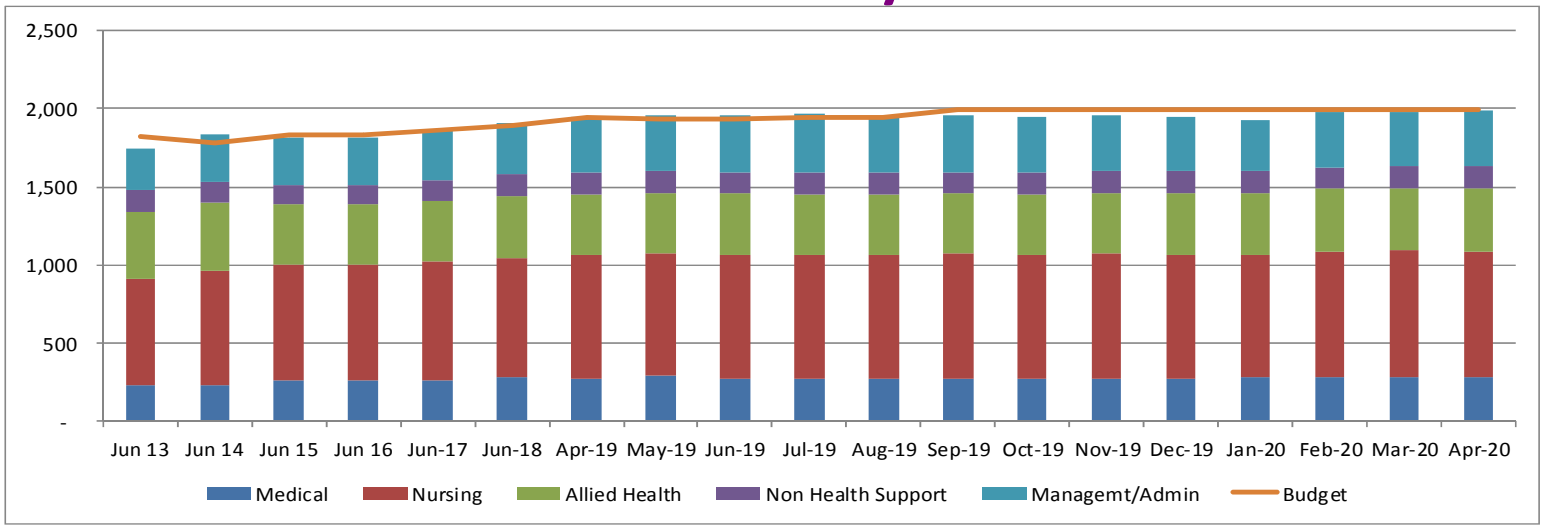
Nursing over by (11) FTE for the month , this included the partial impact of 66 FTE on COVID-19 leave of which 3 FTE were Casual staff. Internal Bureau Nurses are over budget (12) FTE mostly driven by ED (8), Plastics (4), Maternity (3) and other variances. Internal Bureau Nursing variances are driven by one to one care demands. Health Care Assistants under budget by 2, Registered Midwives are over budget by (3) FTE. Registered Nurses under budget 2 FTE consistent with staff on leave. Personnel cost variance for YTD March ($1,067k) is the result of a price variance of ($983k) mostly overtime and time based allowances.

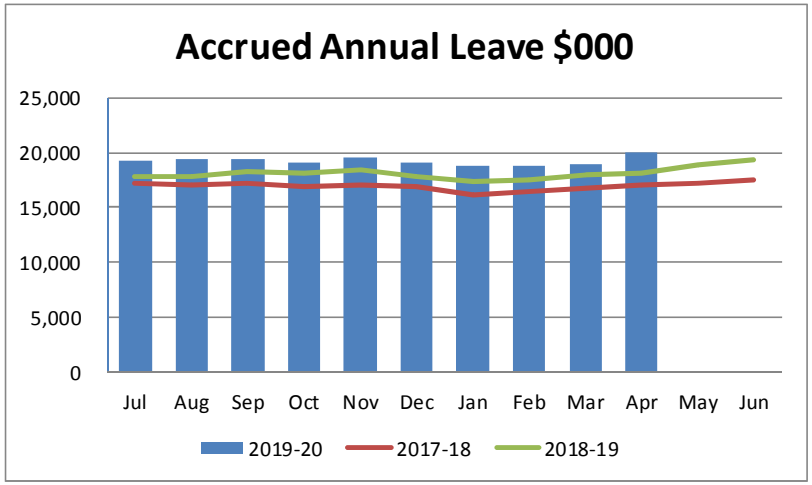
Allied FTEs are under by 6 FTEs for the month due in the main to; Favourable variances in Health promotion offices.

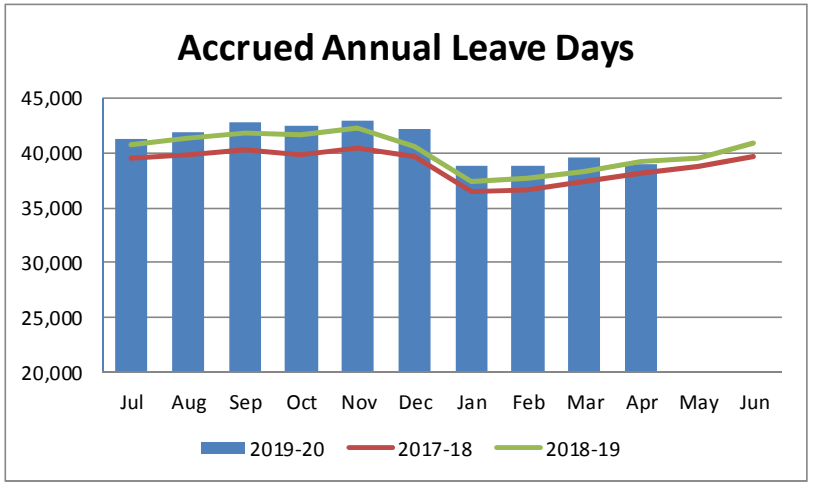
Support FTEs are (8) FTEs over budget driven by Food services (4) FTE and Clinical Services Supply (3), and other minor variances.

Management & Admin are under budget by 26 FTEs. Driven by administrative support staff vacancies and includes the capitalisation of 3 FTE's in April. Some roles are under outsourced personnel if they are now on the CCDHB payroll.

FTE Analysis







Analysis of operating position – other expenses

- **Other Operating Costs**
  - Outsourced other unfavourable ($253k) for the month, driven by Outsource Clinical Services ($256k), predominantly Ophthalmology.
  - Treatment related costs $375k favourable, driven by Treatment Disposables $108k, Instruments and Equipment $70k, Diagnostic and Sterile Supplies $16k, Implants and Prostheses $195k and other minor variances.
  - Non Treatment Related costs unfavourable ($86k) driven Security Costs ($164k), largely related to COVID19 ($148k) offset by other variances.
  - IDF Outflows $143k favourable for the month driven by current year wash-up payments.
  - Other External Provider costs favourable $185k, driven by Pharmaceuticals $1,501k, partly offset by Immunisation ($150k), Public Health ($1,326k) – mostly COVID-19 related and other minor variances.
  - Interest, Depreciation & Capital Charge favourable $267k, driven by the re-confirmation of the Capital charge for the 2019-20 Financial Year and lower than expected depreciation.

