PUBLIC

AGENDA

Held on Wednesday 6 October 2021 Time: 9am
Location: Level 11 Boardroom, Grace Neill Block, Wellington Regional Hospital
Zoom Meeting ID: 876 5068 1844

2DHB CONCURRENT BOARD MEETING

	Item	Action	Presenter	Pg
1	**PROCEDURAL BUSINESS**			
1.1	Karakia		All members	2
1.2	Apologies	**NOTE**	Chair	
1.3	Public Participation Wellington Hospitals Foundation and Lions International (District 202m)	**NOTE**	Bill Day and Lions International Representative	
1.4	Continuous Disclosure 1.4.1 Board Interest Register 1.4.2 ELT Interest Register	**NOTE**	Chair	3 8
1.5	Minutes of Previous Concurrent Meeting	**APPROVE**	Chair	10
1.6	Matters Arising	**NOTE**	Chair	17
1.7	Chair's Report and Correspondence	**NOTE**	Chair	
1.8	Chief Executive's Report	**NOTE**	Chief Executive	18
1.9	Board Work Plan 2021/2022	**NOTE**	Chair	32
2	**DHB Performance and Accountability**			
2.1	HVDHB Financial and Operational Performance Report – July 2021 2.1.1 Report	**NOTE**	Chief Financial Officer Director Provider Services Director Strategy, Planning and Performance	35 38
2.2	CCDHB Financial and Operational Performance Report – July 2021 2.1.2 Report	**NOTE**	Chief Financial Officer Director Provider Services Director Strategy, Planning and Performance	86 89
3	**UPDATES**			
3.1	HSC update and items for approval from meeting dated 29/09/21	**NOTE**	Chair of HSC	132
3.2	DSAC update and items for approval from meeting dated 29/09/21		Chair of DSAC	134
4	**OTHER**			
4.1	General Business	**NOTE**	Chair	
4.2	Resolution to Exclude the Public	**APROVE**	Chair	136

Next concurrent Board meeting:
Date: Wednesday 3 November 2021, **Location:** Auditorium, Level 1 Clocktower Building, Hutt Hospital **Time:** 9.30am

Karakia

Kia hora te marino

Kia whakapapa pounamu te moana

Hei huarahi mā tātou i te rangi nei

Aroha atu, aroha mai

Tātou i a tātou katoa

Hui e! Tāiki e!

Translation

May peace be wide spread

May the sea be like greenstone

A pathway for us all this day

Let us show respect for each other

For one another

Bind us all together!

CAPITAL & COAST AND HUTT VALLEY DISTRICT HEALTH BOARDS

Interest Register

30/09/2021

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

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

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

Yvette Grace	• Member, Hutt Valley District Health Board • Member, Wairarapa District Health Board

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

	• Member, Te Ohu Rata o Aotearoa (Māori Medical Practitioners Association) • Wife, Member 3DHB Disability Advisory Group & Tāngata Whaikaha Roopu
Dr Chris Kalderimis	• National Clinical Lead Contractor, Advance Care Planning programme for Health Quality & Safety Commission • Locum Contractor, Karori Medical Centre • Contractor, Lychgate Funeral Home
Sue Kedgley	• Member, Consumer New Zealand Board
Ken Laban	• Chairman, Hutt Valley Sports Awards • Broadcaster, numerous radio stations • Trustee, Hutt Mana Charitable Trust • Trustee, Te Awaikairangi Trust • Member, Hutt Valley District Health Board • Member, Ulalei Wellington • Member, Greater Wellington Regional Council • Member, Christmas in the Hutt Committee • Member, Computers in Homes • Member, E tū Union • Commentator, Sky Television
Prue Lamason	• Councillor, Greater Wellington Regional Council • Chair, Greater Wellington Regional Council Holdings Company • Member, Hutt Valley District Health Board • Daughter is a Lead Maternity Carer in the Hutt
John Ryall	• Member, Social Security Appeal Authority • Member, Hutt Union and Community Health Service Board • Member, E tū Union
Naomi Shaw	• Director, Charisma Rentals • Councillor, Hutt City Council • Member, Hutt Valley Sports Awards • Trustee, Hutt City Communities Facility Trust
Vanessa Simpson	• Director, Kanuka Developments Ltd • Executive Director Relationships & Development, Wellington Free Ambulance • Member, Kapiti Health Advisory Group
Dr Richard Stein	• Visiting Consultant at Hawke's Bay DHB • Chairman and Trustee, Crohn's and Colitis NZ Charitable Trust • Member, Executive Committee of the National IBD Care Working Group • Member, Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy • Member, Muscular Dystrophy New Zealand (Central Region) • Clinical Senior Lecturer, University of Otago Department of Medicine, Wellington

	• Assistant Clinical Professor of Medicine, University of Washington, Seattle • Locum Contractor, Northland DHB, HVDHB, CCDHB • Gastroenterologist, Rutherford Clinic, Lower Hutt • Medical Reviewer for the Health and Disability Commissioner

CAPITAL & COAST AND HUTT VALLEY DISTRICT HEALTH BOARDS

Interest Register

EXECUTIVE LEADERSHIP TEAM

6 OCTOBER 2021

Fionnagh Dougan *Chief Executive Officer 2DHB*	• Board, New Zealand Child & Youth Cancer Network • Trustee, Wellington Hospital Foundation • Adjunct Professor University of Queensland
Rosalie Percival *Chief Financial Officer 2DHB*	• Trustee, Wellington Hospital Foundation
Joy Farley *Director Provider Services 2DHB*	• Nil
Rachel Haggerty *Director, Strategy Planning & Performance 2DHB*	• Director, Haggerty & Associates • Chair, National GM Planner & Funder
Arawhetu Gray *Director, Māori Health 2DHB*	• Co-chair, Health Quality Safety Commission – Maternal Morbidity Working Group • Director, Gray Partners • Chair, Tangata Whenua Advisory Group, Te Hiringa Hauora, Health Promotion Agency
Junior Ulu *Director, Pacific Peoples Health DHB*	• Member of Norman Kirk Memorial Trust Fund • Paid Member of Pasifika Medical Association
Helen Mexted *Director, Communications & Engagement 2DHB*	• Director, Wellington Regional Council Holdings, Greater Wellington Rail • Board member, Walking Access Commission • Partner owns Mexted Motors (supplies/services vehicles for the CCDBH)
John Tait *Chief Medical Officer 2DHB*	• Vice President RANZCOG • Ex-offico member, National Maternity Monitoring Group • Member, ACC taskforce neonatal encephalopathy • Trustee, Wellington Hospitals Foundation • Board member Asia Oceanic Federation of Obstetrician and Gynaecology • Chair, PMMRC • Director, Istar • Member, Health Practitioners Disciplinary Tribunal
Christine King *Chief Allied Health Professions Officer 2DHB*	• Brother works for Medical Assurance Society (MAS) • Sister is a Nurse for Southern Cross
Sarah Jackson *2DHB Acting Director Clinical Excellence*	• Nil
Rachel Gully *Director People, Culture & Capability 2DHB*	• NIL

Wednesday, 29 September 2021

Chris Kerr *Chief Nursing Officer 2DHB*	• Member and secretary of Nurse Executives New Zealand (NENZ) • Relative is HVDHB Human resources team leader • Relative is a senior registered nurse in SCBU • Relative is HVDHB Bowel Screening Programme Manager • Adjunct Teaching Fellow, School of Nursing, Midwifery and • Health Practice, Victoria University of Wellington
Karla Bergquist *3DHB Executive Director MHAIDS*	• Former Executive Director, Emerge Aotearoa Ltd • Former Executive Director, Mind and Body Consultants *(organisations that CCDHB and HVDHB contract with)*
Sally Dossor *Director of the Chief Executive Office & Board Secretary*	• Partner is a Director of Magretiek, BioStrategy and Comrad
Paul Oxnam *Executive Clinical Director MHAIDS*	• Member, NZ College of Clinical Psychologists
Sue Gordon *Transformation Director*	• Board Member, Netball New Zealand
Martin Catterall *Chief Digital Officer 3DHB*	• NIL

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HUTT VALLEY DHB / Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**MINUTES** Held on Wednesday 1 September 2021 Location: Zoom Zoom: 876 5068 1844 Time: 9:30am
2DHB CONCURRENT BOARD MEETING	**PUBLIC**

Due to Covid 19 alert level (level 3) only the Chair and limited staff attended in person (in person marked with * and all others on zoom).

PRESENT

*David Smol	Chair, Hutt Valley and Capital & Coast DHBs

Dr Kathryn Adams	Board Member	Keri Brown	Board Member
Dr Tristram Ingham	Board Member	Ria Earp	Board Member
Brendan Boyle	Board Member	Ken Laban	Board Member
Sue Kedgley	Board Member	Yvette Grace	Board Member
Roger Blakeley	Board Member	Prue Lamason	Board Member
Dr Chris Kalderimis	Board Member	Naomi Shaw	Board Member
Vanessa Simpson	Board Member	Dr Richard Stein	Board Member
		John Ryall	Board Member
		Josh Briggs	Board Member
		Wayne Guppy	Deputy Chair

APOLOGIES

'Ana Coffey
Stacey Shortall
Hamiora Bowkett

IN ATTENDANCE

Hutt Valley and Capital & Coast DHB

*Fionnagh Dougan	Chief Executive
Rosalie Percival	Chief Financial Officer
Arawhetu Gray	Director Māori Health
Karla Bergquist	Executive Director Mental Health, Addictions and Intellectual Disability Service
Paul Oxnam	Executive Clinical Director Mental Health, Addictions and Intellectual Disability Services
Rachel Haggerty	Director Strategy, Planning and Performance
Sarah Jackson	Director of Clinical Excellence
Joy Farley	Director Provider Services
Rachel Gully	Director People and Culture
Sue Gordon	Director Transformation
Helen Mexted	Director of Communication and Engagement
*Sally Dossor	Director Office of the Chief Executive and Board Secretary
*Meila Wilkins	Board Liaison Officer

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1 PROCEDURAL BUSINESS

1.1 KARAKIA

The Board opened the meeting with a karakia.

1.2 APOLOGIES

As noted above.

1.3 PUBLIC PARTICIPATION/PETITION

The HVDHB Board agreed:

a) to receive the petition and thank Hutt Families for Midwives for the petition

The HVDHB Board noted:

a) the petition received by HVDHB on 23 August 2021 in relation to Te Awakairangi Birthing Centre

b) The list of e-signatures and the associated document titled 'Evidence paper to support a publicly funded Birthing Centre in the Hutt Valley', which are available to Board members in the Diligent Resource Centre for the meeting dated 1 September 2021.

	Moved	**Seconded**	
HVDHB	Ken Laban	Ria Earp	**CARRIED**

The following members of the public presented to the Boards:

- Sarah Adams, Hutt Families for Midwives
- Vida Rye
- Oropai Leith Porter-Samuels

Notes

- The presentations were in relation to the closure of the Te Awakairangi Birthing Centre in Lower Hutt.
- The presenters acknowledged the services that the Te Awakairangi Birthing Centre has provided since it opened in 2018, and highlighted the importance of choice for women giving birth.
- The Board asked questions of each of the presenters regarding options for postnatal care, midwifery services in the Hutt Valley, distribution of the petition, engagement with the Ministry of Health and Ministers, and other birthing facilities in the Hutt Valley.
- The Board thanked all presenters for their presentations.

1.4 INTEREST REGISTER

1.4.1 COMBINED BOARD INTEREST REGISTER

The Boards **noted** that any further changes were to be sent to the Board Liaison Officer via email.

1.4.2 COMBINED EXECUTIVE LEADERSHIP TEAM INTEREST REGISTER

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

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1.5 MINUTES OF PREVIOUS CONCURRENT MEETING

The Boards **approved** the minutes of the concurrent Board Meeting held on 4 August 2021 (public).

	Moved	**Seconded**	
HVDHB	Keri Brown	Josh Briggs	**CARRIED**
CCDHB	Roger Blakeley	Sue Kedgley	**CARRIED**

1.6 MATTERS ARISING FROM PREVIOUS CONCURRENT MEETINGS

- **21-P03**: Work continues on the Māori Data sovereignty issue which may be ongoing for some time.
- **21-P07:** The Chair noted that **t**his action can be removed from the action list as it is unlikely to be a priority for the Ministry. Richard Stein clarified that the intention for this action item was for staff to meet with the Māori and Pacific community to increase participation in the bowel cancer screening programme. Staff will continue to keep Richard updated with progress on this issue.
- **21-P08:** The issue of reimbursing costs incurred by people with disabilities accessing vaccines is an issue that is being considered by Minister Sepuloni, it is not an issue that DHBs can address. Staff are aware of the issues and will focus on ensuring that people utilise the booking system which makes provision for payment of travel.

1.7 CHAIR'S REPORT AND CORRESPONDENCE

The Chair noted that correspondence has been received in relation to Te Awakairangi Birthing Centre including a Letter from Chris Bishop dated 13 August 2021. The correspondence is being managed by the DHBs' correspondence team.

1.8 CHIEF EXECUTIVE'S REPORT

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

Notes:

- Significant improvement on vaccine delivery.
- Working on a plan to support Auckland.
- No indication of issues with vaccine supply.

1.9 BOARD WORK PLAN 2021/2022

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

2 DHB PERFORMANCE AND ACCOUNTABILITY

2.1 HVDHB JUNE 2021 FINANCIAL AND OPERATIONAL PERFORMANCE REPORTREPORTS

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

The HVDHB Board noted:

(a) The DHB had a ($6.4m) deficit for the month of May 2021, being ($5.5m) unfavourable to budget;

(b) The DHB year to date had a deficit of ($15.3m), being ($6m) unfavourable to budget;

(c) The DHB year to date deficit excluding $1.8m unfunded COVID-19 Costs and $2.5m Holidays Act provision was a deficit of ($11m), being ($5m) unfavourable to budget, which includes a $6.5m impairment of the RHIP;

(d) The Funder result for May was $1.7m favourable, Governance $0.01m favourable and Provider ($7.4m) unfavourable to budget;

(e) Total Case Weighted Discharge (CWD) Activity was 8% ahead of plan

	Moved	**Seconded**	
HVDHB	Josh Briggs	Wayne Guppy	**CARRIED**

2.2 CCDHB JUNE 2021 FINANCIAL AND OPERATIONAL PERFORMANCE REPORTS

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

The Capital & Coast DHB Board noted:

(a) The DHB had a ($0.73m) deficit for the month of May 2021, being $4.3m favourable to budget before excluding COVID-19 and Holidays Act;

(b) The DHB year to date had a deficit of ($42.4m), being ($6.8m) unfavourable to budget before excluding COVID-19 and Holidays Act;

(c) In the eleven months we have incurred $5.4m additional net expenditure for COVID-19 and $7.7m against provision for Holidays Act;

(d) This means that the DHB has an overall YTD deficit of ($29.3m) from normal operations (excluding COVID-19 and Holidays Act) being $6.3m favourable to our underlying budget.

	Moved	**Seconded**	
CCDHB	Sue Kegley	Brendan Boyle	**NOTED**

Notes (items 2.1 and 2.2):

- The financial performance is close to budget – the main change being in relation to revenue from the Ministry.
- The rest of the results were expected and the Boards and the Ministry can be confident in our forecasting.
- The Director of Nursing gave an update on the status of the recruitment drive for midwives and nurses. Noted that staff are working with an external recruitment company to recruit midwives locally and internationally. This will be extended out to nursing in due course. There are ongoing advertisements for maternity staff. Noted interest from overseas workers, but highlighted challenges with immigration. Return to work campaign is about encouraging people who have been out of work for 8+ years to return to the workforce.

3 STRATEGIC PRIORITIES

3.1 THE PRO-EQUITY PEOPLE-BASED COMMISSIONING POLICY AND THE EQUITY COMMUNICATIONS AND ENGAGEMENT STRATEGY

The Director Strategy, Planning and Performance introduced the paper and answered questions.

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The Boards noted:

(a) our DHBs' progress in relation to implementing the Equity Goal, Definition and Principles with the achievement of two significant milestones:

i. the Pro-Equity People-based Commissioning Policy describing the **standards** health commissioners must meet when commissioning new health services and/or recommissioning existing services to improve health equity for our priority populations: Māori, Pacific people, and disabled people.

ii. the Equity communications and engagement strategy communicating our DHBs' equity commitment and the framework for showing proactive progress towards our DHBs' Equity Goal.

The Boards approved:

(b) the Pro-equity People Based Commissioning Policy in attachment 1, subject to the final published policy being amended as follows:

i. Paragraph 3.1 – delete the second sentence

ii. Paragraph 3.2 – delete the paragraph

	Moved	**Seconded**	
CCDHB	Tristram Ingham	Roger Blakeley	**CARRIED**
HVDHB	John Ryall	Keri Brown	**CARRIED**

Procedural note:

- (a)ii. there was a typographical error in the motion in the paper, which was corrected as shown in the underlined text.

Notes:

- Members questioned the discretionary nature of the Policy and why it is only mandatory for the commissioning function. It was explained that this is a commissioning policy and sits within our broader Pro-equity policy framework.
- Amendments were suggested to the policy to clarify this issue and were accepted through the amended motion above.

4 DECISION

4.1 SALE AND SUPPLY OF ALCOHOL ACT 2012 AND SMOKEFREE AOTEAROA 2025 GOAL

*The paper was taken as **read** and the Director, Māori Health was available for questions.*

The Boards agree:

(a) To adopt the position statement on the Sale and Supply of Alcohol Act 2012 (the Act) asking for a review of the Act (refer attachment 1 - appendix 1)

(b) To endorse the recommendations in section 1 of the report titled 'DHBs and the Smokefree Aotearoa 2025 Goal' (refer attachment 2).

The Boards note:

(a) The 20DHB Chairs and Chief Executives commissioned research in relation to the adverse health effects of alcohol and tobacco, with a view to supporting initiatives and opportunities

within the sector to advocate for change to address alcohol related harm and support the Smokefree Aotearoa Goal 2025.

(b) The 20DHB Chairs and Chief Executives received the following final reports:

I. DHB Position Statement on the Sale and Supply of Alcohol Act 2012 – attachment 1.

II. DHBs and the Smokefree Aotearoa 2025 Goal – attachment 2.

	Moved	**Seconded**	
CCDHB	Roger Blakeley	Brendan Boyle	**CARRIED**
HVDHB	Prue Lamason	Ria Earp	**CARRIED**

4.2 3DHB ENVIRONMENTAL SUSTAINABILITY STRATEGY

*The paper was taken as **read**. The Chief Financial Officer was available for questions.*

The Boards approve:

(a) 3DHB Sustainability Strategy (Attachment 1), noting the additional

The Boards note:

(a) Attached Infrastructure Energy Efficiency and Decarbonisation Policy (Attachment 2)

(b) Attached Preliminary Infrastructure Energy Efficiency and Decarbonisation Implementation Plan (Attachment 3: *Energy Transition Accelerator report)*

(c) 6 monthly reports on this strategy, including the supporting Policies and Plans as appropriate, will be provided to the 2DHB and WrDHB Boards

	Moved	**Seconded**	
CCDHB	Kathryn Adams	Tristram Ingham	**CARRIED**
HVDHB	Prue Lamason	Yvette Grace	**CARRIED**

Notes:

- Noted work being done on replacement of our emergency generation capacity and looking at options which could move away from diesel.
- An implementation plan which falls under the strategy will provide more guidance on targets and timelines, noting it is dependent on funding and affordability.
- Investigation into process for transitioning to electric vehicles is well progressed. Highlighted infrastructure challenges and noted that a plan is being worked on to understand steps required to introduce electric fleet. Board members expressed a desire to accelerate the programme, including through 'quick wins'.
- The Environmental Sustainability Strategy does not apply to organisations which we commission services from, but does apply to organisations that supply us with services.
- Environmental sustainability will be addressed in the Transition Unit and will become an integral part of our future system.

5 OTHER

5.1 GENERAL BUSINESS

Nil.

PUBLIC

5.2 RESOLUTION TO EXCLUDE THE PUBLIC

	Moved	**Seconded**	
HVDHB	Wayne Guppy	John Ryall	**CARRIED**
CCDHB	Kathryn Adams	Roger Blakeley	**CARRIED**

6 NEXT MEETING

Date: 6 October 2021, **Location:** Level 11 Boardroom, Grace Neill Block, WRH **Time:** 9am

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

DATED this day of 2021

David Smol
BOARD CHAIR

MATTERS ARISING LOG AS AT 30 SEPTEMBER 2021

Action Number	Date of meeting	Assigned	Status	Date Completed	Meeting	Agenda Item #	Agenda Item title	Description of Action to be taken	Status
21-P03	7-Apr-21	Chief Digital Officer	In progress		Board - Public	3.2	Māori Health Strategy Reporting	Māori data sovereignty paper to be shared with Board when it is appropriate.	The issue is still a work in progress with all regional Directors Maori, Iwi, and the Ministry of Health continuing discussions. Refer update oral update at 7 July 2021 Board meeting at item 6.3 of the minutes.

Chief Executive's Report

Prepared by: Fionnagh Dougan, Chief Executive

1 Introduction

This report covers the period from 24 August 2021 to 23 September 2021.

2 COVID-19 Update

2.1 Current cases (as at 27/09/2021)

	2DHB	HVDHB	CCDHB
Number of active cases	0	0	0
Number of recovered cases	135	24	111
Number of cases deceased	2	0	2
Total number of cases	137	24	113
Number of days without community cases	-	25	313

2.2 Managed Isolation Facilities (as at 27/09/2021)

	Grand Mercure	Bay Plaza
Total guests processed through facilities	1,784	1,230

2.3 Testing – total tests and people served (from 18/08/2021 to end 26/09/2021)

	2DHB			HVDHB			CCDHB		
	Māori	Pacific	Other	Māori	Pacific	Other	Māori	Pacific	Other
Total tests processed	3,938	3,373	32,329	1,198	878	5554	2,593	2,446	26775
Total people tested	3,433	2,883	28,360	1,074	763	5270	2,239	2,074	23,189

2.4 Testing – 2DHB people served (from 18/08/2021 to end 26/09/2021)

	2DHB			HVDHB			CCDHB		
	Māori	Pacific	Other	Māori	Pacific	Other	Māori	Pacific	Other
Est. domiciled population tested	5.0%	7.9%	7.6%	3.7%	6.0%	5.5%	5.7%	8.7%	8.6%

2.5 Vaccination –2DHB providers delivery (from 22/02/2021 to end 26/09/2021)

	2DHB	HVDHB	CCDHB
Total doses administered	487,364	148,829	338,535
Total people served	330,421	98,928	233,815

2.6 Vaccination – 2DHB people coverage (from 22/02/2021 to end 26/09/2021)

	2DHB		2DHB	
	1st Dose Delivery	Est. 1st Dose Coverage	Complete Course Delivery	Est. Completed Course Coverage
Māori	29,290	64%	13,914	30%
Pacific	20,422	70%	11,030	38%
65+	61,668	94%	53,641	82%
Other	281,470	86%	137,179	42%
Total	331,182	83%	162,123	40%

2.7 Vaccination coverage of DHB workforce (from 22/02/2021 to end 26/09/2021)

	CCDHB	HVDHB
1st Dose	91%	90%
Complete course	86%	84%

3 Communications and Engagement

3.1 External engagement with partners and stakeholders

Given the alert level 4 and 3 for much of the period, the main focus for the past month has been ongoing engagement, outreach and events for the COVID-19 vaccination programme.

3.2 External communications and engagement – press releases and pitches

DHB	Subject	Outlet / Channel
2DHB	COVID-19	Promoted the partnership with the NZDF to administer COVID-19 vaccinations.
2DHB	COVID-19	Visitor restrictions under alert level 3.
2DHB	COVID-19	Information about mandatory QR scanning and signing into our hospitals.
2DHB	COVID-19	Update on the move from local visitor policy to the national 20 DHB visitor policy.
CCDHB	Child health	Highlighted the opening of the Pataka Miraka Mothers' Milk bank.

3.3 Health promotion campaigns

3.3.1 COVID-19 vaccination programme

The 2DHBs have now reached significant milestones with almost 80 per cent of people in the Wellington region having received at least their first dose of the vaccine, and at least 35 per cent of people fully vaccinated.

We continue to support the Ministry of Health's nationwide rollout with local and regional communication via digital channels, media, events, and targeted engagement for Māori, Pacific people, and the disabled community.