Section 5

ADDITIONAL FINANCIAL INFORMATION & UPDATES

Financial Position as at 30 April 2020

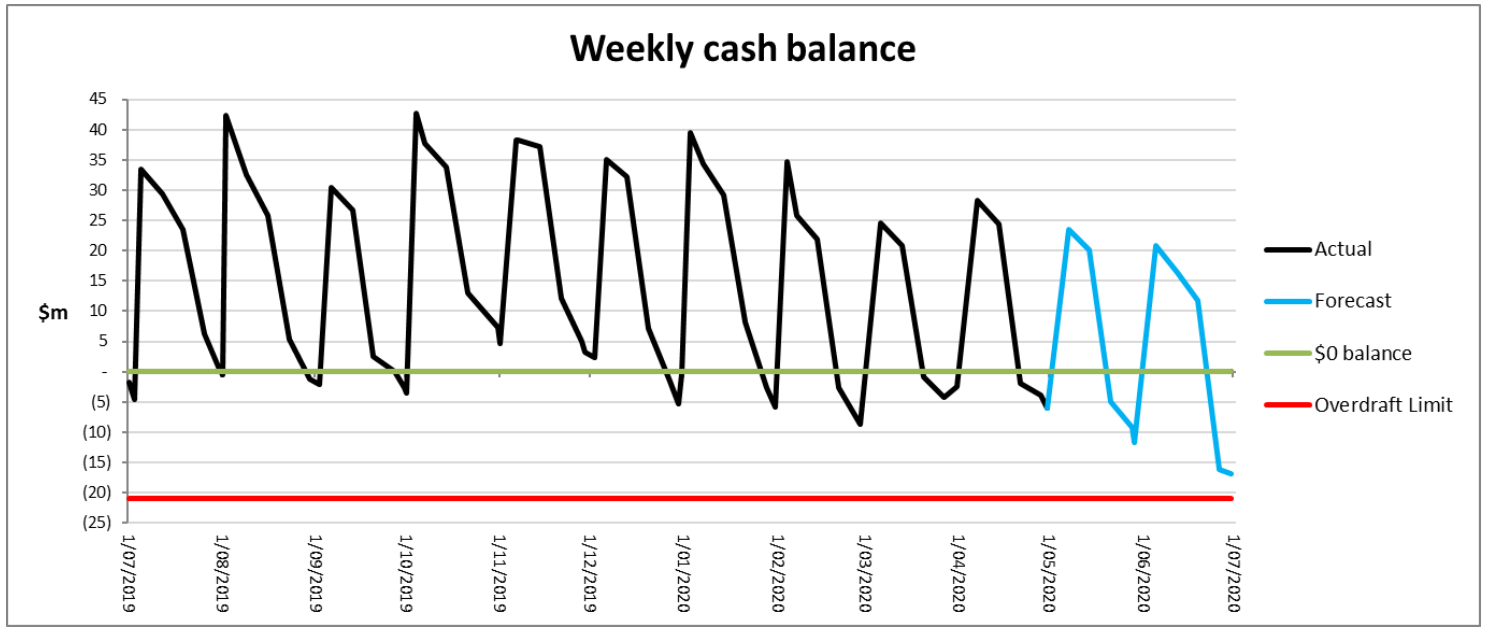
$000s	Actual	Budget	Variance	Jun 19	Variance	Explanation of Variances Between Actual and Budget
Assets						
Current Assets						
Bank - Non DHB Funds *	7,045	5,216	1,828	5,216	1,828	Payments from NHMG to DHB's paid later than budgeted
Accounts Receivable & Accrued Revenue	30,437	27,045	3,392	27,095	3,342	
Stock	2,026	1,486	540	1,434	592	
Prepayments	1,104	727	377	727	377	
Total Current Assets	**40,612**	**34,475**	**6,137**	**34,473**	**6,139**	
Fixed Assets						
Fixed Assets	208,085	208,686	(601)	210,483	(2,398)	
Work in Progress	18,132	19,710	(1,578)	19,710	(1,578)	
Total Fixed Assets	**226,217**	**228,397**	**(2,180)**	**230,193**	**(3,976)**	
Investments						
Investments in Associates	1,150	1,150	0	1,150	0	Allied Laundry
Trust Funds Invested	1,685	1,409	276	1,409	276	Restricted trusts
Total Investments	**2,835**	**2,559**	**276**	**2,559**	**276**	
Total Assets	**269,664**	**265,431**	**4,233**	**267,225**	**2,439**	
Liabilities						
Current Liabilities						
Bank	5,939	6,952	1,013	1,433	(4,506)	Average bank balance in Apr-20 was $12.6m
Accounts Payable and Accruals	55,906	52,164	(3,742)	52,164	(3,742)	Higher than budgeted accrued expenses
Crown Loans and Other Loans	13	221	208	221	208	
Capital Charge Payable	3,360	0	(3,360)	0	(3,360)	
Current Employee Provisions	25,868	24,190	(1,677)	24,190	(1,677)	
Total Current Liabilities	**91,086**	**83,528**	**(7,558)**	**78,009**	**(13,078)**	
Non Current Liabilities						
Other Loans	220	0	(220)	0	(220)	
Long Term Employee Provisions	8,245	8,245	0	8,245	0	
Non DHB Liabilities	7,045	5,216	(1,828)	5,216	(1,828)	Payments from NHMG to DHB's paid later than budgeted
Trust Funds	1,674	1,409	(265)	1,409	(265)	
Total Non Current Liabilities	**17,183**	**14,870**	**(2,313)**	**14,870**	**(2,313)**	
Total Liabilities	**108,269**	**98,398**	**(9,871)**	**92,879**	**(15,391)**	
Net Assets	**161,395**	**167,033**	**(5,638)**	**174,346**	**(12,952)**	
Equity						
Crown Equity	124,123	124,123	0	124,123	0	
Revaluation Reserve	126,422	126,422	0	126,422	0	
Opening Retained Earnings	(76,199)	(76,199)	(0)	(56,323)	(19,876)	
Net Surplus / (Deficit)	(12,952)	(7,314)	(5,638)	(19,876)	6,924	
Total Equity	**161,395**	**167,033**	**(5,638)**	**174,347**	**(12,952)**	

* NHMG - National Haemophilia Management Group

Statement of Cash Flows to 30 April 2020

$000s	Jul Actual	Aug Actual	Sep Actual	Oct Actual	Nov Actual	Dec Actual	Jan Actual	Feb Actual	Mar Actual	Apr Actual	May Forecast	Jun Forecast
Operating Activities												
Government & Crown Agency Revenue	39,286	38,734	39,537	38,354	39,000	39,508	38,611	37,686	39,520	40,064	39,759	39,095
Receipts from Other DHBs (Including IDF)	8,191	8,284	7,981	15,604	9,403	11,289	7,699	8,968	7,914	3,314	8,555	8,890
Receipts from Other Government Sources	1,100	1,188	(134)	1,210	774	180	340	555	467	634	646	675
Other Revenue	1,472	553	(406)	738	(1,975)	(608)	1,419	990	21	420	380	385
Total Receipts	**50,049**	**48,759**	**46,978**	**55,906**	**47,202**	**50,368**	**48,070**	**48,200**	**47,922**	**44,433**	**49,341**	**49,045**
Payments for Personnel	(18,535)	(17,294)	(15,756)	(17,871)	(16,974)	(18,656)	(17,957)	(16,467)	(16,295)	(19,656)	(17,396)	(18,193)
Payments for Supplies (Excluding Capital Expenditure)	(1,524)	(6,314)	(6,549)	(3,500)	(4,315)	(4,426)	(6,511)	(6,636)	(4,336)	(1,790)	(6,163)	(5,777)
Capital Charge Paid	0	0	0	0	0	(5,244)	0	0	0	0	0	(5,040)
GST Movement	22	(297)	120	1,389	(1,537)	2,412	(2,162)	(391)	1,050	(676)	0	0
Payments to Other DHBs (Including IDF)	(8,416)	(8,221)	(7,778)	(9,363)	(7,921)	(8,151)	(7,881)	(8,118)	(8,594)	(8,291)	(8,757)	(8,434)
Payments to Providers	(18,044)	(18,060)	(17,755)	(15,737)	(19,590)	(18,745)	(18,343)	(19,119)	(12,609)	(16,771)	(18,930)	(17,787)
Total Payments	**(46,498)**	**(50,186)**	**(47,719)**	**(45,083)**	**(50,337)**	**(52,809)**	**(52,854)**	**(50,730)**	**(40,785)**	**(47,183)**	**(51,246)**	**(55,230)**
Net Cashflow from Operating Activities	**3,551**	**(1,427)**	**(741)**	**10,823**	**(3,135)**	**(2,440)**	**(4,785)**	**(2,530)**	**7,137**	**(2,750)**	**(1,905)**	**(6,185)**
Investing Activities												
Interest Receipts	26	22	16	23	27	18	14	6	5	1	46	46
Dividends	0	47	0	0	0	0	0	65	0	0	0	0
Total Receipts	**26**	**68**	**16**	**23**	**27**	**18**	**14**	**71**	**5**	**1**	**46**	**46**
Capital Expenditure	(1,708)	(132)	(758)	(912)	(874)	(892)	(1,137)	(105)	(851)	(830)	(1,736)	(824)
Increase in Investments and Restricted & Trust Funds Assets	(75)	(82)	106	(32)	(19)	0	35	(208)	(6)	4	0	0
Total Payments	**(1,782)**	**(213)**	**(652)**	**(944)**	**(893)**	**(891)**	**(1,102)**	**(313)**	**(858)**	**(826)**	**(1,736)**	**(824)**
Net Cashflow from Investing Activities	**(1,756)**	**(145)**	**(635)**	**(922)**	**(867)**	**(873)**	**(1,089)**	**(242)**	**(853)**	**(825)**	**(1,690)**	**(778)**
Financing Activities												
Interest Paid on Finance Leases	(1)	(1)	(1)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(5)	(5)
Total Payments	**(1)**	**(1)**	**(1)**	**(0)**	**(0)**	**(0)**	**(0)**	**(0)**	**(0)**	**(0)**	**(5)**	**(5)**
Net Cashflow from Financing Activities	**(1)**	**(1)**	**(1)**	**(0)**	**(0)**	**(0)**	**(0)**	**(0)**	**(0)**	**(0)**	**(5)**	**(5)**
Total Cash In	50,075	48,827	46,995	55,928	47,229	50,386	48,083	48,270	47,927	44,434	49,386	49,091
Total Cash Out	(48,280)	(50,400)	(48,371)	(46,027)	(51,231)	(53,700)	(53,957)	(51,043)	(41,642)	(48,009)	(52,987)	(56,060)
Net Cashflow												
Opening Cash	(1,433)	362	(1,211)	(2,588)	7,313	3,311	(3)	(5,876)	(8,649)	(2,364)	(5,939)	(9,540)
Net Cash Movements	1,795	(1,573)	(1,376)	9,901	(4,002)	(3,314)	(5,873)	(2,773)	6,285	(3,575)	(3,600)	(6,969)
Closing Cash	**362**	**(1,211)**	**(2,588)**	**7,313**	**3,311**	**(3)**	**(5,876)**	**(8,649)**	**(2,364)**	**(5,939)**	**(9,540)**	**(16,508)**

Weekly Cash Flow
Actual to 30 April 2020



Note

- the overdraft facility shown in red is set at $21 million as at April 2020
- the lowest bank balance for the month of March was $5.9m overdrawn

Capital Expenditure
Actual to 30 April 2020

- Capital projects are behind plan and not expected to catch up during this financial year due to limited technical resource availability.
- A 3DHB Digital and Data Intelligence Governance Group has been set up to guide future ICT strategy and investment.
- Capital projects from 20/21 have been brought forward if required to mitigate COVID-19 risk areas, Other less urgent 19/20 capital projects will be delayed.

Project description	Budget rolled over from 2018/19	New budget for 2019/20	Committed costs from prior year approved projects budget	Total maximum spend in 2019/20	Actual 2019/20 spend till date	Remaining funds available in 2019/20
	$000	$000	$000	$000	$000	$000
Baseline						
Buildings and Plant	1,545	3,355	1,532	6,432	2,014	4,418
Clinical Equipment	215	3,500	948	4,663	2,700	1,964
Information Technology (Hardware)	100	750	372	1,222	503	718
Intangible Assets (Software)	932	625	950	2,507	514	1,994
Baseline Total	**2,792**	**8,230**	**3,802**	**14,824**	**5,731**	**9,093**
Strategic						
Buildings and Plant	1,185	480	-	1,665	-	1,665
Clinical Equipment	1,390	1,500	716	3,606	523	3,083
IT	2,394	2,750	1,173	6,317	707	5,610
Strategic Total	**4,969**	**4,730**	**1,889**	**11,588**	**1,230**	**10,358**
Total Capital (excluding Trust & Covid-19 Funds	**7,761**	**12,960**	**5,691**	**26,412**	**6,961**	**19,451**
Covid-19 Emergency					275	
Total Capital (excluding Trust)					**7,235**	

Summary of Leases – as at 30 April 2020

		Original Cost	Monthly Amount	Annual Amount	Total Lease Cost	Start Date	End Date	Lease type
Rental Property Leases	**Occupants**							
Wainuiomata Health Centre	District Nurses		1,149	13,787		1/11/2017	31/10/2020	Operating
Public Trust House Lower Hutt	Community Mental Health		21,887	262,643		1/09/2017	1/09/2023	Operating
CREDS - Johnsonville	Eating Disorders		5,370	64,435		1/01/2015	Rolling lease	Operating
RPH - Porirua Public Health	RPH School Health - Promotional Health		9,088	109,055		15/03/2015	14/03/2021	Operating
Criterion Lane Upper Hutt	Lagans Pharmacy - Physiotherapy		2,363	28,359		5/01/2019	31/12/2020	Operating
CBD Towers Upper Hutt	Community Mental Health		9,854	118,247		8/06/2015	7/06/2021	Operating
Upper Hutt Health Centre	District Nurses		974	11,688		24/01/2015	1/02/2022	Operating
			50,685	**608,214**				
Car Park Leases								
CBD Towers Upper Hutt			542	6,500		8/06/2015	7/06/2021	Operating
Public Trust House Lower Hutt			1,603	19,240		1/09/2017	1/09/2023	Operating
St Peters (SPO)			270	3,240		Ongoing	Ongoing	Operating
			2,415	**28,980**				
Motor Vehicle Leases								
Motor Vehicle Lease plus Management Fees (115 Vehicles)			33,329	399,946		Ongoing	Ongoing	Operating
			33,329	**399,946**				
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
Theatre Equipment (FAR0135105)	All Leasing (paid quarterly in advance)	98,266	2,904	34,850	104,550	1/07/2017	1/07/2020	Finance
Plastics Micro Power Tools	Stryker New Zealand Ltd	293,188	3,490	41,884	125,652	1/10/2018	30/09/2025	Finance
Orthopaedic Tools	Stryker New Zealand Ltd		9,024	108,292	758,044	1/09/2016	31/08/2023	Operating
3 x Ultrasounds (Equigroup)	GE Healthcare Ltd		7,303	87,641	438,205	28/06/2017	28/06/2022	Operating
1 x Ultrasound (Equigroup)	Philips NZ Commercial Ltd		1,761	21,129	105,645	28/08/2017	28/07/2022	Operating
CT Scanner (Equigroup)	Toshiba Medical Systems		24,976	299,711	1,498,555	28/05/2017	28/05/2022	Operating
		391,454	**81,709**	**980,525**	**4,965,741**			
Total Leases			**168,138**	**2,017,665**				

Treasury as at 30 April 2020

1) Short term funds / investment ($000)

NZHP banking activities for the month	Current month ($000)	Last month ($000)
Average balance for the month	$12,637	$9,638
Lowest balance for the month	($5,953)	($9,501)
Average interest rate	0.09%	0.61%
Net interest earned for the month	$1	$5

2) Hedges

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

3) Foreign exchange transactions for the month ($)

No. of transactions involving foreign currency	2
Total value of transactions	$16,916 NZD
Largest transaction	$15,729 NZD

	No. of transactions	Equivalent NZD
AUD	2	$16,916
GBP		
SGD		
USD		
Total	**2**	$16,916

4) Debtors ($000)

Top 10 Debtors	Outstanding	Current	1-30 Days	31-60 Days	61-90 Days	91-120 Days	121-180 Days	181+ Days
Capital & Coast District Health Board	$2,692	$248	$244	$149	$164	$38	$67	$1,783
Ministry of Health	$1,714	$974	$27	$33	$271	$23	$321	$66
Wairarapa District Health Board	$871	$4	$0	$28	$34	$61	$218	$527
Accident Compensation Corporation	$574	$304	$38	$23	$50	($119)	$184	$95
Wellington Southern Community Laboratories	$108	($4)	$107	$2	$3	$0	$0	$0
Health Workforce NZ Limited	$57	$0	$57	$0	$0	$0	$0	$0
Non Resident	$53	$0	$0	$0	$0	$0	$0	$53
Oranga Tamariki - Ministry for Children	$42	$0	$0	$0	$42	$0	$0	$0
Te Awakairangi Health Network Trust	$41	$41	$0	$0	$0	$0	$0	$0
Otago Polytechnic Limited	$31	$0	$0	$0	$0	$9	$22	$0
Total Top 10 Debtors	**$6,184**	**$1,566**	**$473**	**$234**	**$564**	**$11**	**$811**	**$2,524**

Board Information - Public

July 2020

Children's Hospital Programme Update	
Action Required **The Board note:** (a) McKee Fehl are forecasting Project Handover on 16 July 2021. (b) The Engineering Services contractor has been appointed and project planning is underway with long lead items on order. (c) Grace Neill Block – L3 office area has been occupied. Final documentation being reviewed. (d) Wellington Regional Hospital – WBCC, Link Bridge & Raised Carpark roof Building Consents are being reviewed by Wellington Council.	
Strategic Alignment	A new children's hospital and reconfigured child health service will improve the health of our children.
Author	Thomas Davis, Executive Director Corporate Services
Endorsed by	Fionnagh Dougan, Chief Executive
Presented by	Thomas Davis, Executive Director Corporate Services
Purpose	Update on the progress of the New Children's Hospital Programme of work
Contributors	Sam Walker, Project Manager David Fullarton, Director Capital Projects
Consultation	NA

Executive Summary

1. The project has been further delayed by COVID-19. The full impact will be assessed as we move through COVID-19 levels 3 and 2.