The vaccination programme to 21 September is delivering at 126 per cent against plan on the back of significant increases in vaccinating capacity via popular drive-through events during alert levels 3 and 4 in August and September. During the three weeks of alert levels 3 and 4, teams administered almost 175,000 doses including at drive-through clinics in Porirua, Waiwhetū and Sky Stadium.

We now have a total of 67 clinics in the Wellington region - a mix of GP, Pharmacy, community vaccination centres, and outreach/pop up sites. Further events and outreach is being planned to accommodate the extra people that have received their first dose since the eligibility opened up to everyone aged 12 and over.

3.3.2 Supporting our equity populations

Work continues with the vaccination programme's equity leads to provide supporting communications and engagement, including outreach and events, for Māori, Pacific, and disabled communities.

Māori-led clinics provide a kaupapa Māori approach to vaccinating, incorporating an all-of-whānau approach under the 'trusted faces in trusted places' model. The drive-through model proved particularly popular with Māori and Pacific people in Porirua, where more than 75 per cent of the people vaccinated at the event run by Ora Toa were Pacific or Māori.

Māori health partners and providers are operating three marae-based clinics located at Wainuiomata Marae in Lower Hutt, Maraeroa Marae in Porirua, and Whakarongotai Marae in Waikanae, as well as a Māori-led clinic at Waiwhetū in Lower Hutt. The Porirua Community Vaccination Centre is run by Ora Toa, a Māori PHO, and Māori provider Hora Te Pai has partnered with Tū Ora PHO to set up the Kāpiti-based Community Vaccination Centre.

As at 21 September, more than 55 per cent of Māori have had their first dose, however, there are emerging levels of hesitancy, especially among younger people. Maori providers in particular are working on outreach events to provide safe and welcoming spaces for people to ask questions and to put in place mobile options to reach communities with pockets of unvaccinated people.

The Pacific Health team working alongside Pacific providers and PHOs are organising Pacific Festival Days, with a focus on reaching young people. As at 21 September, 66 per cent of Pacific people in our region have received at least one dose of the vaccine.

3.3.3 Accessible events and in-home vaccinations

The 2DHB Disability team continues to hold tailored events at vaccination clinics for disabled people and those with impairments or long-term conditions throughout September, and a further six events are booked in September and October so that people vaccinated at earlier events can receive their second dose.

A network of four community pharmacy teams with homecare experience started the in-home vaccination programme, and have so far visited just under 50 people who are unable to safely visit a clinic or who are homebound, sometimes due to severe disability.

Bronwen Shepherd, Unichem & Life Pharmacy COVID-19 operations lead for Wellington, says patients have appreciated the opportunity to be vaccinated in their own homes, and their trusted relationships help foster conversations about vaccinations that can help ease any concerns.

"Both patients and the pharmacists have enjoyed the 15-minute post-vaccination tea and biscuit chats, it's a valuable experience in these times to be able to take the time and have conversations to address any questions, and simply to connect with one another."

A collaborative approach across health sector, including the DHB COVID-19 response team, has created a highly targeted, responsive and personalised service that will help protect the whole community.

3.3.4 Sky Stadium drive-through

Almost 7000 people were vaccinated over eight days at a drive-through clinic at Sky Stadium in Wellington city under alert level 4. The first few days prioritised Māori, Pacific and disabled people, as well as essential workers and their bubbles, following the success of earlier kaupapa Māori drive-through clinic at Waiwhetū. Vaccinations at Sky Stadium then opened up to the general public, with whole bubbles able to be vaccinated together. Vaccinators administered about 1000 doses each day

Clinical nurse coordinator Bee Rutledge led the clinic, and said the experience was 'phenomenal'.

"We were able to deliver a very slick service. I'm proud to lead such an awesome, formidable team."

Strong interagency relationships led to the success of this clinic. Alongside DHB staff, the New Zealand Defence Force provided ten nurses and medics to help with the roll-out, along with Whitireia Polytechnic students, Wellington Free Ambulance, IMAC, and Tū Ora

Compass Health. Other organisations such as Fulton Hogan, Red Badge Security and Interwaste have also been working behind the scenes to help the clinic run smoothly.

3.3.5 COVID-19: Contact Tracing

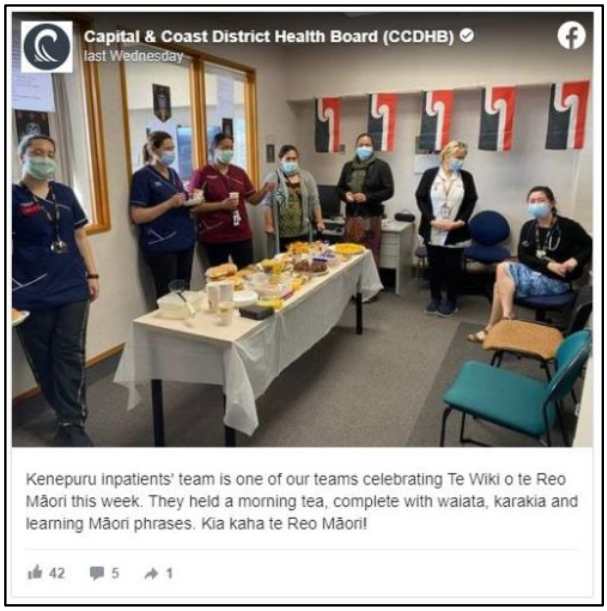
Last month we saw a reasonable level of public alarm around quickly wanting to access Locations of Interest information following confirmed cases of COVID-19 in our region. This led to creating a promotion on 'Contact Tracing and Keeping Safe' that focused on the NZ COVID Tracer App as an effective tool for individuals to be quickly alerted if they have been to a location of interest or potentially exposed to COVID. The aim was to drive down alarm around knowing locations of interest and increase usage of the COVID Tracer App. The promotion aligns with mandatory record keeping of tracking movements which came into force on 7 September. We know that the usage of the NZ COVID Tracer App was very low prior to Wellington going into lockdown.

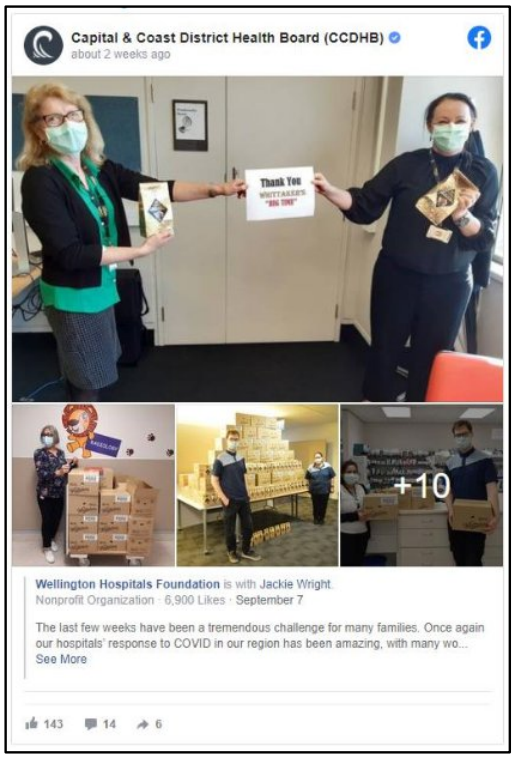
3.3.6 Social media views and stories

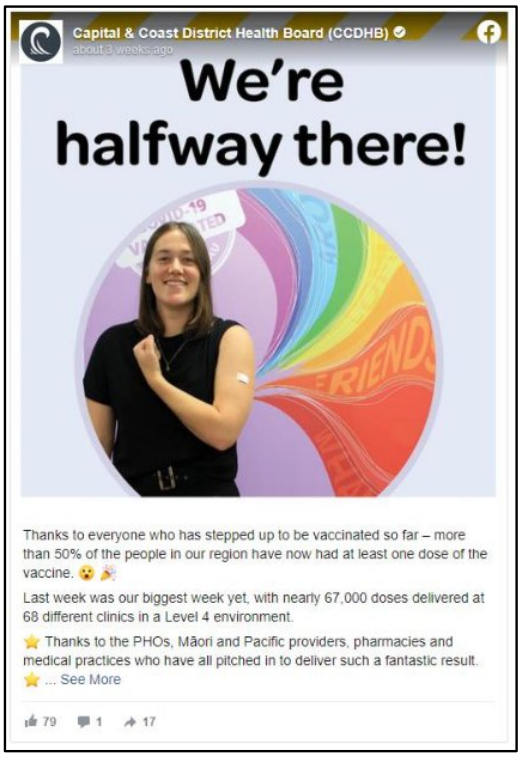
Top social media posts

CCDHB impressions	HVDHB impressions	RPH impressions
Facebook: 307,763 Twitter: 141,579 LinkedIn: 47,425	Facebook: 211,680 Hutt Maternity Facebook: 10,074 Twitter: 43,113 Instagram: 6,183 LinkedIn: 15,219	Facebook: 87,559


Capital & Coast District Health Board (CCDHB)
Vaccinations at a glance
Total doses given to date: 412,866
People who have had their first dose
281,847 - 70%
People who are fully vaccinated
116,255 - 29%
Upper Hutt 67%
Lower Hutt 67%
Kāpiti Coast 64%
Porirua 68%
Wellington 75%
Māori 51%*
First dose: 23,713
Both doses: 10,333
Pacific 61%*
First dose: 17,613
Both doses: 8,518
Aged 65+ 90%*
First dose: 59,106
Both doses: 45,218
www.VaccinateGreaterWellington.nz
More than 70% of the people in our region have now had at least one dose of the COVID-19 vaccine – what a massive effort
Thank you to everyone who has stepped up to be vaccinated so far and to the PHOs, Māori and Pacific providers, pharmacy and medical practices who have played a significant role in this fantastic result.
Book your vaccine today! There are appointments available at clinics across the region and bookings are now open to everyone aged 12 years and over.
... See More
88 6 31


Capital & Coast District Health Board (CCDHB)
last Wednesday
Kenepuru inpatients' team is one of our teams celebrating Te Wiki o te Reo Māori this week. They held a morning tea, complete with waiata, karakia and learning Māori phrases. Kia kaha te Reo Māori!
42 5 1


Capital & Coast District Health Board (CCDHB)
about 2 weeks ago
Thank You
+10
Wellington Hospitals Foundation is with Jackie Wright.
Nonprofit Organization · 6,900 Likes · September 7
The last few weeks have been a tremendous challenge for many families. Once again our hospitals' response to COVID in our region has been amazing, with many wo...
See More
143 14 6


Capital & Coast District Health Board (CCDHB)
about 3 weeks ago
We're halfway there!
Thanks to everyone who has stepped up to be vaccinated so far – more than 50% of the people in our region have now had at least one dose of the vaccine.
Last week was our biggest week yet, with nearly 67,000 doses delivered at 68 different clinics in a Level 4 environment.
Thanks to the PHOs, Māori and Pacific providers, pharmacies and medical practices who have all pitched in to deliver such a fantastic result.
... See More
79 1 17

3.4 Website page views and stories

CCDHB	HVDHB	RPH	MHAIDS
page views: 42,295	page views: 9,281	page views: 4,964	page views: 4,470

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

3.4.1 Top five webpages CCDHB

- Staff login
- Exemptions for face coverings (masks)
- Careers with CCDHB
- COVID-19 CBACs
- Wellington Regional Hospital

3.4.2 Top five webpages HVDHB

- Staff login
- COVID-19 Visitor information
- COVID-19 CBACs
- Careers with HVDHB
- Contact Us

3.4.3 Top five webpages RPH

- Getting vaccinated
- Coronavirus (COVID-19) frequently asked questions
- Vaccinate Greater Wellington
- The COVID-19 Vaccine rollout in Greater Wellington
- Getting vaccinated in Wellington, porirua, the Hutt Valley, & Kāpiti

3.4.4 Top five webpages MHAIDS

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

3.4.5 Website stories and releases

Working for vaccine equity for Pacific People

Alfred Soakai talks vaccination of Pacific Peoples and Tongan Language Week.

Since Alfred Soakai joined the 2DHB COVID Response Team this year, his focus has been on promoting equity for Pacific People – making sure they are factored into decisions made and plans put in place as the 'team of five million' works to halt the spread of the virus.

Equity is about looking at how well different population groups are doing compared with each other, identifying where the differences are, and working to close the gaps. Pacific Peoples experience worse health outcomes than those of European background, and so Alfred's role as Pacific equity lead is to do everything he can to make sure they have the opportunity to be vaccinated against COVID-19.

"Our communities are most at risk with COVID-19," he says. "We see that during community outbreaks time and time again in Aotearoa. Our people need to get vaccinated, to protect ourselves, our families and our communities.

"I'm thankful that the push for equity is coming from the very top in Government, and is echoed by our DHB leadership."

The best part of his job is "seeing our Pacific communities rallying together and coming forward during the vaccination festival events we've been running across Wellington." Festival days have been held in clinics and churches, as Alfred's team works to connect with communities in spaces where they are comfortable.

Pictured: Alfred Soakai (left) with Junior Ulu, 2DHB Director of Pacific People's Health, and Henrietta Hunkin-Tagaloa, Pacific Director of Health at Tu Ora Compass Health.

Alfred is one of approximately 300,000-350,000 Tongans worldwide, including those who live in Aotearoa. Born and raised in Tonga, he moved to New Zealand in 2019 to be with his wife and two children.

He says Tongan language week is "a time to reflect on our heritage. It serves as a reminder on how we're doing in passing our heritage to our children, informing them of they come from. Whether it's language, or other parts of our culture, this is the perfect time to do that. As we take our journeys into the future, it's good to know where we came from."

He'll be celebrating by wearing his ta'ovala when out and about with the vaccination programme, tuning in the online Tongan events in Wellington, and teaching his kids some new phrases.

A fluent speaker, he invites staff at the 2DHBs to also learn and use Tongan phrases – 'it's a great way to celebrate with us'.

3.5 Mum's warning: look-out for signs of ovarian cancer

Mellissa Paulin didn't know much about ovarian cancer but the hardest thing was telling her children she had it.

"You're meant to be the strong person for them, the fighter, the role model," Mellissa said.

"Now you're this vulnerable person that they're not used to.

"I want to get the knowledge out there so other women don't have to go through this horrible journey.

Mellissa Paulin: "Our moto was: I've got this. This chapter of my life is about me. Only I can get through it."

September is Gynaecological Cancer Awareness Month. One woman in New Zealand dies of ovarian cancer every 48 hours, according to the NZ Gynaecological Cancer Foundation.

In 2019, Hutt Valley DHB Health Care Assistant Mellissa Paulin had lost a lot of weight and was suffering persistent stomach cramps among other symptoms which she initially put down to menopause.

It took several visits before her GP decided she needed to be referred for scans and blood tests at Hutt Hospital.

"You have to be your own advocate.

"If it lasts more than two weeks, do something about. Go see your doctor."

A lengthy process of elimination, supported by Mellissa's own sense that something was wrong, lead to a CA125 blood test and ultrasound finding an abnormality.

On 21 September, 2020, the then-54-year-old was told she had cancer.

"It's surreal because on the outside you look fine. It's hard to believe this is happening. You just go numb with disbelief.

"I have been blessed with so much aroha and support from family and friends.

"Everyone deals with it in their own way. It is hard but it can also bring you all together."

About six weeks later, she underwent surgery to remove cancer in her fallopian tubes.

"The staff at Wellington's gynaecology and oncology departments were fantastic. Despite the surgeon being confident they had taken it all out, it had spread."

In Feburary, Mellissa started the first of six rounds of chemotherapy.

"As my daughter would say: 'In with the good; out with the bad. This was a very stressful time, especially with COVID around."

But in June, the news came that she was in remission.

"If every woman had an ultrasound and a blood test each year, then they would pick it up before it was too late. Persist, persist, persist."

3.6 Internal Engagement and Communication

3.6.1 Intranet page views and stories

CCDHB	HVDHB
page views: 45,329	page views 39,565

3.6.2 New Health Matters magazine and staff posters

We released a refreshed edition of our regular Health Matters magazine during August as well as a range of posters for staff to highlight key work programmes.


Health
Matters
2DHB NEWS | July 2021
Crew
Crew
Vaccinator
Clinical Lead
Crew
COVID-19 Vaccinations
Wellington region updates
Bowel Screening
Available across the region
Open Communication
Building trust with patients

3.7 Top intranet stories

Challenging conversations, positive outcomes

Our People | Commissioning and Community

No te Taumata o Tutamure ki nga hiwi o Remutaka,

Rere te awa o Waipaoa ki Te Moana nui a kiwa, tai ki Te Whanganui a Tara ki Te Awakairangi ma runga nga waka o Horouta, Takitimu me nga waka o nga tangata o te Tiriti.

Tipu mai Te Aitanga a Mahaki ratou hoki a Ngati pakeha. No reira,

E nga mana e nga reo, mihi atu, korero mai, nei te whanau Hirini e pepeha, a, ko Rawiri tenei. Tihei Mauri Ora!

Kia ora everyone my name is Rawiri, also known as Ra. As Pou Tikanga at Hutt Valley DHB, Rawiri Hirini has become accustomed to both challenging conversations and positive outcomes.

Pou translates as post or pillar, and Tikanga means correct Māori customary practices or behaviours. This means Rawiri, or Ra, shoulders a very broad role, including providing advocacy for Māori health practice, carrying out staff training, delivering ceremonial support, and providing advice on environmental changes to make sure the hospital its visual designs reflect Aotearoa's Polynesian heritage.

His path to the role was somewhat unconventional. A stint as a teacher saw him realise the power of connecting with young Māori, which initially inspired him to a career in social work, and eventually led him to the Pou Tikanga role last year.

Ra draws on these earlier career paths when providing direct cultural support to Māori patients as part of his advocacy work.

"It can be as simple as a cup of tea and a chat, but you're helping someone relieve their tension and anxiety," he says.

One of his first moves in his role was to refresh the existing cultural safety training for Hutt Valley kaimahi.

He made sure it centred around Te Tiriti o Waitangi and its principles, and the Crown's obligations as a Treaty partner. He believes Māori models of healthcare may offer benefits, such as greater inclusivity, over current Western models used in Aotearoa New Zealand.

He also teaches Māori healthcare principles, and helps staff understand how they can draw on these in their healthcare practice. These can be challenging conversations to have, yet have the potential to make a huge difference for our Māori communities seeking healthcare.

He says Te Wiki o Te Reo Māori has the potential to help breathe life into Māori culture, while acknowledging the harm caused by racism and repression of Māori language and culture.

As identity is inseparable from language, the week also offers an opportunity to more closely understand Te Ao Māori – the Māori worldview. For example whenua means land but also placenta, indicating a strong connection between these. Understanding this could change perspectives in how the land is seen and treated.

"We are affected by the environment and vice versa," explains Ra. "The language is the sharp end of trying to connect our purpose, world and feelings."

He says language learning can be made easier by making it fun. "People can be shy about singing. But it's fun, and you can do it in a group. If you're not enjoying learning, try a different angle.

"Language is alive, and you live it, and when you speak and sing it, you bring it to life."

Māori Language Moment

People across Aotearoa celebrated this year's Māori Language Moment at midday on Tuesday, 14 September.

Here are some of the ideas for ways to mark the moment or do throughout the week, via the Māori Language Commission.

Kōrero / Speak: Why not try ordering your coffee in te reo Māori?

Waiata / Sing: Get a group together and sing an easy te reo song, such as 'Tūtira Mai' 'Te Aroha' or 'National Anthem'.

Tākaro / Play: Download some Māori apps and play with your tamariki. Find more games to play here.

Whakarongo / Listen: Turn on the radio or go online and tune into your local iwi radio station.

Pānui / Read: Take an hour to read a te reo Māori book. Suggestions for books for readers of all levels can be found here.

Ako / Learn: There are many ways to learn te Reo Māori online

Macrons: You can find a guide to installing macrons here.

Visit the Te Wiki o te Reo Māori Facebook page for even more resources, as well as giveaways. Find COVID-19 resources in te Reo Māori.

3.8 Drive-through vaccinations across our region

Living Well Our Services

Porirua's Pacific community turned up to be vaccinated by the carload at a drive-through clinic this week.

This contributed to yesterday seeing the highest number of doses administered to Pacific People in Wellington, with 1107 vaccinations across various sites.

This clinic followed the success of the kaupapa Māori Waiwhetū drive-through which began last weekend with 600 doses delivered in the first two days.

Wellington City is next in line, with a drive-through clinic at Sky Stadium in Wellington city open now. The first day on Friday 27 August was for essential workers and their bubbles, while the general public can book in now for appointments from Saturday 28 August.

Bookings for Sky Stadium can be made online at www.BookMyVaccine.nz (enter Pipitea in the location box and select 'Sky Stadium Drive-Thru') or freephone 0800 28 29 26.

In Porirua, Cars lined up from early morning at the pop-up clinic in North City Plaza Porirua, facilitated by Ora Toa, Pacific Health Providers, and Whitireia School of Nursing.

2DHB Pacific Health director Junior Ulu said the initial focus was on vaccinating Māori, Pacific, and Disabled people. "These minority groups can get lost," he said. "So the DHB has prioritised reaching out to these groups today." The drive-through clinic will continue to operate for several days.

The COVID-19 pandemic continues to impact on Pacific communities in New Zealand. As Pacific people also experience worse health outcomes, this is a worrying time, and so CCDHB's Pacific Health team has doubled down on efforts to make sure families are tested and vaccinated.

The team has pivoted from the 'festival days' – mass vaccination events aimed at Pacific People that took place at alert level 1 – to lower-contact events that are safer under alert level 4. It's been able to achieve this by working closely with government departments, inter-agency organisations, church leaders, and crucially with Pacific Health providers.

"We are actively working towards organising further drive-through clinics across our region in the coming days," said 2DHB Chief Executive Fionnagh Dougan.