Strategic Considerations

Service	The environment in which child health services are delivered will be greatly improved on completion of this programme of work.
People	The facilities provided by this project for staff will improve significantly on the current situation in the old children's hospital.
Financial	Programme funding provided by Mark Dunajtschik, Ministry of Health, Wellington Hospital Foundation and CCDHB. Programme cost to completion currently within budget.
Governance	NA

Engagement/Consultation

Patient/Family	Ongoing

Clinician/Staff	Ongoing
Community	Ongoing

Identified Risks

Risk ID	Risk Description	Risk Owner	Current Control Description	Current Risk Rating	Projected Risk Rating
	Refer risk section of attached paper				

Attachment/s

1. Appendix 1 Site Photos - March 2020

New Children's Hospital Programme Update

Health & Safety

Currently there are two active construction sites to report on:

1. Main construction site of McKee Fehl Construction (MFC)
2. Wellington Blood & Cancer Centre reconfiguration

There have been

- No reportable incidents.
- SiteSafe audit of MFC's site for June was conducted on the 1st of July. MFC have also continued to complete internal weekly audits
- The next SiteSafe audit will be will be conducted on the 23rd July 2020.

Benefactor progress

The Benefactor's builder, McKee Fehl Constructors (MFC), are progressing with the installation of the curtain walling, roof plant room structure, building services and internal wall framing. Offsite manufacturing & procurement continues. Updated site photos are included in Appendix 1.

Site Works carried out during June, includes, but not limited too;

- Removal of the tower crane from site.
- Completion of the roof plantroom structure – installation of roof sheeting commenced.
- South canopy completed.
- Level 4 balcony roof cantilever has been installed.
- Façade and roofing works remain a high priority.
- Services installations to L2 and L3 are progressing well.
- Internal partition framing are continuing on L2 (80%) and L3 (60%) – L4 has commenced (5%).
- Roof balustrade installed to 70% of roof along with vapour barrier to the same area.

Site Works planned for July includes;

- Complete erection of stair 03 & installation of stair tread. Commence stair 02 installation.
- Lift structure install.
- Roof insulation and membrane installation (to 80% of area).
- Continue internal partition and services installation on all floors.
- Curtain walling areas nearing completion.

Design

New Children's Hospital project:

- Shop drawings and technical reviews are being completed regularly.
- No specific design updates for this period.

L3 Link & Blood and Cancer Centre Reconfiguration

- **New Blood and Cancer office space - Grace Neill Building level 3 (GNB)**
  - Wellington Blood and Cancer Centre moved in 11-16 March.
  - Only minor works remain outstanding.

- **Wellington Regional Hospital Building Level 3 Link and WBCC Day Ward Reconfigurations (WRH)**
    - Certificate for Public Use application approved and inspected by WCC.
    - Detailed methodologies for hoardings and dust management completed.
    - Demolition, first fix to ceilings, seismic bracing to existing ductwork underway.
    - Consultant and construction contracts review, finalisation and preparation for signature is ongoing.
    - Communications are ongoing for enabling works programme in conjunction with Blood and Cancer Clinic.

Programme

Below is a summary of the project timeline & approximate percentage of works completed;

Task	Target Completion Date	% Complete on site (30/06/2020)	Comment
Demolition Works Project	02/05/2019	100%	Closed
Civil Diversions	16/08/2018	100%	Closed
Internal Reconfiguration works within Regional Hospital	01/03/2021	30%	GNB relocation works complete. WRH works in site set up phase.
Building Services Works Project (WRH), delivery phase	01/12/2020	10%	Contractor appointed, long lead items ordered.
FF&E, Identification of equipment & evaluation of costs	30/06/2019	100%	Next stage to be reporting in this table is; the Development - lists of items to be procured by CCDHB & the process of procurement.
Children's Hospital Construction phase: internal works commenced	25/08/2020	65%	Reflects the percentage of work completed. Practical Completion, as well as handover, is targeted for July 2021 See Milestone programme below.
New Children's Hospital Project – Soft fit out	8/03/2021	0%	Commencement of Time allocation allowance for the CCDHB to complete the final fit out / installation of FF&E and all training & Commission where required.

Programme Milestones as at 16/04/2020

Early delays with structural steel manufacturing have been addressed with additional resources and alternate methodologies. Recent delays due to weather (crane downtime) along with the current Covid-19 pandemic have shifted the anticipated construction completion date into June 2021.

CCDHB Wellington Children's Hospital Project - Milestone dates from MFC Construction Programme			
	MFC May PCG 2020		
Construction and Associated Activities	**Start**	**Complete**	**Current Status**
Design - Stages	28/05/2018	19/07/2021	Commenced (94%)
Approval of Budget and Development Deed Signed	3/09/2018	3/09/2018	Completed
Resource Consent	28/05/2018	25/07/2018	Completed
Building Consents (5 stages)	19/12/2018	12/06/2020	Commenced (97%)
Link Bridge & connection	3/06/2020	6/01/2021	Design Stage
External and Associated works (includes eastern carpark)	27/05/2020	3/02/2021	Design Stage
Construction	15/10/2018	21/06/2021	Commenced (65%)
Handover	21/06/2021	16/07/2021	Not due

New Children's Hospital
Site Progress Photos
To 30th June 2020

Exterior North & East Elevations

Exterior North & West Elevations

Exterior South & East Elevations

Roof plantroom

New Children's Hospital
Site Progress Photos
To 30th June 2020

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

Level 3 wall framing and services first fix

Level 2 wall framing and services first fix

Level 4 wall framing and services first fix

Board Decision – Public EXCLUDED

July 2020

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

Action Required

The Boards note, the Committee:

(a) Received the quarterly report on Te Pae Amorangi, Attachment 1.

(b) Received the quarterly report on Taurite Ora, Attachment 2.

(c) Received the quarterly report on Regional Public Health.

The Board approve, the following decisions endorsed by HSC:

Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region, Attachment 4.

(a) The final draft of the Pacific Health & Wellbeing Strategic Plan for the Greater Wellington region 2020-2025 with the following amendment:

a. The Strategic Plan must make more explicit connections to the other Strategic Plans that overlap, particularly the Disability plan.

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

Executive Summary

The decisions seeking Board approval have been endorsed by the Health System Committee (HSC) in their meeting on 22 July 2020. Amendments requested by the Committee are noted in the papers attached. The full papers can be located in the HSC Diligent Books.

Items worth noting for the Boards in this meeting include an update on COVID-19, Rheumatic Fever and the measles immunisation campaign.

Strategic Considerations

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

Engagement/Consultation

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

Identified Risks

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

Attachment/s

1. Te Pae Amorangi Update
2. Taurite Ora Update
3. Pacific Health and Wellbeing Strategy for the Greater Wellington Region

Board Discussion – Public

June 2020

Māori Health Team Te Pae Amorangi Update
Action Required **Board note:** (a) This report was submitted to the Health System Committee on 22 July 2020. (b) The key discussion points were: • A request to align Te Pae Amorangi with the recent 20 DHB Pro-equity Māori Recruitment Strategy. • Funding has been allocated in the Annual Plans for the implementation work planned in this Financial Year.

Strategic Alignment	Te Pae Amorangi, Our Vision for Change
Author	Kerry Dougall, Director Māori Health
Endorsed by	Fionnagh Dougan, Chief Executive
Presented by	Kerry Dougall, Director Māori Health
Purpose	Update on the implementation of Te Pae Amorangi from a Māori health team perspective. Highlight the organisational and reputational risks to the Hutt Valley DHB
Contributors	Carrie Maniapoto, Māori workforce Development Coordinator Rawiri Hirini, Pou Tikanga Elizabeth Lucie-Smith, Manager Health Intelligence & Decision Support
Consultation	N/A

Executive Summary

This report provides an update for the HVDHB board in relation to the implementation of Te Pae Amorangi.

Strategic Considerations

Service	The HVDHB environment and culture will be improved as a result of this work.
People	Staff will have greater access to resources and services to support their own growth and development and to support their teams.
Financial	Inequitable Māori health outcomes have a direct impact on the financial performance of the DHB. Te Pae Amorangi is a strategic enabler to provide long term cost savings.

Governance	Māori health expertise needs to be strengthened at every level of the system to create the sustainable change which will impact outcomes.

Engagement/Consultation

Patient/Whanau	Targeted involvement with Māori whanau occurs through the Māori health teams
Clinician/Staff	Ongoing involvement with a wide range of staff
Community	Ongoing active relationships and engagement with Māori communities and leaders

Identified Risks

Risk ID	Risk Description	Risk Owner	Current Control Description	Current Risk Rating	Projected Risk Rating
	Māori Health Equity is under prioritised	HVDHB Board ELT	We have completed a Bowtie risk assessment to identify risks and mitigation strategies		

Attachment/s

1. Māori Health Data Dashboard
2. COVID-19 Māori Health Action Plan

1. BACKGROUND

Te Pae Amorangi was launched in July 2019 to support culture and system change, with a focus on achieving improved Māori health outcomes within nine years.

Te Pae Amorangi explicitly builds on the principles for decision-making provided in *Our Vision for Change*. We know that how we deliver health services has a big impact on health outcomes and so we will look at how we invest, how we work in partnership with and across our communities, and how we engage across the sector.

For the next nine years we will focus our efforts and investments in five key focus areas, including:

- Workforce
- Organisational Development and Cultural Safety
- Commissioning
- Mental Health and Addictions
- First Thousand Days

By identifying and investing in these focus areas we will challenge the 'status quo' and redefine the long standing 'cultural norms' of our organisation that no longer support us to achieve our goals.

2 TE PAE AMORANGI HUTT VALLEY DHB MĀORI HEALTH STRATEGY

2.1 Te Pae Aronga Tuatahi – Increasing Our Māori Workforce across the System

2.1.1 Hutt Valley DHB collaborates with Career force

Career force is dedicated to assisting young people into a career in the health & wellbeing, and social & community sectors. Their Gateway Programme is a work placement initiative for senior school students (Year 11 to 13) funded by the Tertiary Education Commission.

Hutt Valley DHB are piloting a work placement from Hutt Valley High School, a young wahine Māori who has a desire to be a nurse. The aim is to take our learnings from the pilot and improve our internal processes so we can commit to a schedule of work placements in 2021, with Māori and Pacific students taking priority to reflect our commitment to a workforce that reflects our population.

The programme is aimed at introducing students to a variety of career options and providing them with an opportunity to access workplace learning. Students' learning is assessed in the workplace and they can achieve credits on the New Zealand Qualifications Framework (NZQF) towards their National Certificate of Educational Achievement (NCEA).

Our pilot student will start in July 2020 with 10 days of work experience over 10 weeks.

2.1.2 Tuakana Teina Māori Leadership Model Launch

Utilising Matariki as a platform for launching this new Māori workforce initiative, we launched our Tuakana Teina programme on 14 July. Bringing together Māori workforce from across all disciplines

to celebrate the New Year ahead and plan for mobilising our people. This new initiative focuses on growth and development from a Te Ao Māori perspective for all Māori staff across the DHB.

Our Māori Workforce Development Co-ordinator has worked with a wide range of stakeholders to develop and implement a leadership development program focused on the growth and sustainability of Māori, incorporating Te Ao Māori worldviews on a wide range of topics including

- Rangatiratanga
- Kawangatanga
- Tikanga
- Kaiako and Tauira

There were 35 staff in attendance from across the disciplines, and the plan is to increase the momentum, mobilise Māori participation and support the Māori workforce to thrive. Over the coming year, events have been planned to grow this initiative, including deeper connections with Māori across the community.

2.1.3 Pipeline for Rangatahi Māori

We are partnering with Tihei Rangatahi, a Kaupapa Māori Youth Hub in Wainuiomata to identify opportunities to develop a health workforce focus for young Māori. We have deliberately focused this in Wainuiomata as this is the only area that has a Kaupapa Māori youth hub, and they already have a range of options developed. We are working with them to identify the value add across the community with the range of initiatives on offer for Māori. This includes

- Hutt Sciences in schools
- Māori and Pacific focused whanau hui through schools
- Tihei Rangatahi education events

We are also preparing HVDHB Tuakana Teina model to offer this as a program to all years 11, 12 and 13 rangatahi Māori across the Hutt Valley, launching in February 2021.

They will be offered kanohi ki te kanohi with a health professional working in their area of interest to:

- Seek assistance with career pathway planning
- Receive advice and real life experience that cannot be given in a brochure
- Bring along their whanau as their whanau will be their key support system while they are studying
- Ask any questions that are relevant to them and their future dreams.

2.1.4 Pro Māori equity recruitment processes

A small working group to drive a collective approach across the two DHBs has been developed. Scope and explicit actions/outcomes have been defined. While there is still much work to be done in this area some small wins that we can celebrate are:

- All Hutt Valley DHB roles are now advertised using Te Reo Māori translations for the role title
- All Hutt Valley DHB roles will now be advertised using a kowhaiwhai unique and distinct to Hutt and Capital and Coast DHBs

- When applying for a role at Hutt Valley DHB choosing an ethnicity is now mandatory, and not optional as it has been in the past.

The project team is working through the wide list of commitments made by the 20 DHB CEOs and Te Tumu Whakarae. As 2DHBs we are behind on the reporting requirements and are working through how to collect this information from our current systems, as well as how we develop training specific to hiring managers.

2.2 TE PAE ARONGA TUARUA – ORGANISATIONAL DEVELOPMENT AND CULTURAL SAFETY

2.2.1 Te Kawa whakaruruhau – Māori Cultural Safety Training

As an agency of the Crown and under the auspices of Te Tiriti o Waitangi we have an obligation to protect the health of Māori and we have an opportunity to be an active partner in supporting their right to healthcare and a health system that is fair, adequate and appropriate.

Our aspiration is that everyone who works with and for us will be culturally safe, highly skilled and knowledgeable around Māori health, equity and our local community needs. We will implement training that ensures all DHB employees are responsive to whānau Māori and understand the ongoing impacts of colonisation and its effects on health status. Most importantly employees will know and understand how they can contribute to a more equitable environment.

Te Kawa Whakaruruhau is posited within a Māori pedagogy and seeks to take the best of both the Māori and Pākehā worlds and combine them to produce an interesting and thought-provoking training programme for HVDHB staff and employees.

In response to Te Pae Amorangi, Our Vision for Change and the current shift in the health sector we will deliver training to all staff and employees of HVDHB in order to support and lift the competence and awareness of tikanga Māori practices by designing, developing and delivering Māori cultural safety training for the HVDHB workforce. Alongside this the Māori Health Team will also provide advice and guidance, where applicable, to HVDHB staff, leaders, managers and board members with a view to addressing health inequities for Māori.

We are indebted to the ground-breaking PhD dissertation “Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu.” and the ongoing Treaty work of Irihapeti Ramsden and others who have laid the foundation for us to strive even further.

The key objectives over the next 12 months are to:

- Launch the first of a suite of training modules consistent with tikanga Māori for delivery across all vocations within HVDHB. The launch date is set for Monday 27th July during HVDHB pōwhiri and orientation process.
- Define and develop a clear suite of options which include an online presence, face to face, shorter or longer, internal or external and marae based modalities.
- Deliver and evaluate the effectiveness of training for HVDHB employees.
- Design and implement key measures for equity, including key performance Indicators and policy or procedural changes where necessary in order to compliment training outcomes.
- Lift the awareness amoungst HVDHB staff of local history, New Zealand history, marae kawa, kōrero tawhito and te reo me ōna tikanga

2.2.2 Bilingual Signage Project

The Project ownership sits within property, and has not made any gains or progress forward. From a Māori Health team perspective we are developing a principle framework to ensure the active practice of the Treaty principles are maintained throughout any initiatives. And are working through how we enable all departments and services across the HVDHB to be active within their space.

We continue to work with the Project owners to support this and the focus will be on starting with the entrance ways, utilising Waharoa as a visual and wairua driven presences.

2.3 TE PAE ARONGA TUATORU – COMMISSIONING

2.3.1 Whānau Ora Partnership

1. Alongside the Strategy, Planning and Outcomes team, we are currently working with our two whanau ora providers to review their service specifications and reporting frameworks to support the ongoing development of partnerships and outcomes that are relevant to their communities.