2DHB BOARD WORK PLAN 2021/2022 – 6 OCTOBER 2021

	Wed 3 Nov 2021	Wed 1 Dec 2021	Wed 16 Feb 2022	Wed 30 Mar 2022	Fri 13 May 2022	Wed 22 Jun 2022
	Hutt Hospital	WLG Hospital	Hutt Hospital	WLG Hospital	Hutt Hospital	WLG Hospital
Service Spotlight	**Rheumatology**	**Cardiology**	**TBC**	**TBC**	**TBC**	**TBC**
Quality and Safety/Health and Safety						
2DHB Quality and Safety	2DHB Quality and Safety Report Gap analysis on the Health and Disability Standards Update on the corrective actions from the surveillance audits	2DHB Quality and Safety Report	2DHB Quality and Safety (and selected focus area)	2DHB Quality and Safety Report	2DHB Quality and Safety Report	2DHB Quality and Safety Report (and selected focus area)
MHAIDS Quality and Safety	MHAIDS Quality and Safety Report	MHAIDS Quality and Safety Report	MHAIDS Quality and Safety Report	MHAIDS Quality and Safety Report	MHAIDS Quality and Safety Report	MHAIDS Quality and Safety Report
2DHB Health and Safety	2DHB Health and Safety Report	2DHB Health and Safety Report	2DHB Health and Safety Report	2DHB Health and Safety Report	2DHB Health and Safety Report	2DHB Health and Safety Report
Financial and Operational Performance Reporting						
Financial and Operational Performance HVDHB	Report for September 2021 (from FRAC)	Report for October 2021 (from FRAC)	Report for November and December 2021	Report for January (from FRAC) and February 2022	Report for March (from FRAC) and April 2022	Report for May 2022
Financial and Operational Performance CCDHB	Report for September 2021 (from FRAC)	Report for October 2021 (from FRAC)	Report for November and December 2021	Report for January (from FRAC) and February 2022	Report for March (from FRAC) and April 2022	Report for May 2022

	Wed 3 Nov 2021	Wed 1 Dec 2021	Wed 16 Feb 2022	Wed 30 Mar 2022	Fri 13 May 2022	Wed 22 Jun 2022
Scheduled reporting						
People and Culture Report		People and Culture Report		People, Capability and Culture Report		People, Capability and Culture Report
3DHB Digital Report	Q1 Report		Q2 Report		Q3 Report	
Māori Stratey (Te Pae Amorangi and Taurite Ora)	Q1 Report		Q2 Report		Q3 Report	
Pacific Health and Wellbeing Strategic Plan	Q1 Report and selected focus area		Q2 Report and selected focus area (To be advised)		Q3 Report and selected focus area (To be advised)	
Strategic Priorities						
Pro-Equity						
Strategic Priorities Overview	Reporting on implementation and engagement on next steps. *The papers marked * are on the HSC work plan for 29 September 2021 and 24 November 2021 – and will be reported to the Boards via HSC or DSAC.*					
Our Hospitals		*2DHB Maternal and Neonatal Health System Strategy				
		*2DHB Hospital Network				Master Site Plan
Commissioning and Community		*Complex Care and Long-term Conditions				
		*Inter-sectoral Priorities				
Mental Health and Addiction Services		*Kaupapa Māori and MHA development				
Enablers						

	Wed 3 Nov 2021	Wed 1 Dec 2021	Wed 16 Feb 2022	Wed 30 Mar 2022	Fri 13 May 2022	Wed 22 Jun 2022
Committees						
FRAC items for Board Approval	FRAC items for Board Approval from meeting dated 27/10/21	FRAC items for Board Approval from meeting dated 26/11/21		FRAC items for Board Approval from meeting dated 03/03/22	FRAC items for Board Approval from meeting dated 27/04/22	FRAC items for Board Approval from meeting dated 01/06/22
MCPAC update	MCPAC update from meeting dated 27/10/21	MCPAC update from meeting dated 26/11/21		MCPAC update and items for approval from meeting dated 3/03/2022	MCPAC update and items for approval from meeting dated 27/04/2022	MCPAC items for Board Approval from meeting dated 01/06/22
HSC update and items for Board Approval		HSC update and items for approval from meeting dated 24/11/21		HSC update and items for approval from meeting dated 16/03/22		
DSAC update and items for Board Approval		DSAC update and items for approval from meeting dated 24/11/21		DSAC items for Board Approval from meeting dated 16/03/22		
Engagement						
Te Upoko o te Ika Māori Council (TUI MC)		Boards meet with TUI MC		Boards meet with TUI MC		Boards meet with TUI MC
Sub-Regional Disability Advisory Group		Sub-Regional Disability Advisory Group			Sub-Regional Disability Advisory Group	
Annual Planning and Reporting						
Budgets/Annual Plan	Planning process for 2022/2023 – subject to confirmation of process required for HNZ					
Annual Report			N/A			
Other items						
Environmental Sustainability Strategy				Sustainability Strategy update		
Procedural and Board process issues		Delegations for Summer Break				
Action log items						
Workshops/Training/Site Visit at conclusion of Board meeting (where time allows)						
Site Visit		Te Wao Nui/Children's Hospital – **TBC**				

Board Information – Public

6 October 2021

HVDHB Financial and Operational Performance Report – July 2021

Action Required

The HVDHB Board notes:

(a) the DHB had a ($3.3m) deficit for the month of July 2021, being ($0.5m) unfavourable to budget;

(b) the DHB year to date deficit excluding $0.1m net COVID-19 costs was ($3.2m);

(c) the Funder result for July was ($1.7m) unfavourable, Governance $0.1m favourable and Provider $1.1m favourable to budget;

(d) total Case Weighted Discharge (CWD) Activity was 12% ahead of plan.

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

Executive Summary

The COVID-19 response costs for the 21/22 financial year are expected to be fully funded by the Ministry of Health, net costs for July are $118k. The Ministry have asked DHBs to separately report ongoing provisions for the liability due to Holidays Act remediation from the base budget. The Ministry have confirmed that remediation costs and costs to calculate the remediation and rectify the systems will be funded via additional deficit support not operating income.

- Excluding the Holidays Act provision and the net COVID-19 costs the DHB's result for the one month to 31 July 2021 is a ($2.9m) deficit, versus a budget deficit of ($2.8m).
    - The monthly provision for increasing Holidays Act liability is $227k.
    - For the one month to 31 July 2021 the overall DHB result, including COVID-19 and Holidays Act costs is a ($3.29m) deficit compared to a budget deficit of ($2.8m). This includes an estimate for an IDF outflow highcost burns patient of $1.7m.
- Key underspends in the provider include; Medical personnel, Allied Health personnel and depreciation. In the funder underspends in demand driven costs including; Aged Residential Care (ARC) and Other Health of Older People (Other HoP).

- Capital Expenditure for July was $0.8m with $36.8m remaining including projects that were delayed and funding which has been transferred into this financial year.
- The DHB has a positive cash balance at month-end of $21.6 million which is better than was budgeted due to delayed capital spend. We are expecting an equity injection for capital in relation to two capital projects approved for MoH funding (TWA replacement and the Maternity upgrade projects). The equity injection is expected in 2021/22 to line up with forecast expenditure.

Hospital:

The pressures in July see the principles of our Winter Plan in action. ED and specialities have worked together to consider alternative pathways of care rather than an inpatient stay; Inpatient areas are flexing up in bed numbers in order to better match the needs of our community who are presenting for care. This is the whole of system approach working together to enable shorter stays in ED. The ministry is collating data on a weekly basis to develop a national view about the impact of the increased demand seen across the country.

- Planned care – the delivery of Specialist assessments or Treatment within 120 days continues to be a major challenge in managing this against acute volumes however we are making slow progress against our long wait patients, continuing work is in place to achieve the Recovery wait list trajectories. We continue to liaise weekly with the Ministry planned care team seeking support and advice as we lead out our system improvement project aimed at making progress around all aspects of managing elective flow.
- We continue with the 2D Bed & Theatre Capacity project to identify and deliver solutions for short to medium term improvement in OT capacity across 3 Hospitals (Kenepuru, Wellington & Hutt).
- Workforce shortages across midwifery and nursing, allied health in particular sonographer social work and radiographers are at critical levels in some areas; we are continually refining and reviewing processes to manage demand during busy periods and continue to work closely with our staff and union partners on workforce planning across the region noting this issue as requiring national solutions. The 2D Nursing and Midwifery Recruitment and Retention Strategy, written to assist with the drive we need right now to fill vacancies in both workforces, at both DHBs and seek to retain our existing staff is being led by our Chief Nurse.
- A cautious start to the new financial year – meeting budget.

Funder

- Engagement with the full set of WCTO visits in the first year of life is challenging. The factors influencing performance are complex and varied, particularly for Māori and Pacific women. A lack of continuity in support throughout the first 1,000 days, exacerbated by ongoing midwifery shortages. Our commissioning team is looking at our learnings from COVID Vaccine Commissioning to see how we can achieve equity using a different commissioning and provider model.
- Poor control of long term conditions are a driver of ASH rates, in particular cardiovascular and respiratory conditions are the top presenting conditions, particularly for Māori and Pacific peoples. To address these areas we are focusing on access to acute care in primary care practices including the focus for diabetes is on upskilling nurses and GPs with regard to the new funded specialist authority medication Empagliflozin.
- A Mental Health and Addiction Commissioning Forum has been established to steer the redesign and implementation of a whole of population, equitable, MHA system of care to support the wellbeing of the people in the region. The Commissioning Forum will focus on upholding our Te Tiriti o Waitangi obligations developing a kaupapa Māori approach across the continuum of services and designing services that improve wellbeing and achieve equity for our priority populations: Māori, Pacific people and Disabled people.

Strategic Considerations

Service	Financial performance and funding is a key to delivering the services for the Hutt Valley populations.
People	Staff numbers for HVDHB are 53 below plan.
Financial	Planned deficit for HVDHB is $30.8 million with no COVID-19 impacts included.
Governance	The FRAC committee is accountable for scrutinising the financial and operational performance on behalf of the board, and reporting back to the board on issues as identified by the committee.

Engagement/Consultation

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

Identified Risks

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

Attachments

3.2.1 Hutt Valley DHB Financial and Operational Performance Report – July 2021

Monthly Financial and Operational Performance Report

For period ending
31 July 2021 (unaudited)

Contents

Section 1

Financial and Performance Overview and Executive Summary

Executive Summary

- The COVID-19 response costs for the 21/22 financial year are expected to be fully funded by the Ministry of Health, net costs for July are $118k. The Ministry have asked DHBs to separately report ongoing provisions for the liability due to Holidays Act remediation from the base budget as this has not been funded. The Ministry have confirmed that remediation costs and costs to calculate the remediation and rectify the systems will be funded via additional deficit support not operating income.
- Excluding the Holidays Act provision and the net COVID-19 costs the DHB's result for the one month to 31 July 2021 is a ($2.9m) deficit, versus a budget deficit of ($2.8m).
  - The monthly provision for increasing Holidays Act liability is $227k.
  - For the one month to 31 July 2021 the overall DHB result, including COVID-19 and Holidays Act costs is a ($3.29m) deficit compared to a budget deficit of ($2.8m). This includes an estimate for an IDF outflow highcost burns patient of $1.7m.
- Key underspends in the provider include; Medical personnel, Allied Health personnel and depreciation. In the funder underspends in demand driven costs including; Aged Residential Care (ARC) and Other Health of Older People (Other HoP).
- Capital Expenditure for July was $0.8m with $36.8m remaining including projects that were delayed and funding whcih has been transferred into this financial year.
- The DHB has a positive cash balance at month-end of $21.6 million which is better than was budgeted due to delayed capital spend. We are expecting an equity injection for capital in relation to two capital projects approved for MoH funding (TWA replacement and the Maternity upgrade projects). The equity injection is expected in 2021/22 to line up with forecast expenditure.

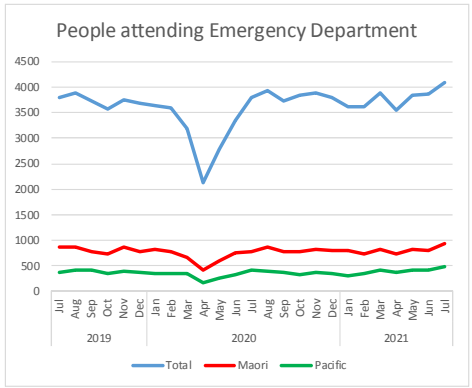
Executive Summary (continued)

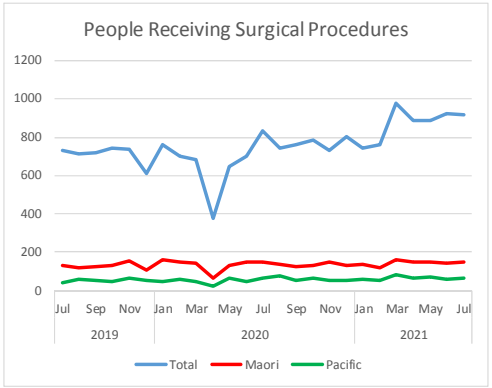
- **Hospital:** The pressures in July see the principles of our Winter Plan in action. ED and specialities have worked together to consider alternative pathways of care rather than an inpatient stay; Inpatient areas are flexing up in bed numbers in order to better match the needs of our community who are presenting for care. This is the whole of system approach working together to enable shorter stays in ED. The ministry is collating data on a weekly basis to develop a national view about the impact of the increased demand seen across the country.
- Planned care – the delivery of Specialist assessments or Treatment within 120 days continues to be a major challenge in managing this against acute volumes however we are making slow progress against our long wait patients, continuing work is in place to achieve the Recovery wait list trajectories. We continue to liaise weekly with the Ministry planned care team seeking support and advice as we lead out our system improvement project aimed at making progress around all aspects of managing elective flow.
- We continue with the 2D Bed & Theatre Capacity project to identify and deliver solutions for short to medium term improvement in OT capacity across 3 Hospitals (Kenepuru, Wellington & Hutt).
- Workforce shortages across midwifery and nursing, allied health in particular sonographer social work and radiographers are at critical levels in some areas; we are continually refining and reviewing processes to manage demand during busy periods and continue to work closely with our staff and union partners on workforce planning across the region noting this issue as requiring national solutions. The 2D Nursing and Midwifery Recruitment and Retention Strategy, written to assist with the drive we need right now to fill vacancies in both workforces, at both DHBs and seek to retain our existing staff is being led by our Chief Nurse.
- A cautious start to the new financial year – meeting budget.
- **Funder**
- Engagement with the full set of WCTO visits in the first year of life is challenging. The factors influencing performance are complex and varied, particularly for Māori and Pacific women. A lack of continuity in support throughout the first 1,000 days, exacerbated by ongoing midwifery shortages. Our commissioning team is looking at our learnings from COVID Vaccine Commissioning to see how we can achieve equity using a different commissioning and provider model.
- Poor control of long term conditions are a driver of ASH rates, in particular cardiovascular and respiratory conditions are the top presenting conditions, particularly for Māori and Pacific peoples. To address these areas we are focusing on access to acute care in primary care practices including the focus for diabetes is on upskilling nurses and GPs with regard to the new funded specialist authority medication Empagliflozin.
- A Mental Health and Addiction Commissioning Forum has been established to steer the redesign and implementation of a whole of population, equitable, MHA system of care to support the wellbeing of the people in the region. The Commissioning Forum will focus on upholding our Te Tiriti o Waitangi obligations developing a kaupapa Māori approach across the continuum of services and designing services that improve wellbeing and achieve equity for our priority populations: Māori, Pacific people and Disabled people.

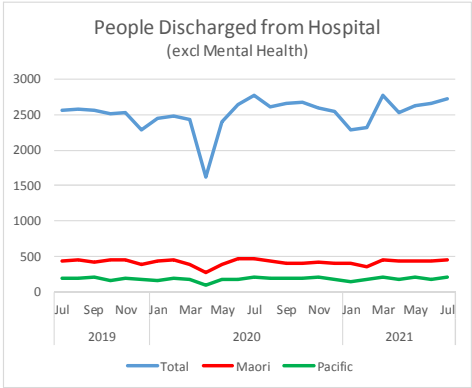
Performance Overview: Activity Context (People Served)

The numbers below count individuals once and are based on Hutt Valley DHB being the DHB of Service. Our services have returned to delivering services to our population without the restrictions due to COVID-19. July was busy with acute cases. Note Mental Health now reported by CCDHB as they are the DHB of service for MHAIDS

People attending ED	**4,098**	933 Maori, 474 Pacific
People receiving Surgical Procedures	**917**	148 Maori, 64 Pacific
People discharged from Hospital (excl Mental Health)	**2,726**	448 Maori, 213 Pacific







Performance Overview: Activity Context (People Served)

People seen in Outpatient & Community

8,878

1,305 Maori, 594 Pacific

Primary Care Contacts

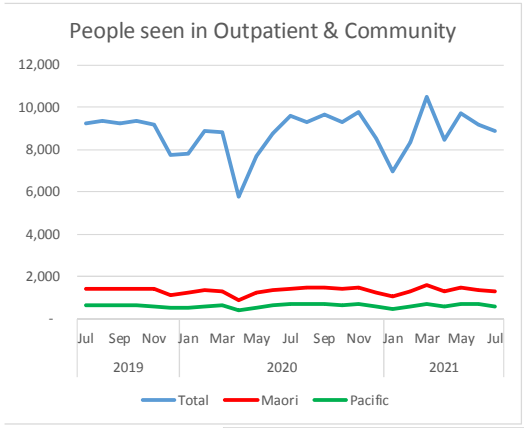
38,791

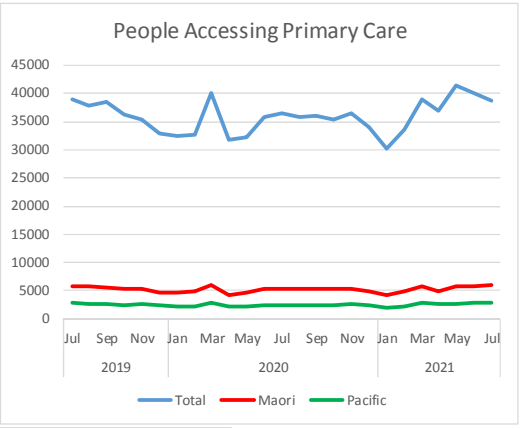
5,975 Maori, 2,845 Pacific

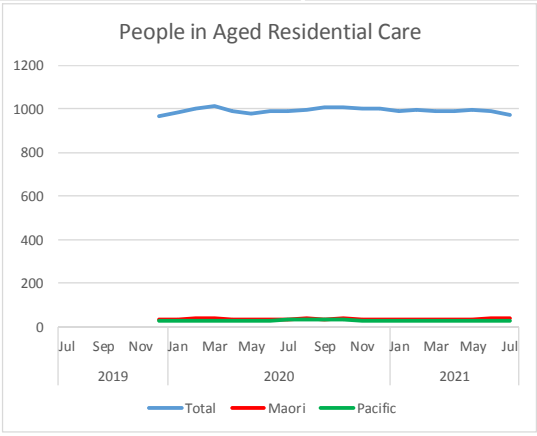
People in Aged Residential Care

972

38 Maori, 28 Pacific







Financial Overview – July 2021

YTD Operating Position	YTD Provider Position	YTD Funder Position	YTD Capital Exp
$3.2.m deficit	$0.7m surplus	$4.1m deficit	N/A
Against the budgeted deficit of $2.8m.	Against the budget deficit of $0.5m.	Against the budget deficit of $2.3m.	Not available for July.

YTD Activity vs Plan (CWDs)	YTD Paid FTE	Annual Leave Accrual
12% ahead	1,871	$21.9m
270 CWDs ahead PVS plan for July. IDFs were 33 CWD above budget for the month	YTD 53 FTE below annual budget of 1,924 FTE.	This is an increase of $0.0m on prior period.

Hospital Performance Overview – July 2021

YTD Shorter stays in ED	People waiting >120 days for treatment (ESPI5)	People waiting >120 days for 1st Specialist Assmt (ESPI2)	Faster Cancer Treatment
80%	930	642	75%
15% below the ED target of 95%, and below July 20 90%.	Against a target of zero long waits a monthly increase of 26.	Against a target of zero long waits a monthly increase of 17	We were below the 62 day target this month. The 31 day target was achieved at 90%

YTD Activity vs Plan (CWD)	YTD Standard FTE	Serious Safety Events
12% ahead	1,862	0
270 CWDs ahead PVS plan for July. IDFs were 33 CWD above budget for the month	186 below YTD budget of 1,915 FTE. Month FTE was 186 under budget an upwards movement from June of 31 FTE.	An expectation is for nil SSEs at any point.

Section 2

FUNDER PERFORMANCE

Executive Summary – Funder

- Overall the funder has an unfavourable variance of ($1.68m) for the month, which includes IDF outflow costs for a high cost burns patient estimated at ($1.7m). Other external costs include additional COVID-19 related costs of ($273k).
- Aged residential care costs are $283k favourable for the month, Other Health of Older People costs are favourable $26k for the month and Pharmaceutical costs are under $47k for the month.
- Mental Health costs are unfavourable ($37k) for the month reflecting timing of contracts which will be rectified with the acute care continuum.
- Engagement with the full set of WCTO visits in the first year of life is challenging. The factors influencing performance are complex and varied, particularly for Māori and Pacific women. A lack of continuity in support throughout the first 1,000 days, exacerbated by ongoing midwifery shortages. Our commissioning team is looking at our learnings from COVID Vaccine Commissioning to see how we can achieve equity using a different commissioning and provider model.
- Poor control of long term conditions are a driver of ASH rates, in particular cardiovascular and respiratory conditions are the top presenting conditions, particularly for Māori and Pacific peoples. To address these areas we are focusing on access to acute care in primary care practices including the focus for diabetes is on upskilling nurses and GPs with regard to the new funded specialist authority medication Empagliflozin. A hui was held to discuss complex patient management with GPs, nurses and MDTs and CVRA screening in Māori and Pacific (particularly males) continues in PHOs through flexible appointment arrangements and Saturday clinics to support prevention and early intervention. We continue to work with our PHOs on new ways to engage and recall Māori and Pacific.
- The average general adult bed deficit is 37 at Wellington Regional Hospital in 2020/21. We have analysed data across our 2DHB Hospital Network and identified a number of demographic and clinical drivers that are impacting acute flow and acute demand across our health system (see June update). We are responding through a series of targeted performance based projects including ‘front of whare’ and ‘planned care’.
- A Mental Health and Addiction Commissioning Forum has been established to steer the redesign and implementation of a whole of population, equitable, MHA system of care to support the wellbeing of the people in the region. The Commissioning Forum will focus on upholding our Te Tiriti o Waitangi obligations developing a kaupapa Māori approach across the continuum of services and designing services that improve wellbeing and achieve equity for our priority populations: Māori, Pacific people and Disabled people.

Funder Financial Statement – July 2021

DHB Funder (Hutt Valley DHB)

Financial Summary for the month of July 2021

Month					$000s	Year to Date					Annual	
Actual	Budget	Variance	Last Year	Variance		Actual	Budget	Variance	Last Year	Variance	Budget	Last Year
					Revenue							
39,832	39,837	(5)	37,970	1,862	Base Funding	39,832	39,837	(5)	37,970	1,862	478,038	455,083
2,434	2,411	23	2,435	(1)	Other MOH Revenue	2,434	2,411	23	2,435	(1)	28,932	34,030
26	26	0	(37)	63	Other Revenue	26	26	0	(37)	63	307	733
9,557	9,557	0	9,171	386	IDF Inflows	9,557	9,557	0	9,171	386	114,678	111,945
51,849	**51,830**	**19**	**49,539**	**2,310**	**Total Revenue**	**51,849**	**51,830**	**19**	**49,539**	**2,310**	**621,955**	**601,791**
					Expenditure							
349	349	0	416	67	DHB Governance & Administration	349	349	0	416	67	4,183	4,652
21,491	21,391	(100)	20,861	(630)	DHB Provider Arm	21,491	21,391	(100)	20,861	(630)	256,689	252,732
					External Provider Payments							
4,192	4,239	47	2,864	(1,328)	Pharmaceuticals	4,192	4,239	47	2,864	(1,328)	50,057	37,162
4,387	4,448	61	4,637	250	Laboratory	4,387	4,448	61	4,637	250	53,169	52,577
2,710	2,684	(26)	2,704	(6)	Capitation	2,710	2,684	(26)	2,704	(6)	32,214	31,021
1,155	1,264	109	1,256	101	ARC-Rest Home Level	1,155	1,264	109	1,256	101	14,858	13,871
1,835	2,009	174	1,865	31	ARC-Hospital Level	1,835	2,009	174	1,865	31	23,599	21,724
2,777	2,803	26	2,711	(66)	Other HoP & Pay Equity	2,777	2,803	26	2,711	(66)	33,635	30,333
1,059	1,022	(37)	915	(144)	Mental Health	1,059	1,022	(37)	915	(144)	12,265	11,898
2,259	2,006	(253)	1,786	(473)	Other External Provider Payments	2,259	2,006	(253)	1,786	(473)	24,403	25,067
13,691	11,991	(1,700)	9,106	(4,585)	IDF Outflows	13,691	11,991	(1,700)	9,106	(4,585)	143,894	108,813
55,905	**54,207**	**(1,698)**	**49,121**	**(6,784)**	**Total Expenditure**	**55,905**	**54,207**	**(1,698)**	**49,121**	**(6,784)**	**648,967**	**589,851**
(4,056)	**(2,377)**	**(1,679)**	**418**	**(4,474)**	**Net Result**	**(4,056)**	**(2,377)**	**(1,679)**	**418**	**(4,474)**	**(27,012)**	**11,939**

There may be rounding differences in this report

Funder Financials – Revenue

Revenue:

- Revenue is made up of base funding, other MOH revenue, other revenue and inter district flows. The table shows the variance for other MOH revenue.
- Base Funding is unfavourable ($5k) to budget for the month.
- Other MoH revenue is favourable $23k for July.
- IDF inflows are on target – until further information becomes available.

Other MOH Revenue Variance	MTH $000's	YTD $000's
Capitation Funding	22	22
B4 School Check Funding	(63)	(63)
More Heart and diabetes checks	(5)	(5)
Additional School Based MH Services	(19)	(19)
Maternity Quality and Safety Programme	100	100
Rheumatic Fever Prevention Services	(9)	(9)
Other CFA contracts	2	2
Year to date Variance $000's	**23**	**23**

Expenditure:

Governance and Administration is on target for July. Provider Arm payments variance includes adjustments to Maternity Quality & Safety Revenue.

External Provider Payments:

Pharmaceutical costs are favourable $47k for July.