2.3.2 Māori Leadership Engagement Framework

2. Through COVID we developed a Māori leadership alliance to work in partnership with our Māori communities to stop the transmission of COVID. From a longer term perspective this group is vital to a sustained approach to overarching service delivery.

2.3.3 Māori Health Dashboard

3. We are developing this alongside HVDHB Business Intelligence managers to inform the work we do across the system and to be transparent and accountability for the areas that need to improve for Māori health.

2.4 TE PAE ARONGA TUAWHĀ – MENTAL HEALTH AND ADDICTIONS – SCOPING PROJECT

2.4.1 Hutt Valley DHB Kaupapa Māori Mental Health Services

4. The purpose of this project is to scope the establishment of Kaupapa Māori mental health and addiction services for the Hutt Valley District Health Board (DHB) region. This will support the implementation of Te Pae Amorangi, Hutt Valley DHB Māori Health Strategy 2018-2027.[1]

   The approach will be implemented using Kaupapa Māori principles, with a strong focus on engaging early with Tangata Tiriti partners that will include, mana whenua, Māori NGO community providers, and key stakeholders, DHB mental health services, whanau and tangata whaiora and other groups identified along the progress of the project. This will ensure that there is a strong community and whanau voice incorporated throughout the project. While also identifying and forming key partnerships that will go on to support the establishment of the service.

   A literature review will be conducted to provide guidance on best practice models of care for Kaupapa Māori mental health and addiction services. Along with consultation with Kaupapa

Māori mental health and addiction services provided nationally to review, build on and adapt models currently used.

A report will then be produced that will provide a set of recommendations to develop and establish a Kaupapa Māori mental health and addictions service for the Hutt Valley region. This will include recommendations for governance, geographical location of the service, skill mix composition, model of care, and recommended quality measures.

The establishment of the service is not within the scope of this project and will be decided at the next phase.

2.5 TE PAE ARONGA TUARIMA – FIRST 1,000 DAYS

5. No specific updates in this area due to workforce shortages within Māori health

3. MĀORI HEALTH UNIT OPERATIONAL WORK

3.1 COVID19 Māori Health Actions

Eliminating health inequities for Māori and their whānau is fundamental to achieving our visions In Te Pae Amorangi. The inequities experienced by Māori who come into contact with our health system are well documented and are widely known across the health system.

The health system is tasked with ensuring that Māori are not left behind during this response and the government has given a clear message of its intention to address the inequities in the health system, particularly in its response to the findings of the Waitangi Tribunal in Stage one of the Wai 2575, the Health Services and Outcomes Inquiry.

We must be proactive to ensure we prioritise and focus on equitable outcomes for Māori and others who have higher vulnerabilities, including Pacific peoples and those living with disabilities.

Clearly, our context has evolved over the past 100 years, but as Wai 2575 highlights, the significant inequities for Māori continue. These two factors are driving iwi, hapu, whānau and the health system to ensure that Māori responses are focused on throughout the COVID-19 response.

Embedding equity for Māori and the principles of Te Tiriti as a structuring framework for all COVID-19 decision-making is critical to ensuring that existing inequitable outcomes are not exacerbated; tangata whenua are actively protected; and the injustices wrought by previous pandemics in Aotearoa are not repeated.

To achieve this we developed a COVID-19 Māori Response Action Plan which outlines the following objectives that are inspired by *Te Pae Amorangi.*

- We will work to advance our Treaty relationships with mana whenua, iwi and Māori.
- We will promote and lead cross-sectorial approaches to support the holistic wellness of whānau.
- Culturally safe service provision is a key component of HVDHB practices for whānau and staff.
- We will champion Māori health equity to ensure it is woven through everything we do, including our policies, practices, norms and organisational culture.
- We will champion the collection, analysis and use of robust data.

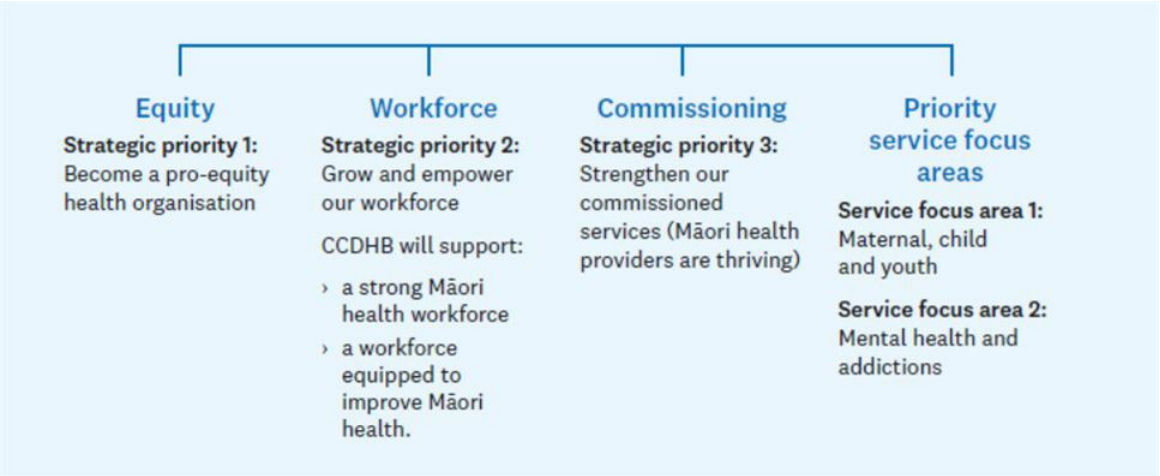
Board Discussion – Public

July 2020

Taurite Ora – Second Report, Update from December 2019	
Action Required **The Board note:** (a) This report was submitted to the Health System Committee on 22 July 2020. (b) The key discussion points were: • The Governance group will be set up over the next month. • Ethnicity data protocols are being used. • Funding has been allocated in the Annual Plans for the implementation work planned in this Financial Year.	
Strategic Alignment	Taurite Ora aligns with the CCDHB Health System Plan 2030
Author	Arawhetu Gray, Executive Director Māori Health
Endorsed by	Fionnagh Dougan, Chief Executive
Presented by	Arawhetu Gray, Executive Director Māori Health
Purpose	Update on the ongoing progress to implement Taurite Ora
Contributors	Jeanette Harris, Project Manager, Māori Health
Consultation	N/A

Executive Summary

The Taurite Ora was officially launched in November 2019 at Maraeroa Marae, Waitangirua. Before the launch, a Project Manager was appointed to deliver on the action plan, which is at the heart of the Strategy. The action plan identifies the following three strategic priorities and two priority service areas:



Taurite Ora action plan also identifies five key measures of equity. These measures are linked to the pro-equity actions with the overall aim of reducing avoidable, inequitable outcomes for Māori:

1. Amenable mortality.
2. Avoidable hospital admission.
3. Accessible appointments.
4. Primary care utilisation (both enrolment and engagement).
5. Community-based services.

The proposition is that success across the strategy and the action plan will become visible in our hospital and community services. Mental Health, Addictions and Intellectual Disability services (MHAIDs) and Mother, Child and Youth (MCY) are service areas where data unequivocally demonstrates that inequitable outcomes for Māori are the norm. By initially focusing on these two areas, we believe that we can make a significant impact on the health outcomes that Māori experience at CCDHB.

Taurite Ora needs sustainable resourcing to continue. Short term, this means that the working group arrangement, agreed by ELG in December 2019 has to proceed as soon as possible. The Equity paper approved by ELG will be progressed to ELT and HSC so that the principles and goals it recommends can be operationalised. Our next report will update you on our success in attracting resources and our progress in delivering against Taurite Ora itself.

Strategic Considerations

Service	Taurite Ora is designed to impact across all levels of CCDHB.
People	Secondment of staff from across the organisation has been agreed.
Financial	Two to three year implementation cost is estimated at $0.5M
Governance	An Equity Leadership Group has been established however, the establishment of a Taurite Ora Governance Group is an outstanding action.

Engagement/Consultation

Patient/Family	None
Clinician/Staff	Clinical Leaders including CMO, Chief Nursing Officer. Members of the Executive Leadership Team.
Community	Taurite Ora was widely consulted and has been endorsed by CCDHB Board and the Māori Partnership Board. Consultation was also undertaken with Kaupapa Māori Providers, Māori academics, and clinicians.

Identified Risks

Risk register for Project Management and an individual register for Outcome Areas will be developed by the Māori Health working group.

Attachment/s

1. Taurite Ora Action Plan (Year One Activities)

1. BACKGROUND/PREVIOUS BOARD DISCUSSION

1.1 A Taurite Ora update was provided to the Māori Partnership Board on 4 December 2019.

1.2 CCDHB began a Change Programme in late 2019. The people and other resources required to undertake the project were drawn from the same pool of resources that Taurite Ora is drawing on. Projects that fundamentally affect our staff have been prioritised and the delay to progress on Taurite Ora from this perspective was inevitable. COVID-19 has also impacted our progress, with the lockdown requiring staff to stay at home or to prioritise COVID-19 related work.

1.3 Work began on the Taurite Ora action plan before the official launch. This involved identifying work streams that could start immediately and reaching agreement with project leads about what we would achieve in the first 12 months.

2. CURRENT STATE

2.1 Since 4 December 2019, then there has been some progress, but overall, the Project has stalled.

2.2 We have not appointed a Governance Group for Taurite Ora, to oversee the implementation of the Action Plan. Noted later in this paper, an Equity leadership Group (ELG) has been convened by the Māori Health Directorate to lead the Equity actions in strategic priority one.

2.3 Given the organisational change work is progressing across parts of CCDHB, and we have moved to response level 1 in relation to COVID-19, we look forward to a renewed focus on Taurite Ora.

Current resources

2.4 The Executive Director Māori Health (EDMH) has appointed a full-time Project Manager to oversee the implementation of Taurite Ora.

2.5 A lead advisor has been engaged to begin the first phase of Taurite Ora. This role is focused on the development of a single Equity goal and additionally developing a set of guiding equity principles for CCDHB.

2.6 Equity in this context is broader than Taurite Ora and will include equity for groups such as Pacific and disability. Therefore, while the Māori Directorate completed the initial work, responsibility for delivering on this part of the project will return to the Director Strategy, Planning and Performance.

2.7 The EDMH has given Taurite Ora project responsibilities to the Manager, Māori Health, Capability and Manager Accountability, to progress.

2.8 Maternal, child and youth have assigned a 0.5 project manager responsible for delivering on Taurite Ora from the permanent staff team.

2.9 Mental Health, Addictions and Intellectual Disabilities (MHAIDs) has nominated a project manager from its permanent staff to lead Taurite Ora and are finalising the initiation plans for each.

Ongoing commitment to Taurite Ora

2.10 At the ELG meeting in December 2019 it was agreed that a working group from key areas/disciplines including Maori, Pacific, Disability, Clinical, and the Provider arm, Human Resources / Organisational Development/People & Capability needed to be included inthe project.

2.11 It is likely that the same staff will continue to work on Taurite Ora projects as part of their business as usual for a period of 12 – 18 months. Without this commitment progress on Taurite Ora inside the DHB is hindered.

3. SUMMARY OF ACTION PLAN PROGRESS

3.1 There are 91 activities and a similar number of sub-activities in the Taurite Ora Action Plan. A table in Appendix One provides the current state of play for first year activities.

3.2 The scale and complexity of the Action Plan has been addressed by breaking it into three tranches:

- Actions that are high priority in year one.
- Actions that are a lower priority in year one.
- Actions that will start in years 2 - 4.

3.3 This year we will also re-engage with Flax Analytics to strengthen the measurement framework in the action plan. Their work will be prioritised to align with the tranches we have identified.

Strategic projects and Service area projects

3.4 The actions set out in Strategic Priority one in particular, and to a lesser extent, Priority two, spell out the conditions necessary for CCDHB to become a pro-equity organisation. Many of these activities are to be finished in year one in order for some other actions to be undertaken.

3.5 For public-facing communications, the Maternal, Child and Youth work stream includes a requirement that CCDHB should apply an equity lens to its Maternity Quality Safety Programme.

3.6 The attached status report is abbreviated to the following: Action required; Completed; On-track or at Start-up. There are also projects in the MHAIDS work stream that we are reviewing in terms of scope. These will be updated in our next report.

Detailed updates on Action Plan Priorities, Outcomes and Outputs

3.7 These activities have stalled and have slowed progress across other activities as a result.

Strategic Priority 1: Outcome 1, Output 2 – Commit to a pro-equity programme of work

3.8 STATUS: In Progress

3.9 This activity describes the environmental changes CCDHB must adopt to become a pro-equity organisation.

3.10 A paper setting out Principles and a high-level Equity goal is under-going consultation with the Māori, Pacific and Disability teams. Once complete this will be provided to ELT and then to the Health System Committee (HSC).

3.11 The actions needed to complete this activity were agreed at the last meeting of the Equity Leadership Group (ELG) on 19 December 2019 and are outlined below.

- Paper to ELT and Health System Committee (HSC)
- Working group nominated by ELG members convened
- Consumer Rep for ELG nominated

3.12 Following the completion of this action, the next steps are the appointment of a working group nominated from the ELG service areas to develop the operational framework that translates principles into policies and practice guidelines. We also need to re-engage with the Project Lead and confirm his availability to continue the project.

Strategic Priority 1: Outcomes 1, outputs 3 – 6

3.13 STATUS: Pending

3.14 These activities describe changes to the key performance indicators at management and clinical leadership level.

3.15 New indicators at this level will leverage off the messages and language developed in Output 2 above. When appropriate resources are made available, a working group will be established to begin further work.

Strategic Priority 1: Outcome 4, output 1 – Implement an improvement programme to ensure CCDHB has high quality, complete and consistent ethnicity data for performance, monitoring and workforce development

3.16 STATUS: Pending

3.17 The actions to complete this activity mean changing the way we collect ethnicity data from our staff in the future so that we can target equity issues across the workforce.

3.18 A clear rationale showing if, and how, the activity will achieve the goal of a strong Māori health workforce is needed before we progress. The action required is to develop indicators measuring the cost/benefit of 'gold standard' ethnicity data compared to current data collection to measure its true value.

Strategic Priority 2: CCDHB will support a workforce equipped to improve Māori health – Outcome 1, output 1 – ***set core competencies and expectation for all staff to achieve health equity and improve Māori health outcomes***

3.19 STATUS: Progressing

Strategic Priority 3: Strengthen our commissioned services – Outcome 1, output 1 – ***the EDMH and EDSPP will develop a work plan that phases all of the actions that are led by SPP.***

3.20 STATUS: Progressing

Service focus area 1: Maternal, child & youth – Outcome 1, output 1 – ***CCDHB applies an equity lens to its MQSP work programme.***

3.21 STATUS: Progressing

Board DECISION – Public

July 2020

Final Draft - Pacific Health & Wellbeing Strategic Plan for the Greater Wellington region 2020-2025

Action Required

The HVDHB and CCDHB Boards approve:

(a) The final draft of the Pacific Health & Wellbeing Strategic Plan for the Greater Wellington region 2020-2025.

The Boards note:

(b) This final draft was endorsed by the Health System Committee at their meeting on 22 July 2020 with the following feedback and amendments required:

- A question was posed around the establishment of targets and it was noted targets would be developed as part of the implementation plan.
- It was noted the Strategic Plan must make more explicit connections to the other Strategic Plans that overlap, particularly the Disability plan.

(c) This final draft has been endorsed by the Wairarapa Board at their June meeting.

(d) The contents of the final draft Pacific Health & Wellbeing Plan, 2020-2025.

(e) The extensive community consultation undertaken by the DHB with the support and guidance of the Sub-region Pacific Heath Advisory Group.

(f) The Pacific Health & Wellbeing Plan, 2020-2025 is one of the key supporting plans for both Hutt Valley & CCDHB strategic direction and transformational change work being undertaken.

Strategic Alignment	Ministry of Health *Ola Manuia* Pacific Health Plan 2020-2025 CCDHB Health System Plan 2030 HVDHB Vision For Change 2017-2027 WrDHB Well Wairarapa –Better Health for All Vision 2017 Faiva Ora National Pacific Disability Plan Ministry of Pacific Peoples Priorities
Author	Tofa Suafole Gush, Director Pacific Health
Endorsed by	Fionnagh Dougan, Chief Executive Officer, CCDHB & HVDHB
Purpose	Seeking Health System Committee endorsement for Board approval of the final draft of the Pacific Health & Wellbeing Strategic Plan for the Greater Wellington region 2020-2025.
Contributors	Candice Apelu-Mariner, Integration Lead Pacific
Consultation	3DHB Sub Regional Pacific Strategic Health Advisory Group, Pacific communities in Wairarapa, Hutt Valley and Porirua.