Capitation expenses are ($26k) favourable for the month, partially offset by changes to revenue.

Aged residential care costs are $283k favourable for the month.

Other Health of Older People costs are favourable by $26k for the month.

Mental Health costs are unfavourable ($37k) for the month, consistent with June 2021.

Other External Provider Payments are ($253k) unfavourable, driven by largely by COVID-19 related payments.

IDF Outflows are unfavourable ($1,700k), due to a high cost patient.

Inter District Flows (IDF)

IDF Wash-ups and Service Changes July 2021		
IDF Outflows $000s	Variance to budget	
	Month	YTD
Base	0	0
	-	-
	-	-
Wash-ups		
2021/22 Outflows - inpatient	(1,700)	(1,700)
	-	-
2020/21 Outflows - inpatient	-	-
2020/21 Outflows - outpatient	-	-
2020/21 Outflows - PCT	-	-
2020/21 Outflows ATR	-	-
2020/21 PHO	-	-
2020/21 FFS	-	-
2020/21 Community Pharmacy	-	-
Rounding (timing) differences	-	-
IDF Outflow variance	**(1,700)**	**(1,700)**

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

IDF inflow (revenue):

- Based on the data available, overall IDF inflows are on target.

IDF Outflow (expense):

- Based on the data available, overall IDF outflows are over budget by ($1,700k) due to the recognition of a high cost burns patient.

Commissioning: Families & Wellbeing

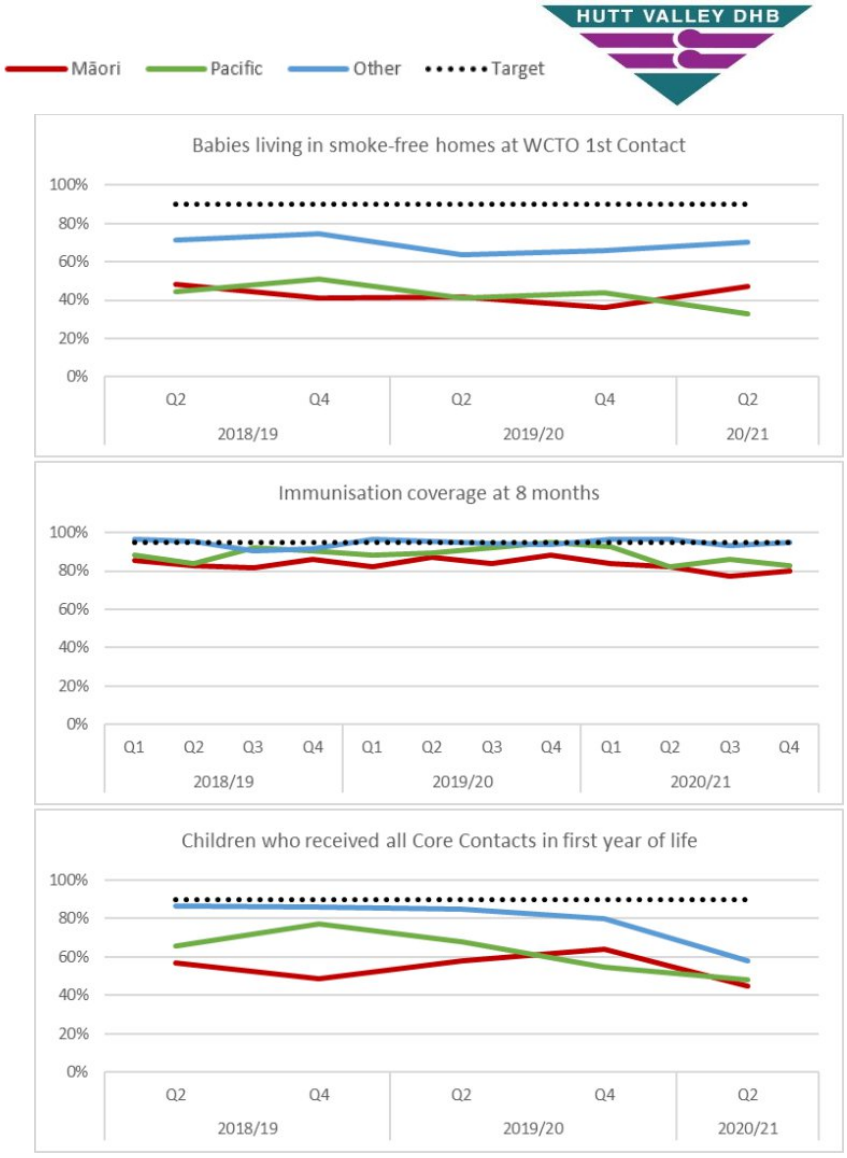
What is this measure?
- 90% of babies living in a smokefree home at 1st WCTO Contact
- 95% of children fully immunised at 8 months
- 90% of infants receive all WCTO core contacts in first year of life

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

How are we performing?
- Performance is below the 90% target for babies living in smoke-free homes at first WCTO Contact for Māori (47%), Pacific (33%) and non-Māori, non-Pacific (70%).
- Performance is below the 95% target for 8 month immunisation coverage for Māori (80%), Pacific (83%). Non-Māori, non-Pacific achieved target in Q4 (95%).
- Performance is below the 90% target for children receiving all WCTO Core Contacts by 1 years old for Māori (58%), Pacific (45%) and non-Māori, non-Pacific (58%).

What is driving performance?
- The deterioration in completed WCTO visits in late 2019/20 and early 2020/21 is a reflection of changes in (MoH set) expectations through the Covid-19 lockdown. Through this period some core checks were paused for most families, with the exception of specific high needs groups

Management comment
- We are focused on developing a pro-equity commissioning approach adopting the learnings of our COVID vaccine programme. What we know from our COVID Vaccine programme is that commissioning vaccination, with our priority populations (Maori, Pacific & Disability), in addition to the mainstream General Practice system can be more successful. This approach may not be cost neutral but will be developed as the equity gains may be worth a small investment.



Commissioning: Primary & Complex Care

What is this measure?

Management of Long-Term Conditions (LTC):

- 60% of people with diabetes and HbA1c ≤64mmol/mol and no inequity
- ASH admissions rate for cardiovascular conditions (45-64)
- ASH admissions rate for respiratory conditions (45-64)

Why is this important?

- LTCs comprise the major health burden for New Zealand now and into the foreseeable future, and are the leading cause of morbidity. Māori and Pacific people are disproportionately affected by LTC.
- Cardiovascular diseases (CVD) and diabetes are substantially preventable with lifestyle changes for those at moderate or higher risks, and good control of diabetes reduces long-term complications.
- People living with LTC are regarded as leading partners in their own care, and early detection and diagnosis enables treatment and management to begin as soon as possible.

How are we performing?

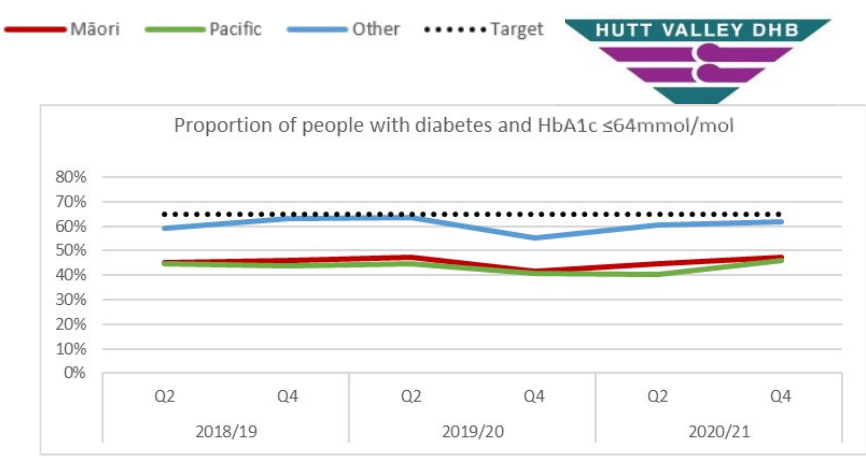
- Performance is below the 60% target for people with diabetes and HbA1c ≤64mmol/mol for Māori (48%), Pacific (46%), and non-Māori, non-Pacific (62%).
- The rate of ASH admissions for CVD conditions for 45-64 year olds was 2,403 for Māori, 3,362 for Pacific, and 1,618 for non-Māori, non-Pacific.
- The rate of ASH admissions for CVD conditions for 45-64 year olds was 1,738 for Māori, 1,362 for Pacific, and 429 for non-Māori, non-Pacific.

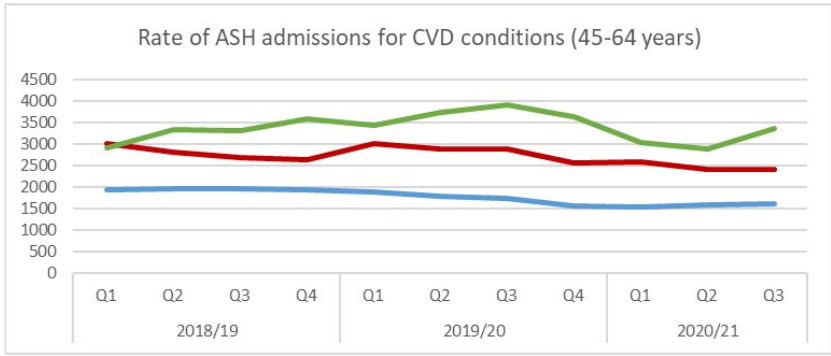
What is driving performance?

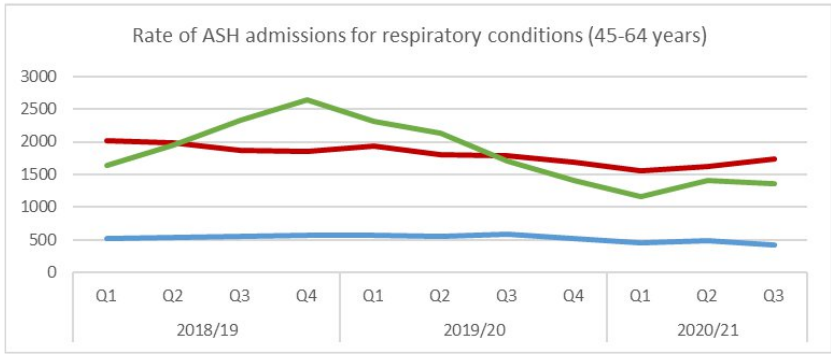
- Poor control of long term conditions are a driver of ASH rates, in particular cardiovascular and respiratory conditions are the top presenting conditions, particularly for Māori and Pacific peoples.

Management Comment

- To address these areas we are focusing on access to acute care in primary care practices:
- In Year 3, Healthcare Homes are to ensure that at least 30% of their high risk patients with a Year of Care plan are Māori and/or Pacific patients. Year of Care Plans are targeted to patients with long-term conditions that most commonly result in ASH admissions, such as respiratory conditions and cardiovascular disease.
- PHSHV is an outreach primary nursing service (similar to Vaka Atafaga in CCDHB) continues to support Pacific families in improving their health and health outcomes. ASH is one of the referral criteria for families, along with diagnosis of long term condition(s) which are high contributors to ASH admissions.







Commissioning: Hospital & Speciality Services

What is this measure?

Acute Flow at Hutt Hospital

- 95% of people presenting to ED seen with 6hrs
- ED Occupancy above 90%
- General Adult Hospital Occupancy

Why is this important?

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

How are we performing?

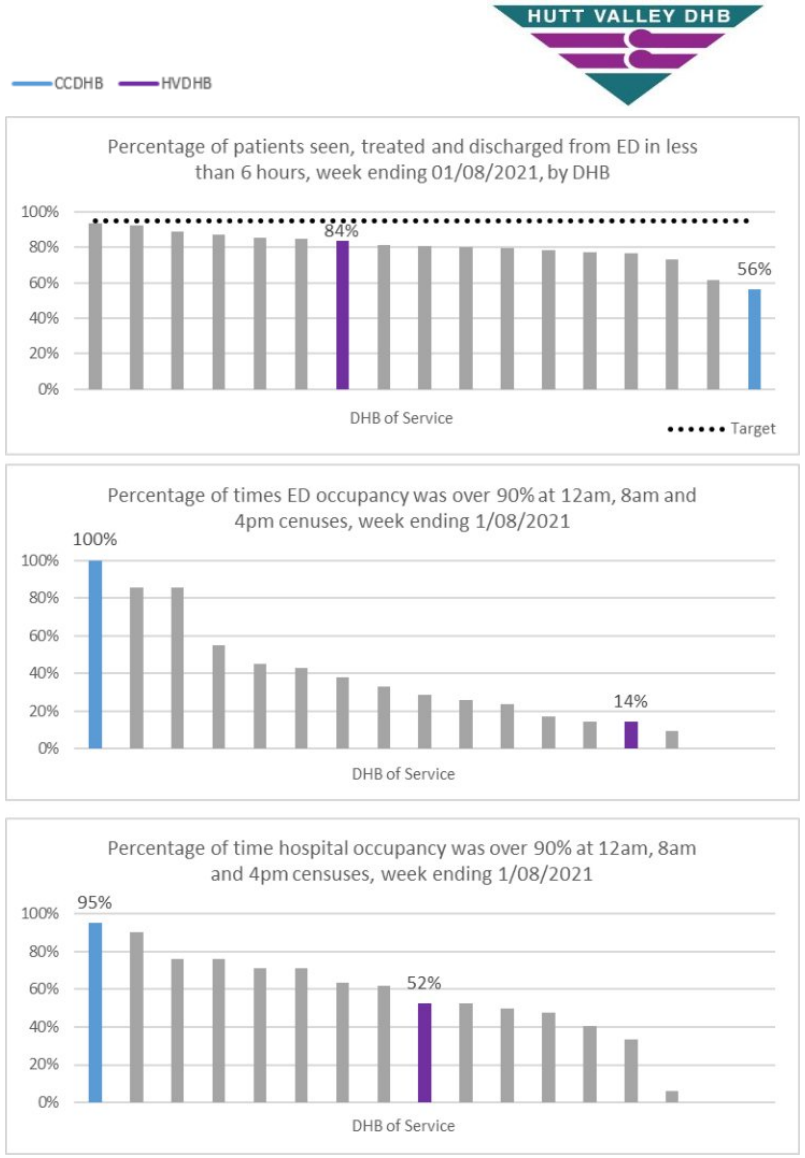
- The proportion of people presenting to ED and seen in under 6 hours was 84% (for the week ending 1 Aug).
- ED occupancy was over 90% in the week ending 1 Aug 14% of the time.
- Hospital occupancy was over 90% in the week ending 1 Aug 52% of the time.

What is driving performance?

- The average general adult bed deficit is 8 at Hutt Hospital in 2020/21.
- We have analysed data across our 2DHB Hospital Network and identified a number of demographic and clinical drivers that are impacting acute flow and acute demand across our health system (see June update).

Management comment:

- Destravis has been engaged to provide options on the best use of facilities across HVDHB and CCDHB in the 2DHB Hospital Network in the medium to long term.
- In response to capacity constraints we are undertaking the following projects identifying options for increasing **Bed and Theatre Capacity** across our three hospitals within the next two years while optimising use of current capacity. We are identifying options for increasing capacity and flow through Wellington ED and acute assessment areas as part of the **Front of Whare** project.
- A range of strategies underway to manage acute demand in both community and hospital settings, including **Winter Planning** to fund inpatient capacity with the provision of additional beds and physical spaces, and fund improved patient flow; and **community Investments** to deliver more care closer to home.
- These are part of the Hospitals strategic work programme for 2021/22.



Commissioning: Mental Health & Addictions

What is this measure?

- Number of specialist NGO and MHAIDS cultural interventions for Māori and Pacific
- Number of primary mental health and addiction interventions for Māori and Pacific
- ≥30% of mental health presentations to ED seen by an ED mental health nurse within an hour

Why is this important?

- In order to provide a pro-equity system of care, providers need to deliver solutions that are designed with people in mind. One such service is culturally specific interventions which are found throughout MHAIDS and NGO specialist services.
- Primary mental health and addiction services aim to provide timely care for people closer to home. Investment in this area will address people with lower levels of acuity earlier on.
- Emergency departments are under-equipped to resolve mental health presentations in a timely manner. The extensive wait times for mental health consultations often results in increasing distress and readmissions.

How are we performing?

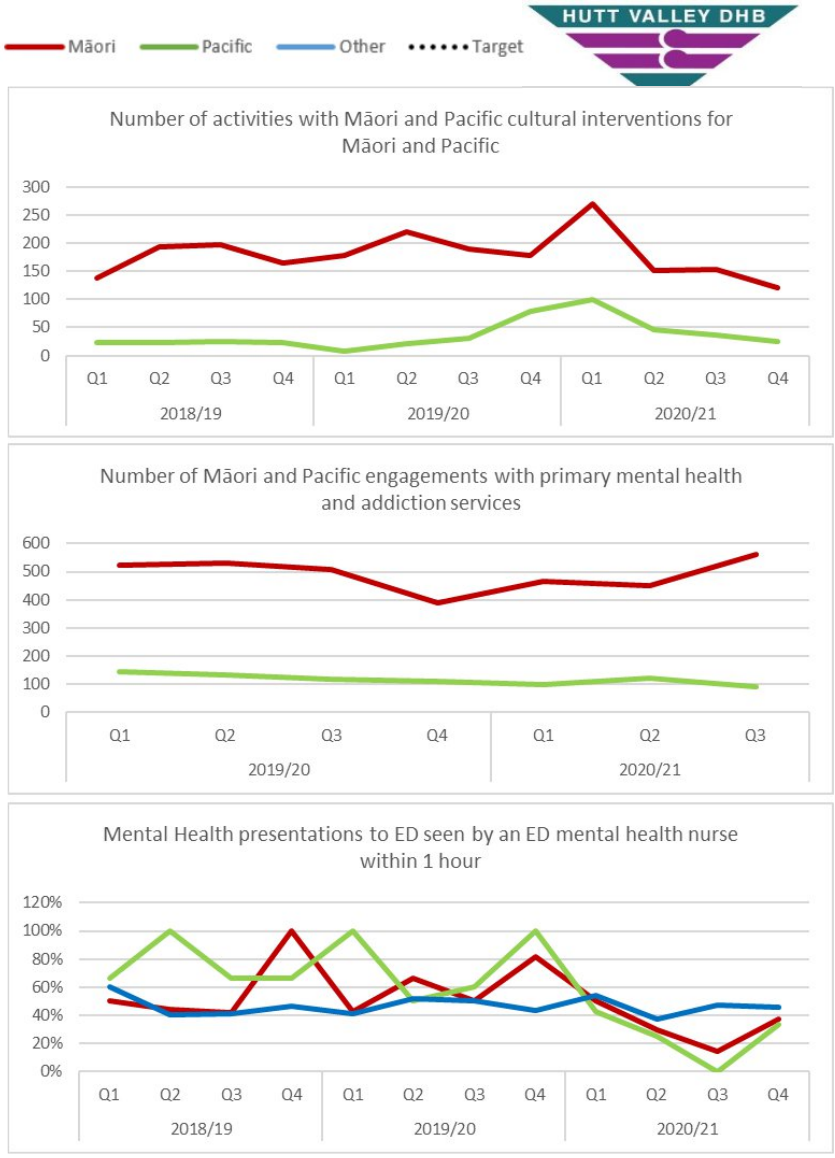
- The number of culturally-specific, specialist mental health and addiction interventions provided in Q4 was 121 for Māori and 26 for Pacific.
- The number of primary mental health and addiction interventions provided in Q4 was 562 for Māori and 90 for Pacific.
- The proportion of presentations to ED for mental health reasons that were seen by a mental health nurse within an hour was above the 30% target for Māori (38%) Pacific (33%), and non-Māori, non-Pacific (46%).

What is driving performance?

- Despite the current level of investment, we're not getting the outcomes we want for our people, particularly for Māori. There is a need to transform the MHA system to support equitable outcomes.

Management comment

- A Mental Health and Addiction Commissioning Forum has been established to steer the redesign and implementation of a whole of population, equitable, MHA system of care to support the wellbeing of the people in the region. The Commissioning Forum will focus on upholding our Te Tiriti o Waitangi obligations developing a kaupapa Māori approach across the continuum of services and designing services that improve wellbeing and achieve equity for our priority populations: Māori, Pacific people and Disabled people.



2DHB COVID-19 Response

What is this measure?

- COVID-19 vaccination roll-out

Why is this important?

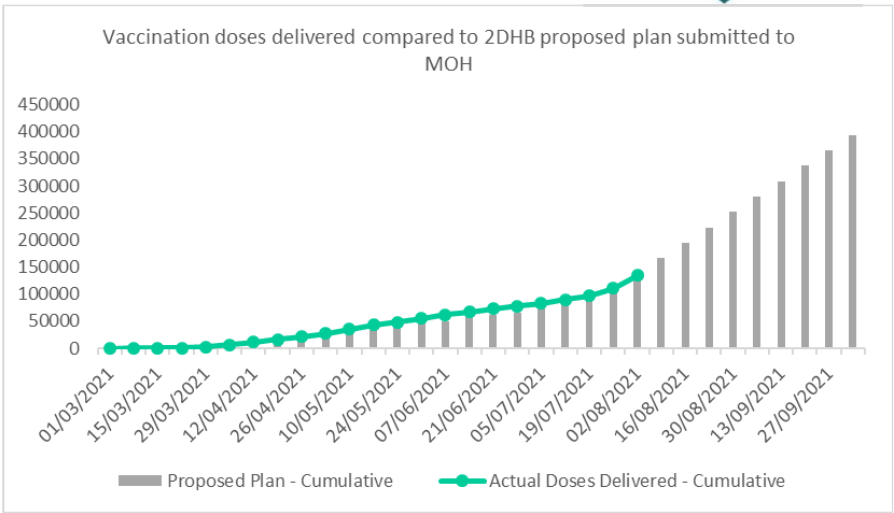
- The COVID-19 vaccine rollout aims to protect Aotearoa by ensuring that everyone over 16 years old receives the two doses. Ensuring equitable access to free COVID-19 vaccines is a priority for New Zealand.
- First we are protecting those most at risk of COVID-19.

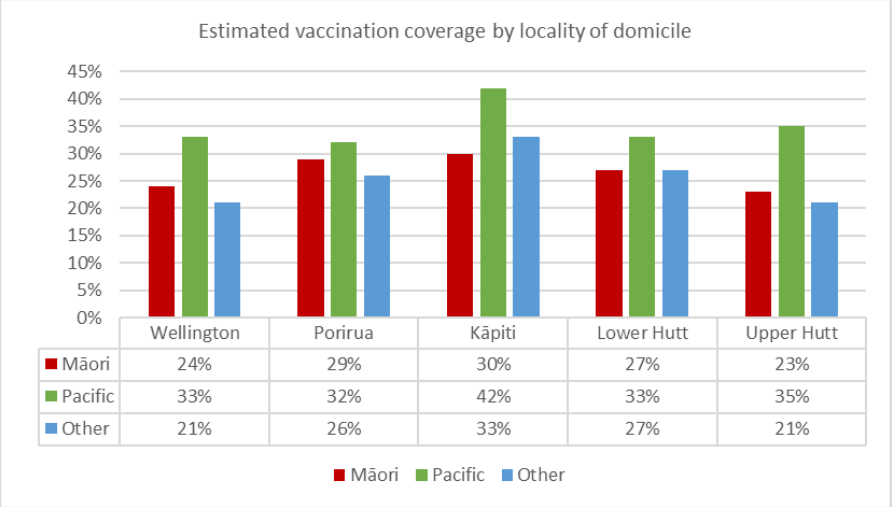
How are we performing?

- **Group 1: Protect our border and MIQ workers**
  - Border and MIQ workers and employees and the people they live with
- **Group 2: Protect our high-risk frontline workers and people living in high-risk places**
  - High-risk frontline health care workers (public and private)
  - People living in long-term residential care
  - People working in long-term residential environments
  - Older Māori and Pacific people cared for by their whānau (and their carers and the people they live with)
  - People aged 65+ or with underlying health conditions or a disability living in the Counties Manukau DHB area
- **Group 3: Protect the people who are at risk of getting very sick from COVID-19**
  - People who are 65+
  - People with underlying health conditions1
  - Disabled people
  - People caring for a person with a disability
  - Pregnant people
  - People in custodial settings
- **Group 4: Protect everyone**
  - Everyone in Aotearoa New Zealand aged 16 and over not already eligible for a vaccine

Data and statistics about the rollout of COVID-19 vaccines in CCDHB can be found here.

Data Sources: COVID-19: Vaccination 2DHB Qlik App
Date Range: 22/02/2021 to 04/08/2021
Data current at: 06/08/2021 @11:00am





	Wellington	Porirua	Kāpiti	Lower Hutt	Upper Hutt
Māori	24%	29%	30%	27%	23%
Pacific	33%	32%	42%	33%	35%
Other	21%	26%	33%	27%	21%

Section 3

Hospital Performance

Executive Summary – Hospital Performance

- The pressures in July see the principles of our Winter Plan in action. ED and specialities have worked together to consider alternative pathways of care rather than an inpatient stay; Inpatient areas are flexing up in bed numbers in order to better match the needs of our community who are presenting for care. This is the whole of system approach working together to enable shorter stays in ED. The Ministry is collating data on a weekly basis to develop a national view about the impact of the increased demand seen across the country.
- Planned care – the delivery of Specialist assessments or Treatment within 120 days continues to be a major challenge in managing this against acute volumes however we are making slow progress against our long wait patients, continuing work is in place to achieve the Recovery wait list trajectories. We continue to liaise weekly with the Ministry planned care team seeking support and advice as we lead out our system improvement project aimed at making progress around all aspects of managing elective flow.
- We continue with the 2D Bed & Theatre Capacity project to identify and deliver solutions for short to medium term improvement in OT capacity across 3 Hospitals (Kenepuru, Wellington & Hutt).
- Workforce shortages across midwifery and nursing, allied health in particular sonographer social work and radiographers are at critical levels in some areas; we are continually refining and reviewing processes to manage demand during busy periods and continue to work closely with our staff and union partners on workforce planning across the region noting this issue as requiring national solutions. The 2D Nursing and Midwifery Recruitment and Retention Strategy, written to assist with the drive we need right now to fill vacancies in both workforces, at both DHBs and seek to retain our existing staff is being led by our Chief Nurse.
- A cautious start to the new financial year – meeting budget.

Hospital Throughput

Month					Hutt Valley DHB Hospital Throughput YTD Jul-21	Year to Date					Annual	
Actual	Budget	Variance Actual vs Budget	Last year	Variance Actual vs Last year		Actual	Budget	Variance Actual vs Budget	Last year	Variance Actual vs Last year	Annual Budget	Last year
					Discharges							
1,224	1,185	(39)	1,284	60	Surgical	1,224	1,185	(39)	1,284	60	14,143	13,880
2,061	1,758	(303)	1,881	(180)	Medical	2,061	1,758	(303)	1,881	(180)	20,853	22,570
382	381	(1)	466	84	Other	382	381	(1)	466	84	4,464	5,221
3,667	**3,324**	**(343)**	**3,631**	**(36)**	**Total**	**3,667**	**3,324**	**(343)**	**3,631**	**(36)**	**39,461**	**41,671**
					CWD							
1,279	1,237	(42)	1,297	18	Surgical	1,279	1,237	(42)	1,297	18	14,879	13,880
1,133	979	(154)	964	(169)	Medical	1,133	979	(154)	964	(169)	11,317	22,570
449	462	12	406	(43)	Other	449	462	12	406	(43)	5,146	5,087
2,862	**2,678**	**(184)**	**2,668**	**(194)**	**Total**	**2,862**	**2,678**	**(184)**	**2,668**	**(194)**	**31,342**	**41,537**
					Other							
4,592	4,114	(478)	4,039	(553)	Total ED Attendances	4,592	4,114	(478)	4,039	(553)	49,261	50,206
1,015	1,015	0	1,069	54	ED Admissions	1,015	1,015	0	1,069	54	11,294	12,086
847	854	7	868	21	Theatre Visits	847	854	7	868	21	10,232	9,587
125	152	27	160	35	Non- theatre Proc	125	152	27	160	35	1,638	1,631
8,057	7,398	(658)	7,590	(467)	Bed Days	8,057	7,398	(658)	7,590	(467)	84,357	89,609
4.60	4.55	(0.05)	4.32	(0.28)	ALOS Inpatient	4.60	4.55	(0.05)	4.32	(0.28)	4.55	4.55
2.11	2.08	(0.04)	1.97	(0.14)	ALOS Total	2.11	2.08	(0.04)	1.97	(0.14)	2.08	2.08
7.15%	8.02%	0.87%	7.23%	0.08%	Acute Readmission	7.15%	8.02%	0.87%	7.23%	0.08%	7.31%	7.80%

For the month of July, Medical discharges much higher than budget and the same time last year, mainly due to high discharges under Emergency (treated over 3 hours and discharged) during the RSV outbreak. Surgical discharges and caseweights over slightly over budget but lower than the same time last year, mainly due to higher Orthopaedics volumes. Other services are close to budget for discharges and caseweights.

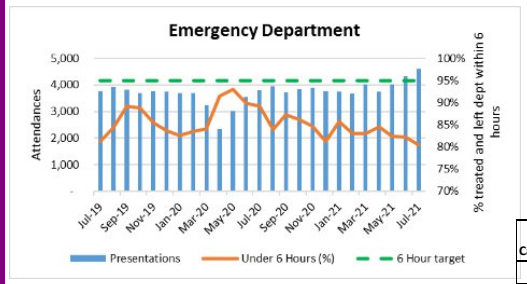
Total ED visits were higher than budget for the month but the number of patients who were admitted to inpatient wards from ED was on budget. Theatre visits was close to budget but Non-theatre procedures were lower than budget for the month, and the previous year (may be impacted by coding lag). Bed days were significantly higher than budget for the month and the same time last year. Inpatient ALOS in July was slightly longer than budget and the same time last year. The acute readmission rate was lower than budget and the same time last year

Operational Performance Scorecard – 13 mths

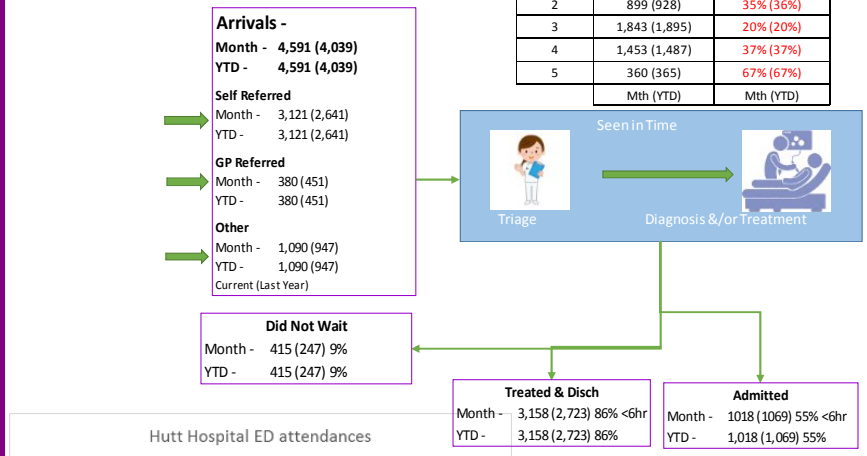
Domain	Indicator (MoH KPIs highlighted yellow)	2019/20 Target	13 Months Performance Trend													Last 4 Weeks			
			Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	5/07/21	12/07/21	19/07/21	26/07/21
Safe	Serious Safety Events[1] confirmed	Zero	3	3	1	2	3	0	1	3	3	3	0	2	0				
	SABSI Cases [2]	Zero	1	0	1	2	1	1	1	0	1	0	0	1	3				
	C. difficile infected diarrhoea cases	Zero	3	4	1	1	4	0	1	0	1	2	1	1	2				
	Hand Hygiene compliance (quarterly)	≥ 80%	82%			79%			79%			80%							
	Seclusion Hours- average per event (MH Inpatient ward TWA)[3]		27.7	36.7	11.4	13.3	1.4	43.6	7.6	22.4	39.8	13.6	21.0	21.4	16.9				
Timely	Emergency Presentations	49,056	4,039	4,281	3,997	4,273	4,328	4,259	4,059	4,026	4,315	3,982	4,315	4,331	4,593	1,144	964	992	966
	Shorter Stays in ED (SSiED) % within 6hrs	≥95%	89.2%	84.0%	87.2%	86.3%	84.8%	81.3%	85.8%	83.1%	83.1%	84.6%	82.6%	81.5%	79.0%	75.9%	79.5%	78.7%	82.4%
	SSiED % within 6hrs - non admitted	≥95%	93.3%	90.7%	91.5%	91.0%	89.8%	86.9%	90.7%	89.9%	89.5%	89.7%	89.6%	89.2%	86.5%	83.1%	88.5%	87.4%	88.2%
	SSiED % within 6hrs - admitted	≥95%	78.6%	64.5%	75.1%	73.2%	71.8%	66.3%	72.0%	62.8%	65.3%	70.3%	61.3%	56.8%	55.5%	51.9%	54.5%	49.5%	64.4%
	Total Elective Surgery Long Waits -ESPI 5	Zero Long Waits	1,082	913	915	992	1,002	1,115	1,251	1,328	1,238	1,177	1,020	904		875	860	922	910
	No. Theater surgeries cancelled (OP 1-8)		140	148	154	142	128	138	87	139	198	124	127	186	149	35	30	43	34
	Total Elective & Acute Operations in MainTheatres 1-8[6]		868	792	805	824	775	744	664	712	898	816	843	856	847	211	190	172	186
	Specialist Outpatient Long Waits- ESPI 2	Zero Long Waits	1,096	798	674	723	704	758	1,016	1,124	1,093	1,015	808	625		664	654	682	707
	Outpatient Failure to Attend %	≤6.3%	6.8%	6.3%	5.4%	5.6%	6.0%	6.2%	7.7%	5.6%	5.5%	6.2%	6.4%	6.6%	6.3%	6.6%	5.5%	6.4%	7.0%
	Full Year Forecast surplus / (deficit) $m - Provider (1) (2)	($2.03)	($10.61)	($10.61)	($15.38)	($12.54)	($14.33)	($14.64)	($14.29)	($16.06)	($19.72)	($20.40)	($25.09)	($25.43)	TBC				
	Full Year Forecast surplus / (deficit) $m - DHB (1) (2)	($8.14)	($10.65)	($10.65)	($13.37)	($12.31)	($12.87)	($14.54)	($14.33)	($14.24)	($14.25)	($14.01)	($16.93)	($12.23)	TBC				
	% Theatre utilisation (Elective Sessions only)[7]	≤90%	85.7%	87.9%	90.4%	86.2%	88.1%	87.2%	86.4%	87.2%	87.8%	88.4%	87.8%	87.3%	87.1%	87.1%	92.9%	83.4%	85.0%
	Overnight Patients - Average Length of Stay (days)	≤4.3	4.39	4.76	4.52	4.26	4.72	4.79	4.50	4.37	4.89	4.35	4.69	4.80	4.64	4.36	4.80	5.44	4.77
	Long Stay Patients Not Yet Discharged (>14 days)	≤5	16	21	17	15	21	24	21	34	20	23	29	22	25	26	26	25	27
	Overnight Beds (General Occupancy) - Average Occupied	≤130	141	151	144	130	138	144	130	149	146	143	148	152	153	152	154	156	149
	Overnight Beds (General Occupancy) - % Funded Beds Occupied	≤85%	86.8%	93.1%	88.8%	80.4%	85.1%	93.4%	84.7%	96.5%	94.8%	92.9%	96.2%	98.5%	94.3%	93.9%	95.3%	96.2%	92.2%
	All Beds - ave. beds occupied[8]	≤250	244	254	249	231	240	240	229	253	253	243	255	256	260	265	260	256	257
	% sick Leave v standard	≤3.5%	4.3%	4.2%	4.0%	3.4%	3.4%	3.1%	2.0%	2.5%	3.5%	3.1%	3.2%	3.8%	4.1%				
	% Nursing agency v employee (10)	≤1.49%	1.6%	1.2%	2.2%	26.2%	12.7%	12.7%	12.8%	12.4%	13.0%	11.8%	0.4%	14.5%	TBC				
	% overtime v standard (medical) (10)	≤9.22%	6.7%	7.8%	8.1%	9.2%	10.7%	6.9%	11.9%	9.6%	7.9%	8.3%	10.1%	8.7%	TBC				
	% overtime v standard (nursing)	≤5.47%	10.8%	13.6%	12.3%	12.3%	14.4%	11.6%	23.7%	14.2%	11.2%	15.7%	13.2%	15.9%	TBC				

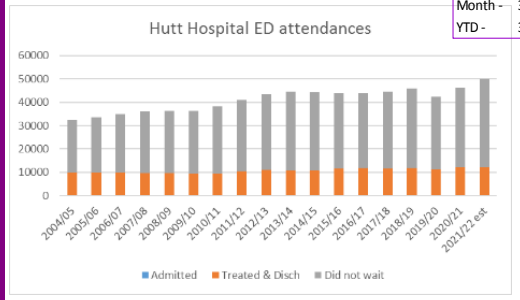
Refer to later pages for more details on HVDHB performance. Highlighted where an identified target in 20/21.

Shorter Stays in Emergency Department (ED)



Category	Volume	% Seen in time
1	37 (37)	100% (100%)
2	899 (928)	35% (36%)
3	1,843 (1,895)	20% (20%)
4	1,453 (1,487)	37% (37%)
5	360 (365)	67% (67%)
	Mth (YTD)	Mth (YTD)





- **What is this Measure**
  - The percentage of patients admitted, discharged and transferred from an Emergency Department within 6 hours.
- **Why is it important**
  - This indicator measures flow through the whole system it is impacted by the number planned of people arriving at ED, how fast ED treats them, availability of beds in the hospital and community service availability.
- **How are we performing**
  - The month of July has seen an overall increase in ED presentations when compared with July 2020. This combined with a sustained increase in presentations of a higher acuity and a hospital bed state running over 90% capacity has pressurised our ability to treat and move on patients from the ED within 6 hours.
- **What is driving Performance**
  - We have seen a record number of presentations in July with over 500 more patients seen during the month compared to July 2020 and yet the department still managed to see, treat and discharge 79% of these patients within 6 hours.
  - 20% of July presentations are under six years of age which is a 100% increase from July 2020.
  - Our admission rate remains unchanged at 22%.
- **Management Comment**
  - Inpatient areas are experiencing the effects of a lack of aged residential care beds in the community. In turn access block into the hospital impacts on ED. Daily management meetings are occurring to assess capacity and ensure best use of all available beds for all patients requiring care.
  - A range of strategies supporting Winter Planning and improved patient flow continue.

Planned Care Funding & Service delivery

Figure one: Planned care funding sources

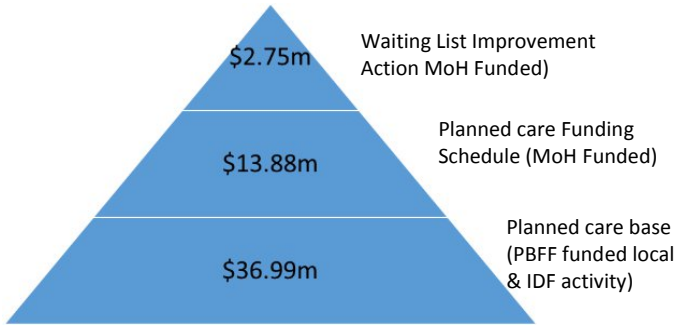
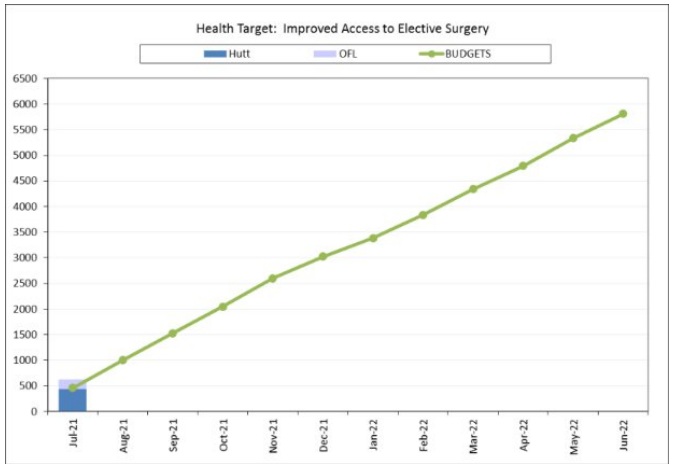
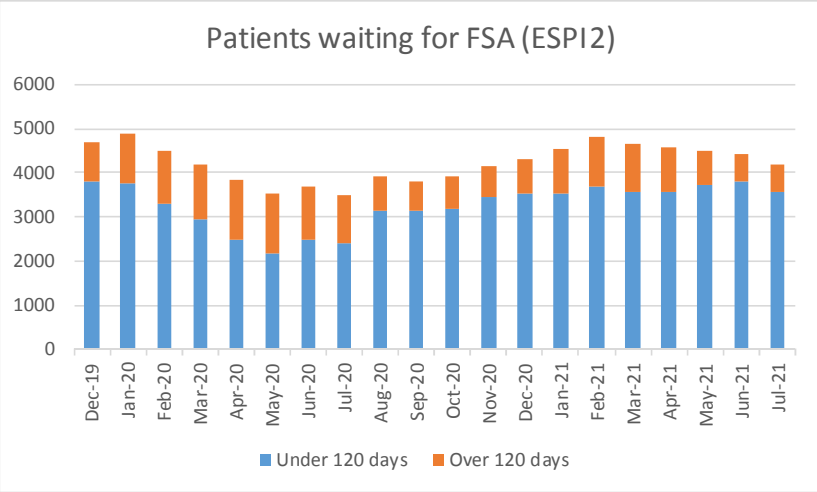


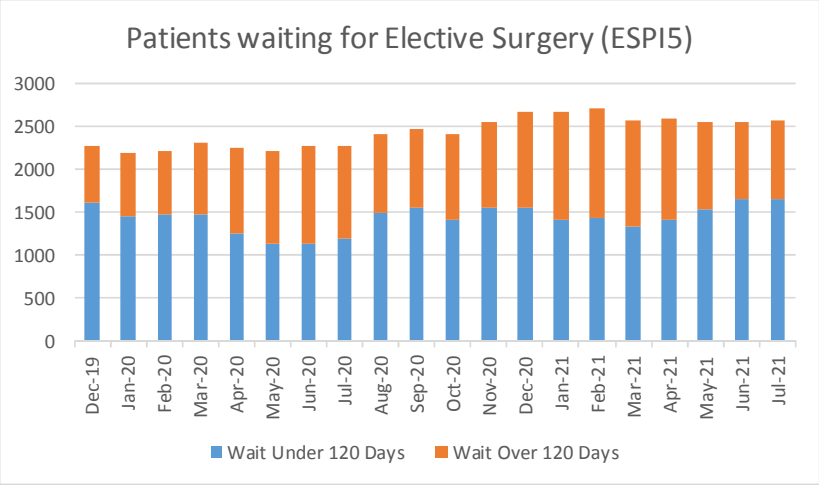
Figure two: Discharge trajectory for Planned care base and Planned care funding schedule – 136%



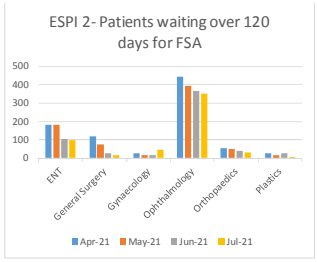
- **What is this measure?**
  - The delivery of an agreed number of inpatient surgical discharges and minor procedures to the Hutt Valley Population
  - The are three funding sources as per figure one – this is important as each has measures and deliverables required to access the funding which is paid after delivery .
- **How are we performing?**
  - Discharges are 164 ahead plan for the Planned care base and Planned Care Funding Schedule (figure one) – this equates to 136% as per figure 2.
  - July results continue to be above expectation.
  - The increase in acute surgical presentations displaces planned surgeries as the theatres and beds are required for acute cases. Two of our most pronounced examples are in General Surgery and Orthopaedics as described earlier
- **What is driving performance?**
  - Saturday elective operating sessions continue to assist with general surgery waitlist recovery.
  - The level of minor procedure skin cancer referrals for CCDHB patients continues to put significant pressure on the Tertiary Plastic Surgery Service. Plastic Service demand is unable to be met through our current model and staffing. Implementation of the agreed sub-regional skin cancer pathway with CCDHB has been delayed but will roll out over quarter one.
  - The orthopaedic initiative to reduce ESPI 2 $275k in 2020-2021 is continuing in the new financial year with funding carried over. This model is significantly assisting in reduction of the orthopaedic ESPI 2 waitlist.
  - Work on the 2 DHB closed RFP for outsourcing progressed and is currently with providers. It is anticipated that this will commence in Quarter 2 at the latest. In the interim an outsourcing schedule for HVDHB is being delivered utilising PCI recovery funding for 2021-2022

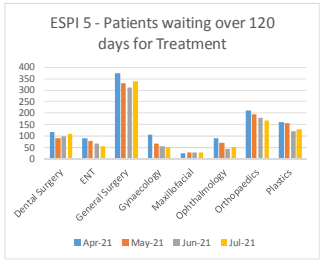
Planned Care – waiting times-

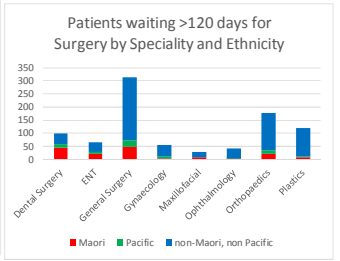




- **What is this measure?**
  - The delivery of Specialist assessments or Treatment within 120 days
- **Why is it important?**
  - It is important to ensure patients receive care at the most appropriate time to support improved health.
- **How are we performing?**
  - The total waiting for an FSA decreased by 4.8% (211) this month. The number waiting over 120 days rose by 3% (17)
  - The number waiting for elective surgery rose by 28 to 2,579 and the number waiting over 120 days by 26 to 930
  - However the numbers of patients waiting longer than 120 days for both assessment and treatment remains high.

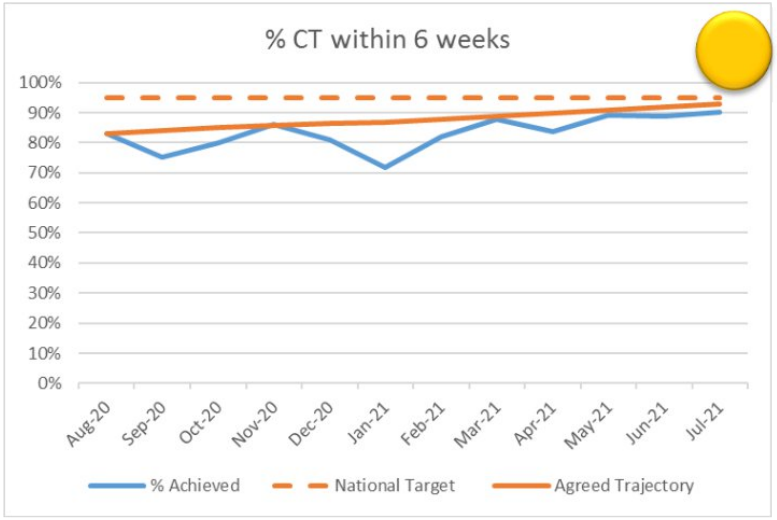


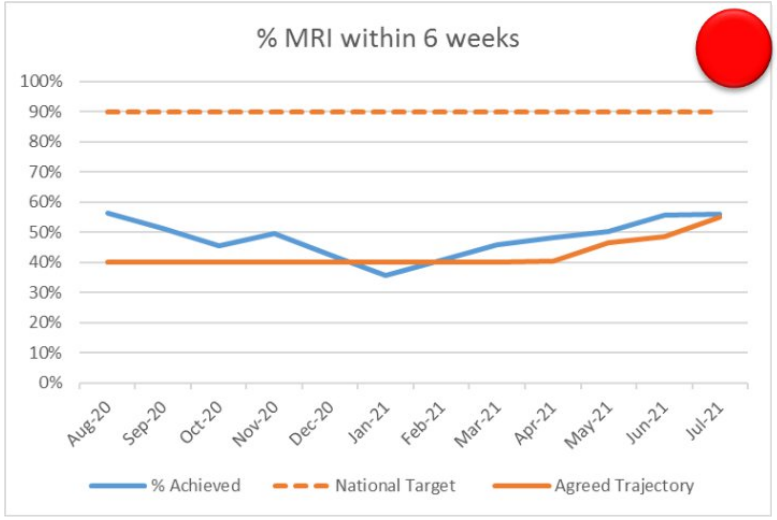




- **What is driving performance?**
  - Work continues on system improvements to address our waiting list management along with a strong focus to maximise clinic capacity and improve scheduling processes.
  - Significant progress has been made in reducing ESPI2 in the last 2 months. July clinics were impacted by sick leave, annual leave and the Respiratory Syncytial Virus (RSV) pandemic.
  - Ophthalmology has the highest non-compliance of 349 ESPI 2 breaches and we will commence a project with Optometrists from Q2 conducting 200 cataract FSAs from the waiting list in 2021-2022.
  - SMOs continue to be involved with planning surgery based on those with greatest clinical urgency and long waiting times.