Executive Summary

In November 2019, each of the three DHB boards approved the development of a 'Single Pacific Health and Wellbeing Plan' for the Greater Wellington region to guide and inform decision making around Pacific

people's health in all three District Health Boards. This is the first joint Pacific Health & Wellbeing Strategy for the 3DHBs of the Greater Wellington region.

The Pacific Health & Wellbeing Strategic Plan for the Greater Wellington region 2020-2025 (the Plan) outlines strategies to address some of the key areas of concern for Pacific Health. The six priorities identified have been developed through extensive consultation with Churches, community groups, Young people, Providers of Health services across the region and DHB workforce. The Plan provides a framework for reducing inequalities and strengthening Pacific Health outcomes. It is written to be easily understood by people in the community as well as providers of health services and their agency partners. The Plan recognises the importance of identifying the realities Pacific people face but does not focus on negative statistics.

Once the Plan is endorsed and approved it will be launched and implementation will commence in August 2020.

Strategic Considerations

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

Engagement/Consultation

Patient/Family	As part of community consultation.
Clinician/Staff	All 3DHB staff were given the opportunity to feedback on the draft
Community	Extensive community consultation with Churches, Pacific Providers and community groups throughout the greater Wellington region was undertaken. An online consultation process was utilised as well.

Identified Risks

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

Attachment/s

1. RESOURCE FOLDER: Final draft - Pacific Health & Wellbeing Strategic Plan for the Greater Wellington region 2020-2025.

3DHB Disability Services Advisory Committee

24th June 2020, 1:30pm – 4:00pm

Board Room, Level 11, Grace Neill Block, Wellington Hospital

Zoom ID: 982 8318 7898

Members Present		
Ana Coffey	Chair person	CCDHB
Yvette Grace	Member	WrDHB & HVDHB
Dr Tristram Ingham	Member	CCDHB
John Ryall	Member	HVDHB
Ayesha Verrall	Member	CCDHB
Vanessa Simpson	Member	CCDHB
Jill Pettis	Member	WrDHB
Ryan Soriano	Member	WrDHB
Jill Stringer	Member	WrDHB
Sue Emirali	Member	CCDHB

District Health Board Present		
Dale Oliff	Wairarapa District Health Board	Chief Executive Officer
Kadeen Williams		Executive Assistant
Sandra Williams		Executive Leader Planning and Performance
Fionnagh Dougan	Capital & Coast District Health Board	Chief Executive Officer
Nicola Holden		Director of Chief Executive Office
Amber igasia		Committee Liaison Officer
Rachel Noble		General Manager Disability
Arawhetu Gray		Director Maori Health
Fionnagh Dougan	(2DHB) Capital & Coast District Health Board / Hutt Valley District Health Board	Chief Executive Officer
Rachel Haggerty		Director Strategy Innovation & Performance
Rod Bartling	Hutt Valley District Health Board	Acting Group Manager, Strategy, Planning & Outcomes

Visitors / Guests	
Rachel Nobel	

1. Procedural Business

1.1 Karakia A.Gray took the Karakia today

1.2 Apologies As noted above

- The Committee **NOTED** apologies as above

1.3 Register of Interest

- The Committee **RESOLVED** to **APPROVE** the register from the previous meeting as true and accurate
- Any updates to be sent through to Board Liaison Officer

1.4 Minutes from previous meeting

- The Committee **RESOLVED** to **APPROVE** the minutes from the previous meeting as a true and accurate record

Moved	A.Coffey	**Seconded**	T.Ingham	**Carried**

1.5 Matters Arising

- First meeting for 2020 round robin introductions and focus is on Disability

1.6 Action List

- No further changes

1.7 Future Meeting Dates

The Committee **NOTED:**

- To be discussed at a later time

2. Presentation

2.1 3DHB Disability Strategy, Disability Charter and Learnings from Covid-19

The presentation was **NOTED** and **DISCUSSED** by the Committee

- **Noted** A large discussion on lived experiences for some members involved with the meeting
- **Noted** Inequity and what this means including getting to the meeting; booking interrupters, travel, reading materials, technology, location (with accessibility);
- **Noted** There is no one response fits all due to differences in disabilities, reasons, abilities, reasons etc.;
- **Noted** First Maori appointment within the Disability team has been made;
- **Noted** UN CRPD is the basis of requests "rights of person with a disability" there is a lot of good background information. Purpose is to provide guidance, reassurance and support for people with disabilities;
- **Noted** Rights of indigenous persons (US Declarations);
- **Noted** There is very limited research and information available for Maori with Disabilities;
- **Noted** Y2575 treaty claim is progressing and there will be some insightful reading items;
- **Noted** A co-designed 3DHB process to improve service offerings;
- **Noted** During the COVID-19 response there has been a number of learnings which need to be addressed for the future of equity in the Health and Disability Services;
- **Noted** Communications during the COVID-19 pandemic were happening fast and appropriate for the different language specifications to be accessible (Five languages, website etc.) this was a great opportunity to show what was possible and will improve responses going forwards;
- **Noted** Fitting in with the DHB Structure with Committees, advisory groups, 3DHB Focus groups and the Disability team sits within Strategy, Innovation and Performance;
- **Noted** Drivers for the Disability team are rights of persons with disabilities, equity, better health outcomes, presence, being valued, leadership and ease through the health journey;
- **Noted** Option to provide more training and knowledge to all DHB staff to allow better communication and interaction with our Disability community;
- **Noted** Accessibility Charter, this will be brought back to DSAC for further discussion and developed across central agencies. Further work on how DHBs can address this and implement the Charter for processes and systems for more equity in the Health Care system to be implemented over 5years; and
- **Noted** It is the DSAC's place to know the issues and to discuss and provide opportunities for learnings and improvements.

ACTIONS	• Load reports into the resource centre; Tangati wha, UN Conventions on rights of persons with Disability, Team presentation and Accessibility Charter, Living Life Well • Follow up on NASC service for who did not receive assistance • Include link "Ripeka Video Story"

3. Discussion

3.1 Update on New MoH Funding within MHAIDs

The report was taken as **READ**, **NOTED** and **DISCUSSED** by the Committee:

- **Noted** highlight the level of resources available as there is not enough resource available but it is still better than previous years
- **Noted** Primary care is able to provide more front line assistance for mental Health needs
- **Noted** The priority has been to strengthen what we have
- **Noted** Porirua does have resources available to work with current workloads within the current system and community
- **Noted** Tu Ora Compass are the funders for wellington. The Service that N.Fairley leads is a 3DHB service and there are current leadership model changes which will be led by CCDHB CEO.
- **Noted** Health improvement practitioners, two roles being established which is based on a model in Auckland.
- **Noted** WrDHB FTE is increasing and further information can be provided off-line

Moved	A.Coffey	**Seconded**	J. Rikihana	**Carried**
ACTION	Greater Wellington Region Collaborative (GWRC) name to be reissued due to confusion with other names			

General Business

- Meetings are usually held quarterly and would be helpful to have another meeting in the next two months
- Proposed next meeting to be held in September, Wednesday
- Updates from the November meeting to be raised and brought forward for approval/discussion and progressed
- DSAC to review and work to the work plan from the November 2019 meeting

ACTION	Extra administration discussion and work to be completed to address work plan, schedules and resources meeting etiquette to be developed for ensuring all members are incorporated

Meeting Closed: 4:18pm

CONFIRMED that these minutes constitute a true and accurate record dated

Capital and Coast DHB and Hutt Valley DHB

CONCURRENT Board Meeting

Meeting to be held on 29 July 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
CCDHB HDC Report: 1 July - 31 December 2019	As above	As above

HVDHB HDC Report: 1 July - 31 December 2019	As above	As above
FRAC items for Board approval	As above	As above
CCDHB and HVDHB Annual Plan	As above	As above
CCDHB and HVDHB Planned Care Plans	As above	As above
2DHB Digital Strategy	As above	As above
Change to existing Right of First Refusal process for the sale of CCDHB Land	As above	As above
Deed of Lease between CCDHB and MRINZ	As above	As above
2DHB Bow-Tie Analysis - Strategic Risk	As above	As above
HVDHB Financial and Operational Performance Report June 2020	As above	As above
CCDHB Financial and Operational Performance Report June 2020	As above	As above
HVDHB and CCDHB Health and Safety Reports	As above	As above
Mental Health Service Update	As above	As above
Maternity Service Review Update	As above	As above
People, Culture and Capability Update	As above	As above
New Children's Hospital Update	As above	As above
Haumietiketike Individual Service Units Quarterly Report	As above	As above
	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.