CT & MRI wait times

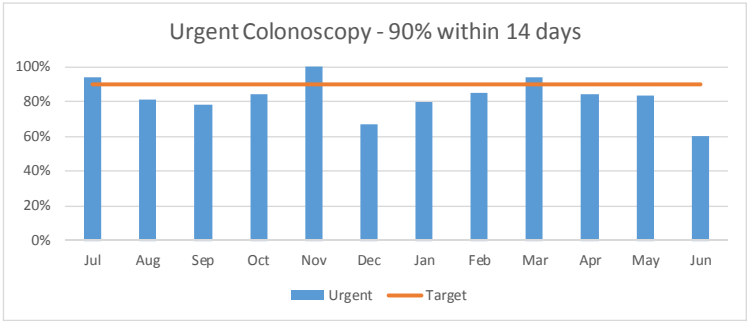




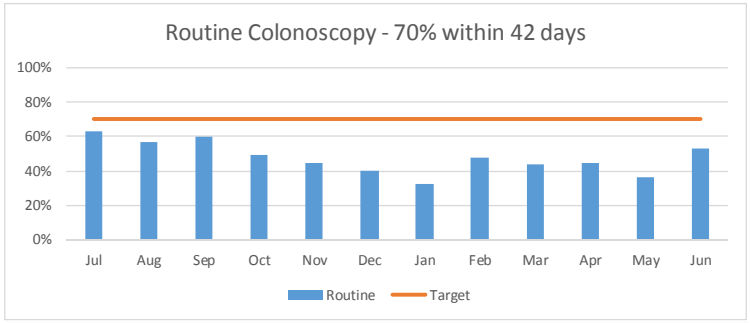
- **What is this measure?**
  - The delivery of computerised tomography (CT) scans and Magnetic Resonance Imaging (MRI) scans in a timely fashion to non-acute patients (within 42 days of referral).
- **Why is it important?**
  - Delayed diagnostic results can negatively affect health outcomes.
- **How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

- **Management comment**
  - Actions currently underway:
    - A further two contract reporters for 2 days per week have commenced
    - Managed daily outsourcing of reporting to Pacific Radiology to support in-house Radiologists.
    - Voluntary overtime weekend MRI day lists – approximately 4 days per month
    - Weekend CT day list - approximately 4 days per month
    - MOH Planned Care funding being used to outsource 30 MRIs per month

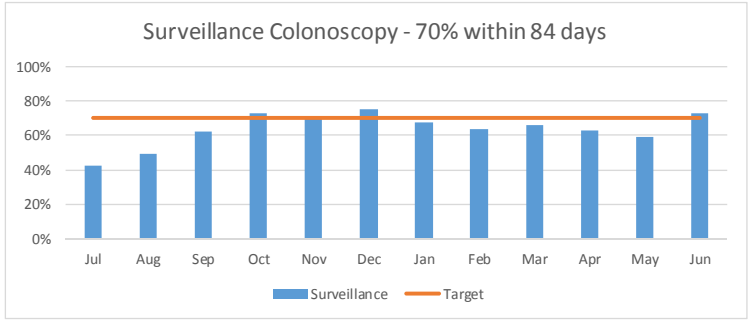
Colonoscopy Wait Times



Urgent
87% YTD



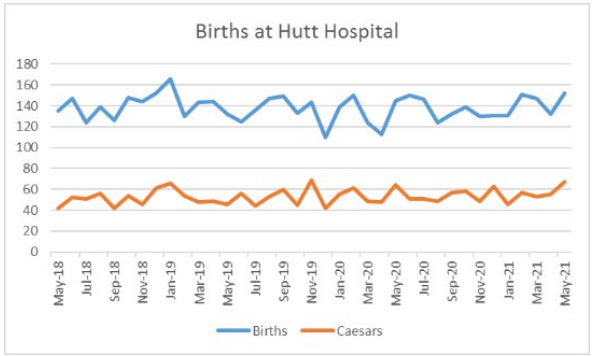
Routine
49% YTD

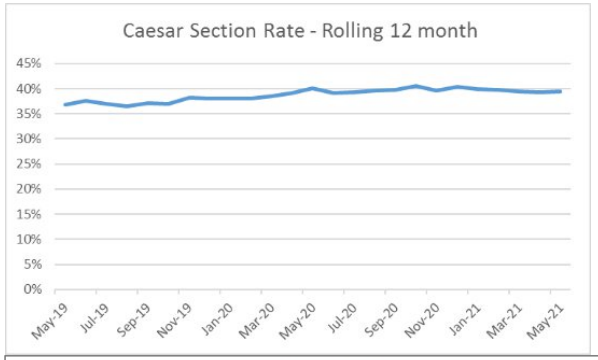


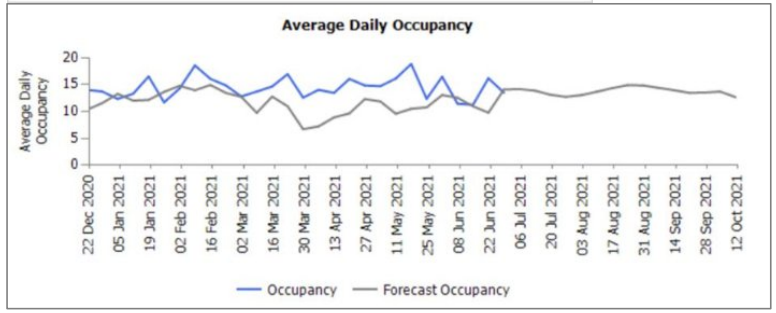
Surveil
62% YTD

- **What is this measure?**
  - The delivery of Colonoscopy, urgent within 14 days, routine 42 days and surveillance within 84 days of being due.
- **Why is it important?**
  - Delayed diagnostic results can negatively affect health outcomes.
- **How are we performing?**
  - The service is balancing the overall improvement in performance with a trajectory to full compliance within the coming months.
  - July sees an improved performance across the urgent wait times and a similar outcome to June for routine and surveillance
- **What is driving performance?**
  - The growing surveillance waitlist continues to put additional pressure on the service along with overall increase in referrals.
  - There is concerted effort occurring to ensure that there are no Maori or Pacific patients overdue for any category however this has been a challenge in July with 2 pacific and 10 Maori overdue 8 of the 12 are booked in August / September, with the remaining 4 deferred due to ill health.
  - All patients that are waiting outside maximum timeframes are booked in for August.
- **Management comment**
  - A new performance and monitoring plan has been developed as is being used in the service.
  - The service is now projecting full recovery by November 2021 with it being in a stable position from then.

Maternity

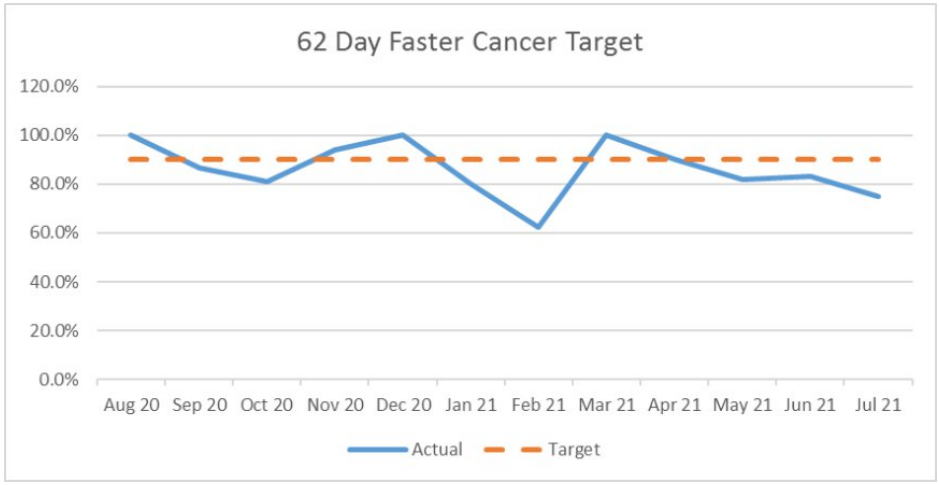


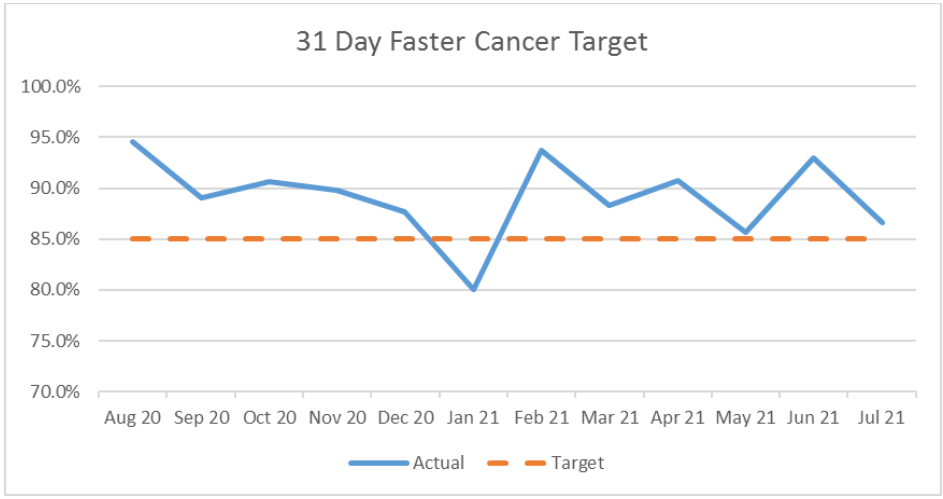




- **What is the issue?**
  - In 2019 a number of clinical and community concerns around Hutt hospital's maternity services were identified.
- **Why is it important?**
  - An external review of the service and HDC investigations showed a number of areas where improvements needed to be made.
- **How are we performing?**
  - Hutt Valley DHB is making positive progress on the birthing optimisation project and audit of caesarean cases. This audit covers the period from April-June 2021 and focuses on the criteria for caesarean sections and pathways for optimal birth. Findings from the audit will be reviewed and analysed over the coming month.
- **Management comment**
  - The Minister of Health confirmed in January 2021 approval to invest $9.47 million capital funding to upgrade the Maternity Assessment Unit, Maternity Ward and Special Care Baby Unit (SCBU). Phase One of building work (CMT space) is complete. Phase Two (MAU) is in final design - concept and building consent stage.
  - A 2DHB International Midwifery campaign is underway.
  - Registered midwife, senior nurse, and registered nurse vacancies across Hutt Valley DHB maternity services currently sit at 14.43FTE.
  - A small number of RNs have been employed to support the care provided in maternity.
  - A comprehensive orientation and education package has been developed to support nurses working in maternity and recruitment for clinical coaching positions is underway.

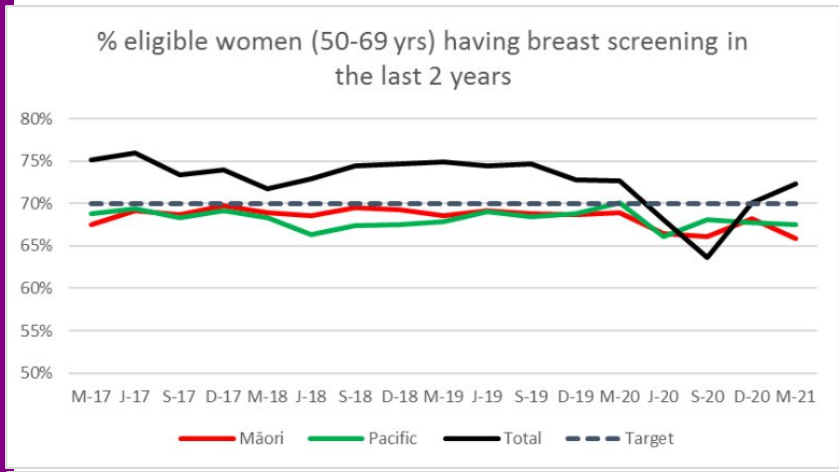
Faster Cancer Treatment

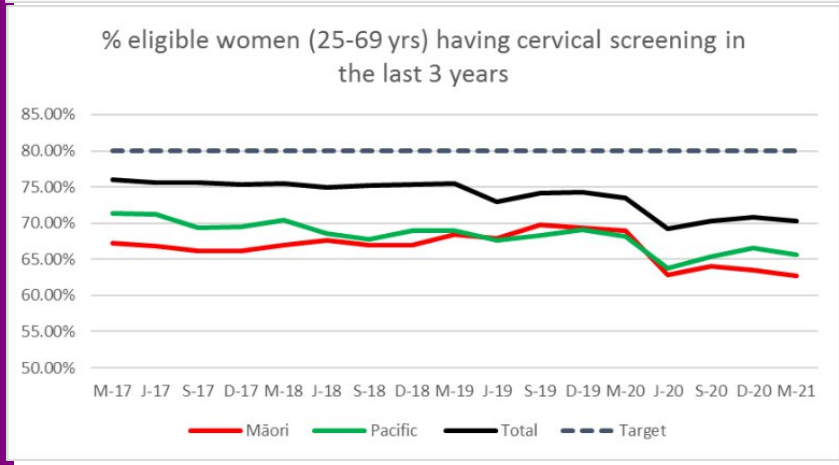




- **What is the issue?**
  - 62 day target: 90% of patients should receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.
  - 31 day indicator: The maximum length of time a patient should have to wait from a date of decision to treat to receive their first treatment (or other management) for cancer is 31 days. Target compliance is 85% of patients start within 31 days.
- **Why is it important?**
  - Prompt investigation, diagnosis and treatment is more likely to ensure better outcomes for cancer patients, and an assurance about the length of waiting time can reduce the stress on patients and families at a difficult time.
- **How are we performing?**
  - 80% of patients met the HVDHB 62 day pathway for July. (2 out of 10 patients breached due to capacity related issues). 90% for the 31 day target pathway was achieved.
- **What is driving performance?**
  - The first component of assessment from referral is well achieved and the latter part of treatment is the area needing focus.
- **Management Comment**
  - Individual breaches are viewed through MDT across both DHBs.

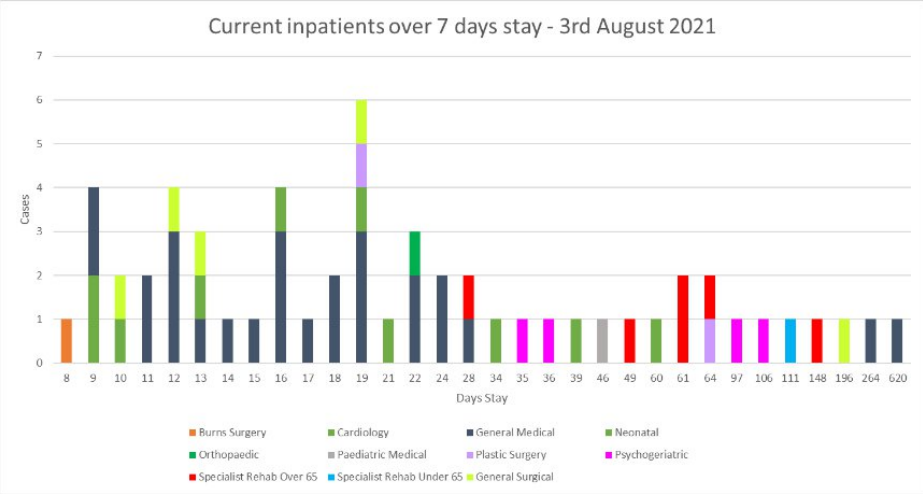
Screening

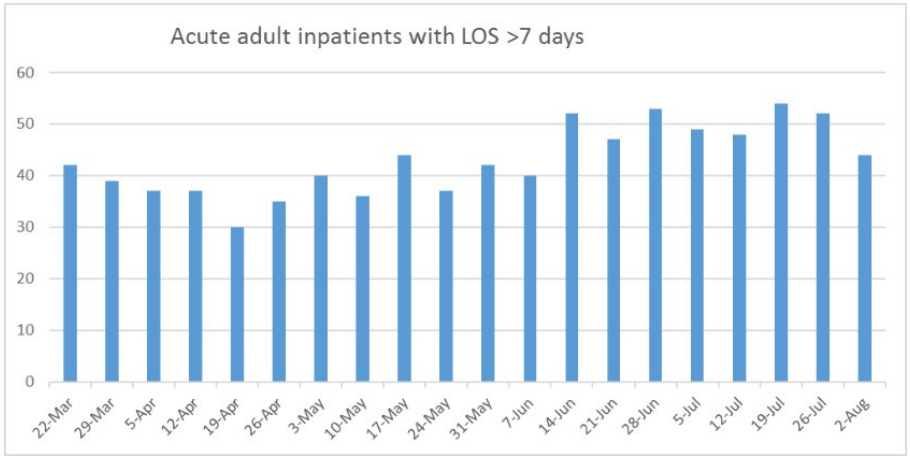




- **What is the issue?**
  - 80% of Women aged 25-69 have completed cervical screening in the previous three years
  - 70% of Women aged 50-69 have completed breast screening in the previous two years
- **Why is it important?**
  - By improving breast and cervical screening coverage DHBs will assist in delivery of the Government's priority to support healthier, safer and more connected communities and our health system outcome that we live longer in good health
- **How are we performing?**
  - Our Breast screening rate in July has exceeded projections by 469 women with 3445 screened.
  - Cervical Screening coverage increased for Māori, Pacific and Asian women for Hutt Valley and Wairarapa DHB region. Māori and Asian increased for Capital and Coast with Pacific women coverage remaining unchanged.
- **What is driving performance?**
  - In July the service continues to provide Saturday and evening sessions
  - Recruitment :
    - Medical Imaging Technologist (MIT) continues.
    - Breast Radiologist two further international candidate interviews scheduled in August.
  - Provision of 'Free Cervical Screening' after hour evening clinics and Saturday clinics targeted at wāhine Māori, Pacific and Asian women has aided increased cervical coverage.
  - Māori, Pacific and Asian (cervical) women continue to be prioritised for screening.
- **Management Comment**
  - Both the breast & cervical teams are actively referring women to Service Providers Mana Wāhine and Central Pacific Collective to engage priority women to cervical screening.
  -

Long Stay inpatients





- **What is this measure?**
  - For medical and surgical these are patients who have stayed more than 7 days. For rehabilitation and neonates where stays are longer these are cases staying over last year's average.
- **Why is it important?**
  - These patients are reducing the ability of the hospital to cope with acute demand. Longer stays are often associated with deconditioning and adverse outcomes for the patient.
- **How are we performing?**
  - On 3rd August there were 57 current long staying patients; 44 were acute adults
- **What is driving performance?**
  - A group of extremely complex patients remain unable to be discharged because community services and supports are reluctant to support these patients on discharge either due to extremely high needs, complex behaviour, housing issues, or health and safety concerns for service staff.
- **Management comment**
  - A dedicated role to work with these and similar patients is planned to work with clinical, NASC, and commissioning staff to put sustainable different discharge arrangements in place for these folk. Enhanced Early Supported Discharge for mild-moderate stroke patients and some medical patients will go live in August. This will support earlier discharge for this group of patients and better hospital flow over all.

Section 4

Financial Performance & Sustainability

Summary of Financial Performance for July 2021

Month					$000s	Year to Date						
Actual	Budget	Variance	Last Year	Variance		Actual	Budget	Variance	Last Year	Variance	Budget	Last Year
					Revenue							
42,266	42,249	16	40,404	1,861	Devolved MoH Revenue	42,266	42,249	16	40,404	1,861	506,994	489,113
2,078	1,621	457	1,998	80	Non Devolved MoH Revenue	2,078	1,621	457	1,998	80	20,179	21,680
354	555	(200)	596	(241)	ACC Revenue	354	555	(200)	596	(241)	6,976	7,129
567	510	56	604	(37)	Other Revenue	567	510	56	604	(37)	6,054	7,483
9,557	9,557	0	9,171	386	IDF Inflow	9,557	9,557	0	9,171	386	114,678	111,945
1,305	1,025	279	472	833	Inter DHB Provider Revenue	1,305	1,025	279	472	833	12,302	13,197
56,127	**55,518**	**609**	**53,246**	**2,881**	**Total Revenue**	**56,127**	**55,518**	**609**	**53,246**	**2,881**	**667,183**	**650,547**
					Expenditure							
					Employee Expenses							
5,232	5,483	251	5,367	135	Medical Employees	5,232	5,483	251	5,367	135	65,246	62,678
6,200	6,147	(53)	6,968	768	Nursing Employees	6,200	6,147	(53)	6,968	768	73,986	72,415
2,415	2,558	143	2,929	515	Allied Health Employees	2,415	2,558	143	2,929	515	30,467	28,663
864	806	(58)	832	(32)	Support Employees	864	806	(58)	832	(32)	9,619	9,579
2,308	2,306	(2)	2,735	427	Management and Admin Employees	2,308	2,306	(2)	2,735	427	27,053	26,733
17,018	**17,300**	**281**	**18,831**	**1,813**	**Total Employee Expenses**	**17,018**	**17,300**	**281**	**18,831**	**1,813**	**206,370**	**200,068**
					Outsourced Personnel Expenses							
176	205	29	226	49	Medical Personnel	176	205	29	226	49	2,458	5,973
(1)	15	16	113	114	Nursing Personnel	(1)	15	16	113	114	181	6,407
18	60	42	32	15	Allied Health Personnel	18	60	42	32	15	715	4,561
80	42	(38)	74	(6)	Support Personnel	80	42	(38)	74	(6)	501	491
550	622	72	116	(434)	Management and Admin Personnel	550	622	72	116	(434)	7,463	7,031
823	**943**	**120**	**560**	**(263)**	**Total Outsourced Personnel Expenses**	**823**	**943**	**120**	**560**	**(263)**	**11,318**	**24,463**
883	952	69	839	(44)	Outsourced Other Expenses	883	952	69	839	(44)	11,454	13,157
2,713	2,479	(234)	2,789	76	Treatment Related Costs	2,713	2,479	(234)	2,789	76	30,698	33,080
2,044	2,079	36	1,838	(205)	Non Treatment Related Costs	2,044	2,079	36	1,838	(205)	24,765	36,000
13,691	11,991	(1,700)	9,106	(4,585)	IDF Outflow	13,691	11,991	(1,700)	9,106	(4,585)	143,894	108,813
20,374	20,476	103	18,739	(1,634)	Other External Provider Costs	20,374	20,476	103	18,739	(1,634)	244,201	223,654
1,872	2,110	238	2,211	339	Interest, Depreciation & Capital Charge	1,872	2,110	238	2,211	339	25,321	23,537
59,418	**58,331**	**(1,087)**	**54,914**	**(4,504)**	**Total Expenditure**	**59,418**	**58,331**	**(1,087)**	**54,914**	**(4,504)**	**698,022**	**662,772**
(3,291)	**(2,814)**	**(478)**	**(1,668)**	**(1,623)**	**Net Result**	**(3,291)**	**(2,814)**	**(478)**	**(1,668)**	**(1,623)**	**(30,839)**	**(12,226)**
					Result by Output Class							
(4,056)	(2,377)	(1,679)	418	(4,474)	Funder	(4,056)	(2,377)	(1,679)	418	(4,474)	(27,012)	11,939
80	12	68	110	(30)	Governance	80	12	68	110	(30)	112	1,261
685	(448)	1,133	(2,196)	2,881	Provider	685	(448)	1,133	(2,196)	2,881	(3,939)	(25,425)
(3,291)	**(2,814)**	**(478)**	**(1,668)**	**(1,623)**	**Net Result**	**(3,291)**	**(2,814)**	**(478)**	**(1,668)**	**(1,623)**	**(30,839)**	**(12,226)**

There may be rounding differences in this report

Executive Summary – Financial Position

Financial performance year to date

- Total Revenue favourable $609k
- Personnel and outsourced Personnel favourable $402k
  - Medical favourable $280k; Nursing unfavourable ($37k); Allied Health favourable $185k, Support Staff unfavourable ($96k); Management and Admin favourable $71k; Annual leave Liability cost has decreased by $46k since July 2020
- Outsourced other expenses favourable $69k
- Treatment related Costs unfavourable ($234k)
- Non Treatment Related Costs favourable $36k.
- IDF Outflow unfavourable ($1,700k), reflecting high cost burns patient
- Other External Provider Costs favourable $103k
- Interest depreciation and capital charge favourable $238k

Analysis of Operating Position – Revenue

- **Revenue:** Total revenue favourable $609k for the month
  - Devolved MOH revenue $16k favourable, a result of minor timing differences.
  - Non Devolved revenue $457k favourable driven largely by Public Health COVID-19 funding $280k.
  - ACC Revenue ($200k) unfavourable.
  - Other revenue $56k favourable for the month driven by Patient Revenue.
  - IDF inflows favourable $0k for the month.
  - Inter DHB Revenue favourable $279k, reflecting the use of shared 2 & 3DHB services. There is a corresponding increase in expenditure.

COVID–19 Revenue and Costs

YTD Result - July 2021	Funder	Provider (excl. Regional Public Health)	Provider - Regional Public Health (RPH) (1)	Total
$000s	Actual	Actual	Actual	Actual
Revenue				
MoH Revenue Recognised - COVID19	0	22	280	301
Expenditure				
Employee Expenses				
Medical Employees		0	16	16
Nursing Employees		17	36	53
Allied Health Employees		1	41	42
Support Employees		0	0	0
Management and Admin Employees		9	10	19
Total Employee Expenses	**0**	**27**	**103**	**130**
Expenses				
Outsourced - Provider	0	0		0.0
External Providers - Funder	273			273.3
Clinical Expenses - Provider	0	0	1	0.9
Non-clinical Expenses- Provider	0	2	14	15.4
Total Non Employee Expenses	**273**	**2**	**15**	**289.6**
Total Expenditure	**273**	**29**	**118**	**419**
Net Impact	**(273)**	**(7)**	**162**	**(118)**

(1) Excludes overhead charges

- The July year to date financial position includes $0.4m additional costs in relation to COVID-19.
- Revenue of $0.3m has been recognised to fund additional costs for community providers and Regional Public Health.
- The net impact year to date is $0.1m additional costs currently unfunded.

Analysis of Operating Position – Personnel

- **Total Personnel** including outsourced favourable $402k for the month
  - Medical personnel incl. outsourced favourable ($280k). Outsourced costs are $29k favourable. Medical Staff Internal are $251k favourable, due to the delay in new appointments.
  - Nursing incl. outsourced ($37k) unfavourable. Employee costs are ($53k) unfavourable, driven by overtime and penal cost ($92k).
  - Allied Health incl. outsourced $185k favourable, with outsourced favourable $60k and internal employees favourable $143k. Employee costs are driven by vacancies in Public Health and Community Dental.
  - Support incl. outsourced unfavourable ($96k), with Outsourced ($38k) unfavourable, and employee costs ($58k) unfavourable, driven by Orderlies ($38k).
  - Management & Admin incl. outsourced favourable $71k internal staff unfavourable ($2k), outsourced favourable $72k.
  - Sick leave for July was 4.1%, which is lower than this time last year.

FTE Analysis

Month					FTE Report	Year To Date					Annual	
Actual	Budget	Variance	Last Year	Variance	Jul-21	Actual	Budget	Variance	Last Year	Variance	Budget	Last Year
					FTE							
285	290	5	284	(1)	Medical	285	290	5	284	(1)	289	279
761	781	21	824	63	Nursing	761	781	21	824	63	790	763
348	365	18	398	51	Allied Health	348	365	18	398	51	365	352
152	147	(5)	143	(9)	Support	152	147	(5)	143	(9)	147	147
326	341	15	348	22	Management & Administration	326	341	15	348	22	338	321
1,871	**1,924**	**53**	**1,997**	**126**	**Total FTE**	**1,871**	**1,924**	**53**	**1,997**	**126**	**1,930**	**1,862**
					$ per FTE							
18,358	18,934	576	18,923	565	Medical	18,358	18,934	576	18,923	565	224,869	233,613
8,151	7,866	(285)	8,456	305	Nursing	8,151	7,866	(285)	8,456	305	93,662	97,019
6,947	7,002	55	7,358	411	Allied Health	6,947	7,002	55	7,358	411	83,014	86,588
5,703	5,497	(206)	5,821	118	Support	5,703	5,497	(206)	5,821	118	65,680	65,337
7,071	6,764	(306)	7,850	780	Management & Administration	7,071	6,764	(306)	7,850	780	79,996	84,263
9,095	**8,992**	**(103)**	**9,429**	**334**	**Average Cost per FTE all Staff**	**9,095**	**8,992**	**(103)**	**9,429**	**334**	**106,762**	**110,832**

Medical under budget for the month by 5 FTE, driven by SMOs under budget by 11FTE, offset by RMO's & House Officers combined.

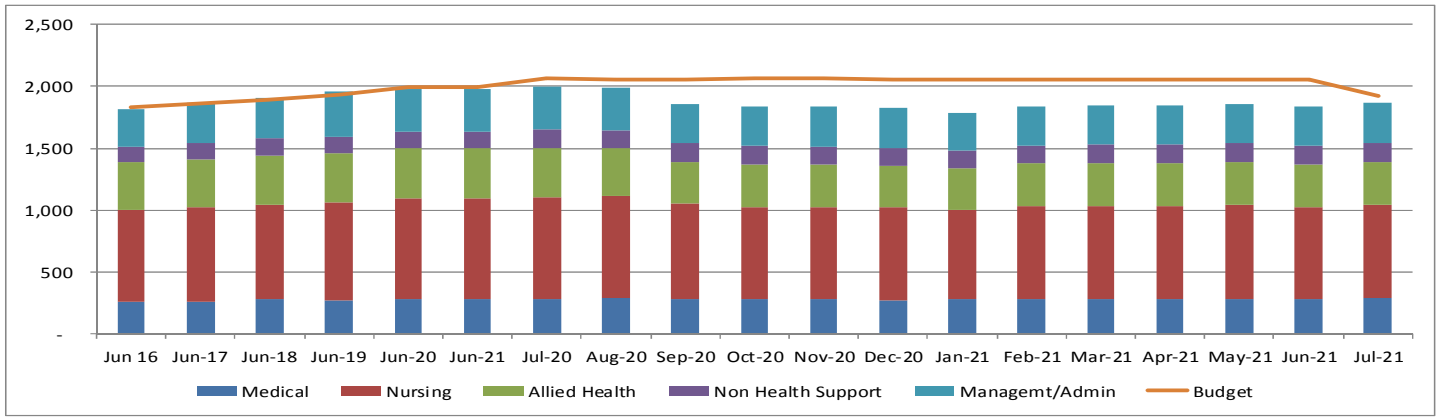
Nursing under by 21 FTE for the month the contribution to movements were; Internal Bureau Nurses, Midwives and HCA's are over budget (19) FTE mostly driven by General Surgery (2) FTE, General Medical (8) FTE, Maternity (3), ED (4FTE) and other variances. This is offset by Midwives 14 FTE and Registered Nurses 10 FTE and HCA's. This reflects the transition to changes made under both CCDM recommendations and the Maternity Review.

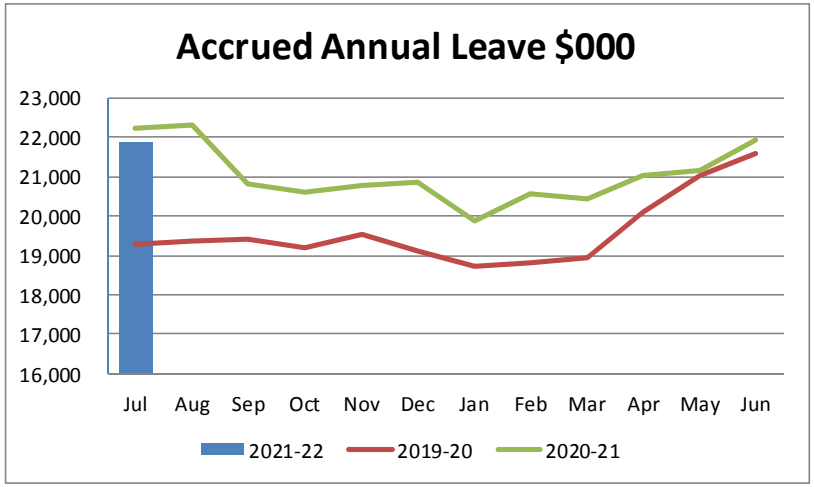
Allied FTEs are under by 18 FTEs for the month, driven by Regional Public Health 8 FTE, Community Health 8FTE.

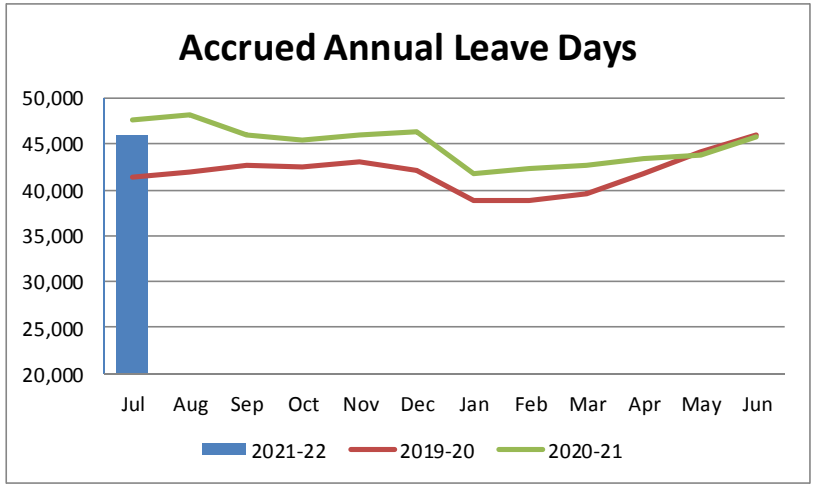
Support FTEs are (5) FTEs over budget driven by CSSD (1) FTE, Cleaning (1) FTE, Property services (1) FTE and Orderlies (5) FTE and other variances.

Management & Admin are under budget by 15 FTEs driven by Executive Office 1 FTE, SPO 1 FTE, Quality 3 FTE, Director of Provider Services 2 FTE, Surgical Women's & Children's 4 FTE and Regional Screening 2 FTE and other variances.

FTE Analysis







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

Analysis of Operating Position – Other Expenses

- **Other Operating Costs**
  - Outsourced other favourable $69k for the month, due to unfavourable variance for Clinical Services ($73k), offset by favourable variances in outsourced Finance functions, Governance , IT and Procurement services.
  - Treatment related costs ($234k) unfavourable for the month, Pharmaceuticals ($133k), Treatment Disposables ($82k), Implants and Prostheses ($20k) and Ambulance ($60k).
  - Non Treatment Related costs favourable $36k.
  - IDF Outflows $1,700k unfavourable for the month, driven by a high cost burns patient.
  - Other External Provider costs favourable $103k, mostly timing differences.
  - Interest, Depreciation & Capital Charge favourable $238k, driven by Depreciation $236k, which is expected to reverse over the coming year.

Section 5

Additional Financial Information & Updates

Financial Position as at 31 July 2021

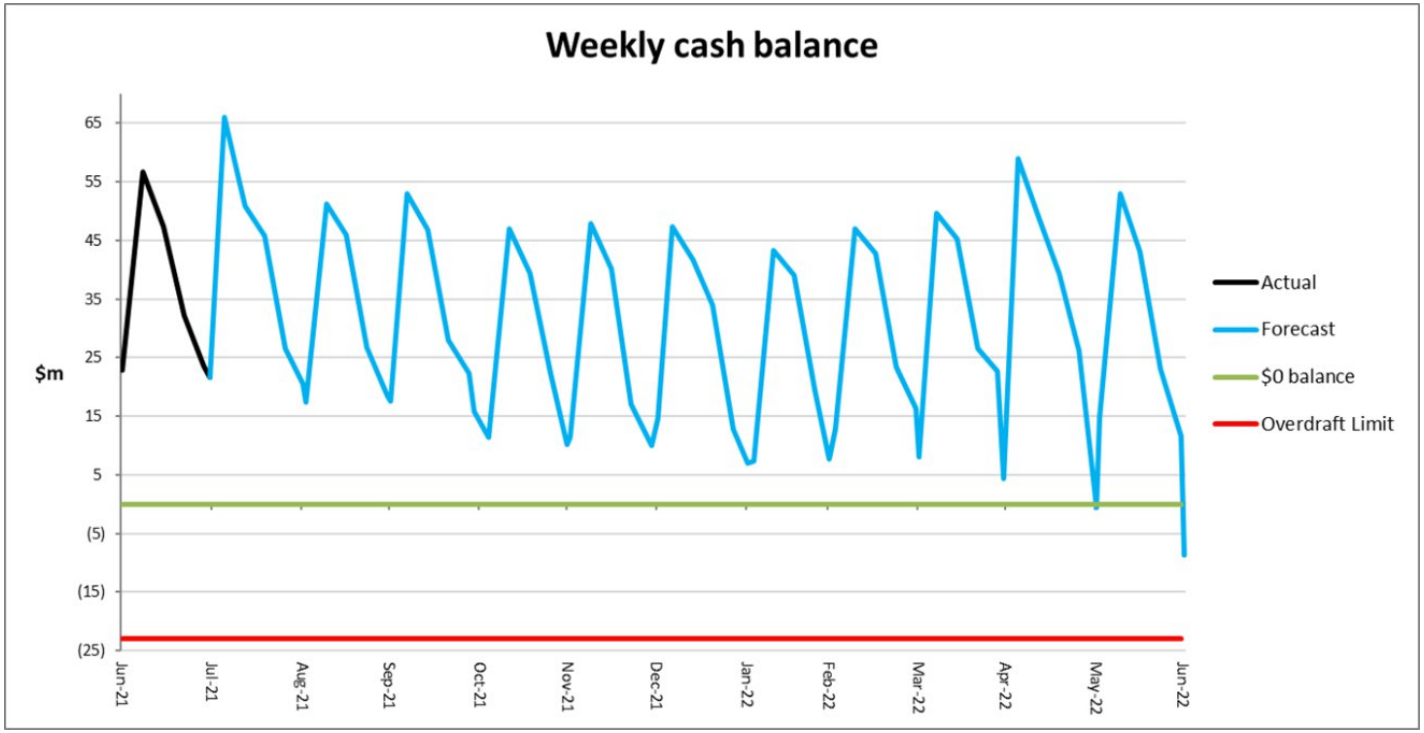
$000s	Actual	Budget	Variance	Jun 21	Variance	Explanation of Variances Between Actual and Budget
Assets						
Current Assets						
Bank	21,575	8,839	12,735	22,890	(1,316)	Average bank balance in Jul-21 was $42.4m
Bank - Non DHB Funds *	4,266	5,831	(1,565)	5,236	(970)	
Accounts Receivable & Accrued Revenue	30,722	23,581	7,141	33,154	(2,431)	
Stock	2,328	2,614	(285)	2,322	6	
Prepayments	1,104	1,161	(58)	1,241	(137)	
Total Current Assets	**59,995**	**42,026**	**17,969**	**64,843**	**(4,848)**	
Fixed Assets						
Fixed Assets	223,242	226,762	(3,520)	223,741	(499)	
Work in Progress	9,729	7,905	1,825	9,218	511	
Total Fixed Assets	**232,971**	**234,667**	**(1,695)**	**232,958**	**13**	
Investments						
Investments in Associates	1,150	1,150	0	1,150	0	
Trust Funds Invested	1,244	1,266	(22)	1,221	24	
Total Investments	**2,394**	**2,416**	**(22)**	**2,371**	**24**	
Total Assets	**295,361**	**279,109**	**16,252**	**300,172**	**(4,811)**	
Liabilities						
Current Liabilities						
Accounts Payable and Accruals	78,202	77,223	(979)	79,570	1,368	Includes Holidays Act Provision of $30.4m
Crown Loans and Other Loans	38	3	(35)	42	3	
Capital Charge Payable	692	4,001	3,309	0	(692)	
Current Employee Provisions	27,168	28,199	1,031	27,029	(139)	
Total Current Liabilities	**106,099**	**109,426**	**3,327**	**106,640**	**541**	
Non Current Liabilities						
Other Loans	136	178	42	136	0	
Long Term Employee Provisions	9,150	8,972	(178)	9,150	0	
Non DHB Liabilities	4,266	5,831	1,565	5,236	970	
Trust Funds	1,211	1,226	14	1,221	9	
Total Non Current Liabilities	**14,764**	**16,207**	**1,443**	**15,743**	**979**	
Total Liabilities	**120,863**	**125,633**	**4,770**	**122,383**	**1,520**	
Net Assets	**174,498**	**153,476**	**21,021**	**177,789**	**(3,291)**	
Equity						
Crown Equity	158,709	141,918	16,790	158,709	0	
Revaluation Reserve	146,289	146,289	0	146,289	0	
Opening Retained Earnings	(127,208)	(131,916)	4,708	(114,982)	(12,226)	
Net Surplus / (Deficit)	(3,291)	(2,814)	(478)	(12,226)	8,934	
Total Equity	**174,498**	**153,477**	**21,021**	**177,789**	**(3,291)**	

* NHMG - National Haemophilia Management Group

Statement of Cash Flows to 31 July 2021

$000s	Jul Actual	Aug Forecast	Sep Forecast	Oct Forecast	Nov Forecast	Dec Forecast	Jan Forecast	Feb Forecast	Mar Forecast	Apr Forecast	May Forecast	Jun Forecast
Operating Activities												
Government & Crown Agency Revenue	43,259	43,871	44,025	43,871	43,882	44,025	43,871	43,871	44,025	43,944	43,895	44,025
Receipts from Other DHBs (Including IDF)	10,208	10,582	10,582	10,582	10,582	10,580	10,582	10,582	10,582	10,582	10,582	10,582
Receipts from Other Government Sources	492	737	720	730	812	687	660	727	615	655	615	727
Other Revenue	4,907	112	112	116	113	263	271	113	113	116	113	113
Total Receipts	**58,866**	**55,302**	**55,439**	**55,299**	**55,388**	**55,555**	**55,384**	**55,292**	**55,335**	**55,296**	**55,205**	**55,446**
Payments for Personnel	(17,569)	(18,255)	(18,248)	(17,468)	(18,263)	(19,137)	(17,534)	(16,859)	(19,223)	(17,632)	(18,411)	(18,415)
Payments for Supplies (Excluding Capital Expenditure)	(9,630)	(5,474)	(5,473)	(5,486)	(5,473)	(5,492)	(5,488)	(5,510)	(5,510)	(5,515)	(5,537)	(6,449)
Capital Charge Paid	0	0	0	0	0	(4,150)	0	0	0	0	0	(4,150)
GST Movement	(848)	0	0	0	0	0	0	0	0	0	0	0
Payments to Other DHBs (Including IDF)	(11,963)	(11,991)	(11,991)	(11,991)	(11,991)	(11,991)	(11,991)	(11,991)	(11,991)	(11,991)	(11,991)	(11,991)
Payments to Providers	(18,979)	(20,551)	(20,230)	(20,482)	(20,411)	(20,631)	(20,254)	(19,217)	(20,125)	(20,516)	(20,786)	(20,523)
Total Payments	**(58,989)**	**(56,271)**	**(55,942)**	**(55,427)**	**(56,137)**	**(61,402)**	**(55,268)**	**(53,577)**	**(56,849)**	**(55,653)**	**(56,725)**	**(61,529)**
Net Cashflow from Operating Activities	**(123)**	**(969)**	**(503)**	**(129)**	**(749)**	**(5,848)**	**115**	**1,716**	**(1,514)**	**(357)**	**(1,520)**	**(6,082)**
Investing Activities												
Interest Receipts	23	21	21	21	21	21	21	21	21	21	21	21
Dividends	0	4	4	4	4	4	4	4	4	4	4	4
Total Receipts	**23**	**25**	**25**	**25**	**25**	**25**	**25**	**25**	**25**	**25**	**25**	**25**
Capital Expenditure	(1,192)	(2,926)	(2,926)	(7,926)	(2,926)	(2,926)	(2,926)	(12,926)	(2,926)	(2,926)	(2,926)	(13,990)
Increase in Investments and Restricted & Trust Funds Assets	(24)	0	0	0	0	0	0	0	0	0	0	0
Total Payments	**(1,216)**	**(2,926)**	**(2,926)**	**(7,926)**	**(2,926)**	**(2,926)**	**(2,926)**	**(12,926)**	**(2,926)**	**(2,926)**	**(2,926)**	**(13,990)**
Net Cashflow from Investing Activities	**(1,193)**	**(2,901)**	**(2,901)**	**(7,901)**	**(2,901)**	**(2,901)**	**(2,901)**	**(12,901)**	**(2,901)**	**(2,901)**	**(2,901)**	**(13,965)**
Financing Activities												
Equity Injections - Capital	0	0	5,000	5,000	0	5,000	0	10,000	7,000	0	0	11,117
Total Receipts	**0**	**0**	**5,000**	**5,000**	**0**	**5,000**	**0**	**10,000**	**7,000**	**0**	**0**	**11,117**
Interest Paid on Finance Leases	(0)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)
Total Payments	**(0)**	**(2)**	**(2)**	**(2)**	**(2)**	**(2)**	**(2)**	**(2)**	**(2)**	**(2)**	**(2)**	**(2)**
Net Cashflow from Financing Activities	**(0)**	**(2)**	**4,998**	**4,998**	**(2)**	**4,998**	**(2)**	**9,998**	**6,998**	**(2)**	**(2)**	**11,115**
Total Cash In	58,889	55,327	60,464	60,324	55,413	60,580	55,409	65,317	62,360	55,321	55,230	66,588
Total Cash Out	(60,204)	(59,199)	(58,870)	(63,355)	(59,065)	(64,330)	(58,196)	(66,505)	(59,777)	(58,581)	(59,653)	(75,520)
Net Cashflow												
Opening Cash	22,890	21,575	17,702	19,296	16,264	12,612	8,862	6,074	4,887	7,469	4,209	(213)
Net Cash Movements	(1,316)	(3,872)	1,594	(3,032)	(3,652)	(3,751)	(2,788)	(1,187)	2,583	(3,260)	(4,423)	(8,932)
Closing Cash	**21,575**	**17,702**	**19,296**	**16,264**	**12,612**	**8,862**	**6,074**	**4,887**	**7,469**	**4,209**	**(213)**	**(9,145)**

Weekly Cash Flow – Actual to 31 July 2021



Note

- the overdraft facility shown in red is set at $23 million as at July 2021
- the lowest bank balance for the month of July was $21.6m

Capital expenditure – Actual to 31 July 2021

Project description	Budget rolled over from 2020/21	New budget for 2021/22	Prior year approved projects budget	Prior year approved projects spend	Committed costs from prior year approved projects budget	Total maximum spend in 2021/22	Actual 2021/22 spend till date	Remaining funds available in 2021/22
	$000	$000	$000	$000	$000	$000	$000	$000
Baseline								
Buildings and Plant	4,385	7,700	3,651	2,740	910	12,996	304	12,692
Clinical Equipment	629	6,043	3,824	974	2,850	9,522	358	9,164
Information Technology (Hardware)	1,211	1,828	862	408	454	3,493	35	3,458
Intangible Assets (Software)	26	1,045	356	185	170	1,241	-	1,241
Baseline Total	**6,252**	**16,617**	**8,691**	**4,308**	**4,384**	**27,253**	**698**	**26,554**
Strategic								
Buildings and Plant	1,065	-	-	-	-	1,065	-	1,065
Clinical Equipment	2,275	1,460	2,301	451	1,850	5,586	45	5,541
IT	722	2,154	1,066	359	707	3,584	35	3,549
Strategic Total	**4,063**	**3,614**	**3,367**	**809**	**2,558**	**10,235**	**80**	**10,155**
Pandemic								
Buildings and Plant	-	-	-	-	-	-	-	-
Clinical Equipment	-	-	-	-	-	-	-	-
IT	-	-	-	-	-	97	-	97
Pandemic Total	**-**	**-**	**-**	**-**	**-**	**97**	**-**	**97**
Total Capital (excluding MOH, Trust, Gym)	**10,315**	**20,231**	**12,058**	**5,117**	**6,941**	**37,585**	**777**	**36,806**

Summary of Leases – as at 31 July 2021

		Original Cost	Monthly Amount	Annual Amount	Total Lease Cost	Start Date	End Date	Lease type
Rental Property Leases	**Occupants**							
Wainuiomata Health Centre	District Nurses		1,199	14,386		1/11/2020	31/10/2023	Operating
Public Trust House Lower Hutt	Community Mental Health		27,717	332,601		1/09/2017	1/09/2023	Operating
CREDS - Johnsonville	Eating Disorders		5,370	64,435		1/01/2015	Rolling lease	Operating
RPH - Porirua Public Health	RPH School Health - Promotional Health		10,241	122,887		15/03/2015	14/03/2025	Operating
Criterion Lane, Lagan Building, Upper Hutt	Physiotherapy & Counselling		2,626	31,510		5/01/2021	31/12/2023	Operating
Criterion Lane, Lagan Building, Upper Hutt	Midwives		500	5,998		16/06/2020	16/05/2023	Operating
Upper Hutt Health Centre	District Nurses		974	11,688		24/01/2015	1/02/2022	Operating
Pretoria St, Lower Hutt	RPH & Covid Team		8,360	100,320		1/08/2021	31/01/2023	Operating
			56,987	**683,825**				
Motor Vehicle Leases								
Motor Vehicle Lease plus Management Fees (121 Vehicles, including 2 Nissan Leaf EV's)			39,286	471,428		Ongoing	Ongoing	Operating
			39,286	**471,428**				
Equipment Leases	**Supplier**							
MRI Ingenia 1.5T	De Lage Landen (paid monthly in arrears)		22,498	269,981	1,349,905	19/09/2019	19/08/2024	Operating
Fluoroscopy Combi Diagnost R90	De Lage Landen (paid monthly in arrears)		9,753	117,037	585,185	1/08/2019	31/07/2024	Operating
Plastics Micro Power Tools	Stryker New Zealand Ltd	293,188	3,490	41,884	125,652	1/10/2018	30/09/2025	Finance
Orthopaedic Tools	Stryker New Zealand Ltd		9,024	108,292	758,044	1/09/2016	31/08/2023	Operating
3 x Ultrasounds (Equigroup)	GE Healthcare Ltd		7,315	87,782	153,618	28/09/2020	28/06/2022	Operating
1 x Ultrasound Epiq (Equigroup)	Philips NZ Commercial Ltd		1,761	21,129	40,498	28/09/2020	28/08/2022	Operating
CT Scanner 128 Slice (Equigroup)	Toshiba Medical Systems		24,976	299,711	499,518	28/09/2020	28/05/2022	Operating
Philips Digital Diagnost C90 (Room 2)	De Lage Landen (paid monthly in arrears)		7,265	87,186	435,930	31/01/2020	31/01/2025	Operating
Philips Digital Diagnost C90 (Room 1)	De Lage Landen (paid monthly in arrears)		6,184	74,214	371,070	31/01/2020	31/01/2025	Operating
Philips Mobile Diagnost R2 (Resus)	De Lage Landen (paid monthly in arrears)		3,932	47,186	235,930	1/06/2020	1/06/2025	Operating
Philips Digital Diagnost C90 (ED)	De Lage Landen (paid monthly in arrears)		6,177	74,118	370,592	30/09/2020	30/09/2025	Operating
Philips Digital Diagnost C90 (Resus)	De Lage Landen (paid monthly in arrears)		3,877	46,520	232,601	31/08/2020	31/08/2025	Operating
Logiq E10 4D Ultrasound (Equigroup)	GE Healthcare Ltd		3,649	43,794	218,969	28/01/2021	28/01/2026	Operating
3 x Carestream Mobile X-ray Units	De Lage Landen (paid monthly in arrears)		9,960	119,517	597,586	27/04/2021	27/04/2026	Operating
2x Digital Diagnost C90 (Room 3 & Room 4)	De Lage Landen (paid monthly in arrears)		11,552	138,623	693,114	13/05/2021	13/05/2026	Operating
		293,188	**131,412**	**1,576,974**	**6,668,212**			
Total Leases			**227,685**	**2,732,227**				

Treasury as at 31 July 2021

NZHP banking activities for the month	Current month ($000)	Last month ($000)
Average balance for the month	$42,449	$46,584
Lowest balance for the month	$21,564	$22,874
Average interest rate	0.64%	0.66%
Net interest earned/(charged) for the month	$23	$25

2) Hedges

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

3) Foreign exchange transactions for the month ($)

No. of transactions involving foreign currency	6
Total value of transactions	$33,319 NZD
Largest transaction	$30,919 NZD

	No. of transactions	Equivalent NZD
AUD	4	$2,100
GBP		
SGD		
USD	2	$31,219
Total	**6**	$33,319

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	$5,741	$412	$1,666	$138	$115	$151	$368	$2,890
Wairarapa District Health Board	$550	$122	$62	$0	$54	$0	$115	$196
Accident Compensation Corporation	$467	$259	($82)	$42	$46	($1)	($24)	$228
Ministry of Health	$307	$133	$113	$35	$9	$9	$12	($4)
Wellington Southern Community Laboratories	$98	$0	$98	$0	$0	$0	$0	($0)
ESR Limited	$61	$61	$0	$0	$0	$0	$0	$0
Non Resident	$54	$0	$0	$0	$0	$0	$0	$54
WellNZ Limited	$52	$25	$2	$2	$19	$0	($0)	$5
Ministry of Social Development	$48	$0	$48	$0	$0	$0	$0	$0
Non Resident	$27	$0	$0	$0	$0	$0	$0	$27
Total Top 10 Debtors	**$7,405**	**$1,012**	**$1,907**	**$217**	**$242**	**$159**	**$471**	**$3,396**

Board Information – Public

6 October 2021

Capital & Coast DHB Financial and Operational Performance Report – July 2021

Action Required

The CCDHB Board notes:

(a) The DHB had a ($2.6m) deficit for the month of July 2021, being breakeven to budget before excluding COVID-19;

(b) In the one month we have incurred $441k additional net expenditure for COVID-19;

(c) The DHB has an overall YTD deficit of ($2.2m) from normal operations (excluding COVID-19) being $400k favourable to the underlying budget.

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

Executive Summary

There is ongoing cost due to the COVID-19 response into the 21/22 fiscal year, which has been largely funded by the Ministry. The Ministry have asked DHBs to separately report unfunded net COVID-19 impacts for 21/22, these being considered outside our responsible deficit and budgets.

For 2021/22 the provisions for the liability due to Holidays Act remediation are now included and reported against the base budget.

Excluding the COVID-19 net expenses the DHB's result for the one month to 31 July 2021 is $2.2m deficit, versus a budget deficit of $2.6m.

Additional net COVID-19 related expenditure above funding, year to date is $441k.

For the one month to 31 July 2021 the overall DHB year to date result, including COVID-19 costs is $2.6m deficit.

The DHB has submitted an Annual baseline budgeted surplus of $1m, resulting from the recognition of $60m donation of the new Children's Hospital expected in March 22. The underlying deficit is ($59m) including Holidays Act Provisions.

Capital Cash Flow Expenditure was $7.7 million year to date including strategic capex.

We had a negative cash Balance at month-end of $29.4 million offset by positive "Special Funds" of $13.2 million, net negative cash balance of $16.2 million. It should be noted that there is an amount of the COVID-19 response that has not been funded by the crown at this time and this has a negative cash impact on the DHB.

The pressures in July see the principles of our Winter Plan in action. ED and specialities have worked together to consider alternative pathways of care rather than an inpatient stay; Inpatient areas are flexing up in bed numbers in order to better match the needs of our community who are presenting for care. This is the whole of system approach working together to enable shorter stays in ED. The ministry is collating data on a weekly basis to develop a national view about the impact of the increased demand seen across the country.

Planned care – the delivery of Specialist assessments or Treatment within 120 days continues to be a major challenge in managing this against acute volumes however we are making slow progress against our long wait patients, continuing work is in place to achieve the Recovery wait list trajectories. We continue to liaise weekly with the Ministry planned care team seeking support and advice as we lead out our system improvement project aimed at making progress around all aspects of managing elective flow.

We continue with the 2D Bed & Theatre Capacity project to identify and deliver solutions for short to medium term improvement in OT capacity across 3 Hospitals (Kenepuru, Wellington & Hutt).

Workforce shortages across midwifery and nursing, allied health in particular sonographer social work and radiographers are at critical levels in some areas; we are continually refining and reviewing processes to manage demand during busy periods and continue to work closely with our staff and union partners on workforce planning across the region noting this issue as requiring national solutions. The 2D Nursing and Midwifery Recruitment and Retention Strategy, written to assist with the drive we need right now to fill vacancies in both workforces, at both DHBs and seek to retain our existing staff is being led by our Chief Nurse.

A cautious start to the new financial year – meeting budget.

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 216 FTE above our annual budget (however note lead DHB roles).
Financial	The YTD result for the DHB was ($32.1m) deficit from normal operations, against our DHB budget of ($39.8m). An additional ($4.0m) was spend on unfunded COVID-19 costs split between the provider and funder arm, and ($8.7m) was recognised for Holidays Act provisions.
Governance	The Board has a responsibility to scrutinise the financial reports alongside FRAC, and report back issues as identified.

Engagement/Consultation

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

Identified Risks

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

Attachment/s

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

Capital & Coast District Health Board

Monthly Financial and Operational Performance Report

For the period ending 31 July 2021

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

Contents

Section 1

Financial and Performance Overview and Executive Summary

Executive Summary

- There are ongoing costs due to the COVID-19 response into the 21/22 fiscal year. The DHB is being reimbursed for the large portion of the DHB COVID-19 response costs in 21/22. The Ministry have asked DHBs to separately report unfunded net COVID-19 impacts for 21/22, these being considered outside our responsible deficit and budgets.
- Excluding the COVID-19 net expenses the DHB's result for the one month to 31 July 2021 is ($2.6m) deficit, versus a budget deficit of ($2.6m).
- Additional net COVID related expenditure above funding, year to date is $441k.
- The monthly provision for increasing Holidays Act liability is $632k, which is slightly favourable to budget.
- For the one month to 31 July 2021 the overall DHB year to date result, including COVID-19 costs is $2.6m.
- The DHB has submitted an Annual baseline budget of $1m surplus, excluding the $60m Donation for the Children's Hospital the underlying deficit is ($59m).
- Capital Expenditure including equity funded capital projects was $7.7m year to date.
- We had a negative cash Balance at month-end of $29.4 million offset by positive "Special Funds" of $13.2 million (net $16.2m). It should be noted that there is a certain amount of the COVID-19 response that remains unfunded by the crown at this time and this has a cash impact on the DHB. Deficit support of $46.5m signalled in the 2021/22 Annual Plan will be requested for the 3rd quarter of the year.

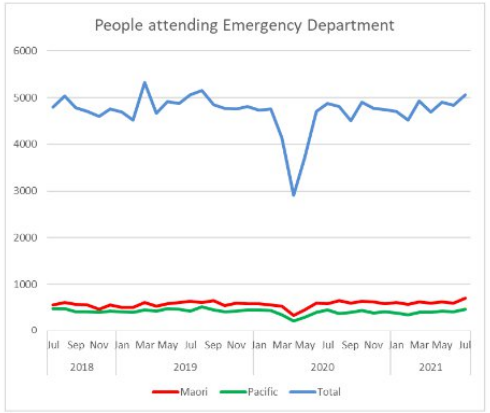
Executive Summary continued

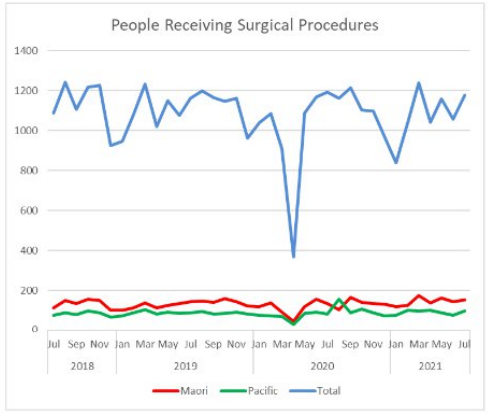
- The pressures in July see the principles of our Winter Plan in action. ED and specialities have worked together to consider alternative pathways of care rather than an inpatient stay; Inpatient areas are flexing up in bed numbers in order to better match the needs of our community who are presenting for care. This is the whole of system approach working together to enable shorter stays in ED. The Ministry is collating data on a weekly basis to develop a national view about the impact of the increased demand seen across the country.
- Planned care – the delivery of Specialist assessments or Treatment within 120 days continues to be a major challenge in managing this against acute volumes however we are making slow progress against our long wait patients , continuing work is in place to achieve the Recovery wait list trajectories. We continue to liaise weekly with the Ministry planned care team seeking support and advice as we lead out our system improvement project aimed at making progress around all aspects of managing elective flow.
- We continue with the 2D Bed & Theatre Capacity project to identify and deliver solutions for short to medium term improvement in OT capacity across 3 Hospitals (Kenepuru, Wellington & Hutt).
- Workforce shortages across midwifery and nursing, allied health in particular sonographer social work and radiographers are at critical levels in some areas; we are continually refining and reviewing processes to manage demand during busy periods and continue to work closely with our staff and union partners on workforce planning across the region noting this issue as requiring national solutions. The 2D Nursing and Midwifery Recruitment and Retention Strategy, written to assist with the drive we need right now to fill vacancies in both workforces, at both DHBs and seek to retain our existing staff is being led by our Chief Nurse.
- A cautious start to the new financial year – meeting budget.

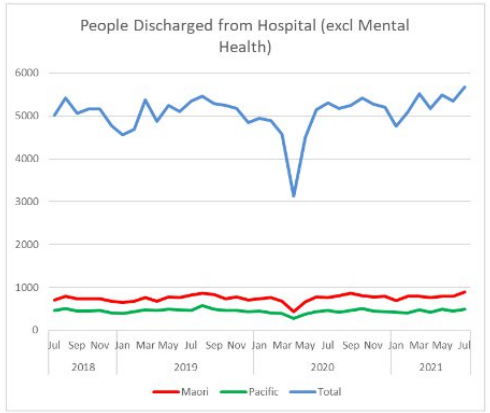
Performance Overview: Activity Context (People Served)

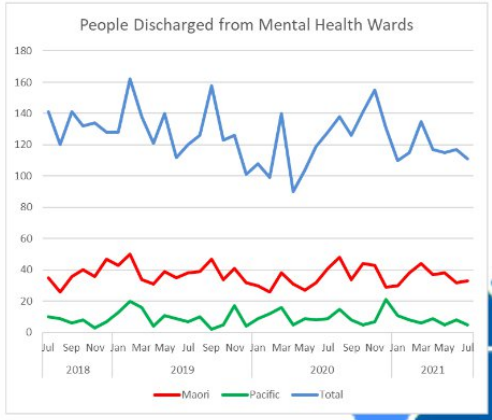
CCDHB funds services that touch thousands of people in our community every month. Unless otherwise indicated, the numbers below count individuals once and are based on CCDHB being the DHB of Service. Our services have returned to delivering services to our population without the restrictions due to COVID-19.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

People attending ED	**5,056**	705 Maori, 463 Pacific
People receiving Surgical Procedures (in main theatres)	**1,179**	151 Maori, 98 Pacific
People discharged from Kenepuru Community Hospital or Wellington Regional Hospital (excl Mental Health)	**5,681**	896 Maori, 494 Pacific
People discharged from Mental Health Wards	**111**	33 Maori, 5 Pacific



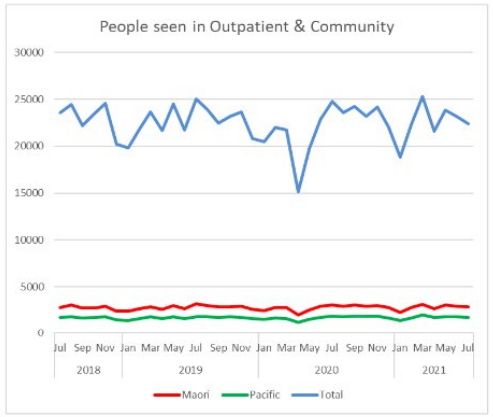


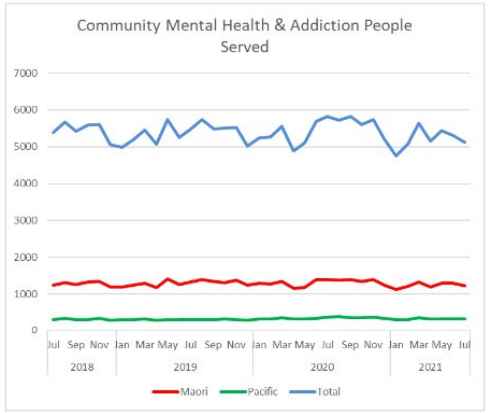


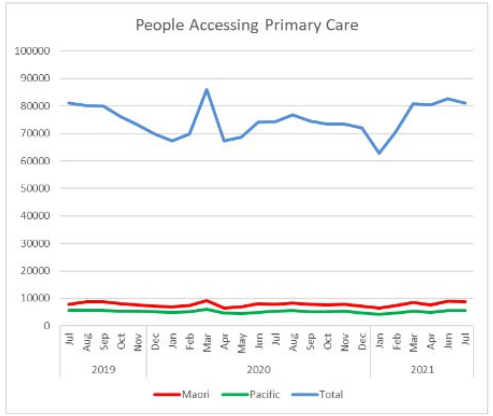


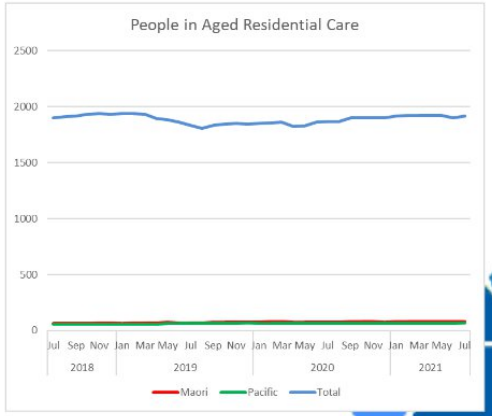
Performance Overview: Activity Context (People Served)

People seen in Outpatient & Community	**22,414**	2,886 Maori, 1,748 Pacific
Community Mental Health & Addiction People Served	**5,120**	1,220 Maori, 318 Pacific
People accessing primary care	**81,052**	8,846 Maori, 5,666 Pacific
People in Aged Residential Care	**1,917**	82 Maori, 68 Pacific









Financial Overview – July 2021

YTD Operating Position

$2.6m deficit

Incl. $441k COVID-19 costs
Incl. $632k Holidays Act

Against a budgeted YTD deficit of $2.6m. BAU Month result was $400k favourable. YTD $400k favourable BAU variance.

YTD Provider Position

$2.3m surplus

Incl. $441k COVID-19 costs
Incl. $632k Holidays Act

Against a budgeted YTD surplus of $2.3m. BAU Month result was $184k favourable. BAU YTD $184k favourable variance.

YTD Funder Position

$5m deficit

Against a budgeted YTD Deficit of $5m. BAU Month result was $200k favourable result. YTD $200k favourable BAU variance.

YTD Capital Exp

$7.7m spend

Incl. $4.5m strategic capex

Against a KPI of a budgeted baseline (non-strategic) spend of $3.5m.
Strategic incorporates funded project such as Children's Hospital

YTD Activity vs Plan (CWDs)

0.72% ahead[1]

45 CWDs ahead PVS plan (-54 IDF CWDs , but -67 Hutt behind). Month result +45 CWDs excluding work in progress.

YTD Paid FTE

5,756[3]

YTD 312 below annual budget of 6,068 FTE. There is 618 FTE vacancies at end of July

Annual Leave Taken

($11.8m) annualised[4]

Underlying YTD annual leave taken is under by 4.8 days per FTE and Lieu leave taken for public holidays is short by 1.7 days.

[1] Note that the PVS (Price volume schedule for HHS/MHAIDS) is not total Surgical/Medical case-weight throughput largely due to Non-Residents & ACC. Also Outsourced PVS cases within this result cannot yet be compared to target, however a total of 294 cwd outsourced (133 events) ~$1.8m dollars at WEIS price. This is largely Cardiothoracic sent to Wakefield and Orthopaedics sent to Southern Cross.
[3] Paid FTE ignores leave balance movement which is YTD 10FTE worse than budgeted growth, Outsourced staff are also not counted in this metric which is currently $6.5m adverse to budget.

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

Hospital Performance Overview – July 2021

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

ED (SSIED) 6 Hour rule	ESPI 5 Long Waits	Specialist Outpatient Long Waits	Serious Safety Events[2]
56.2%	464	214**	9
38.8% below the ED target of 95% Monthly -7.8%	Against a target of zero long waits a monthly movement of +89	Against a target of zero long waits, a monthly movement of -182 .**internal figures	An expectation is for nil SSEs at any point.

YTD Activity vs Plan (CWDs)	YTD Paid FTE	YTD Cost per WEIS
0.72% ahead[1]	3,730[3]	$6,154*
45 CWDs ahead PVS plan (-54 IDF CWDs , but -67 Hutt behind). Month result +45 CWDs excluding work in progress.	YTD 109 below annual budget of 3,839 FTE. 279 FTE vacancies at month end.	Against a national case-weight price per WEIS of $6,100.*to Jul 2021

[1] Note that the PVS (Price volume schedule for HHS/MHAIDS) is not total Surgical/Medical case-weight throughput largely due to Non-Residents & ACC. Also Outsourced PVS cases within this result cannot yet be compared to target, however a total of 294 cwd outsourced (133 events) ~$1.8m dollars at WEIS price. This is largely Cardiothoracic sent to Wakefield and Orthopaedics sent to Southern Cross.
[2] An SSE is classified as SAC1 or SAC2 serious adverse events per HQSC
[3] Paid FTE ignores leave balance movement which is YTD 12 FTE worse than budgeted, Outsourced staff are also not counted in this metric which is currently $1.3m adverse

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

Section 2.1

Funder Performance

Executive Summary – Funder Performance

- Overall the funder has a YTD favourable variance of $0.19m. PHO wash-up revenue contributed a favourable variance of $0.42m with offsetting costs.
- Revenue is $4.56m ahead of budget due to CCDHB having additional COVID-19 accrued and paid revenue of $4.27m. The offsetting COVID-19 costs are ($4.27m). Recovery of all costs remains the subject of negotiations with MoH agreeing a full cost recovery. The ongoing demand for managed isolation facilities, and community surveillance continues. The COVID-19 vaccination rollout is progressing and will ramp up over the next 4 to 6 months.
- Cost of funding community services is ($0.28m) unfavourable to budget with Pharmaceuticals being ($0.2m) over budget. Age residential care reflects the impact of stronger homecare support services and models of care for older people. Primary care demand driven services such as vaccination, urgent dental and other services are also under budget.
- The COVID-19 Vaccine programme is in line with MoH targets. There is a strong focus on equity for Māori and for our Pacific and Disability communities and coverage of these populations is improving. A vaccination model has been agreed with MoH and the DHBs are working with the PHOs, Pharmacies and Aged Care Facilities to continue the rollout.
- In this report we have also highlighted key areas of performance with a focus on our core services and achieving equity. It is recognised that these highlight significant need for improved service delivery and a pro-equity commissioning approach:
    - Engagement with the full set of WCTO visits in the first year of life is challenging. CCDHB is one of the highest performing DHB for this metric across all ethnicities. The factors influencing performance are complex and varied, particularly for Māori and Pacific women. A lack of continuity in support throughout the first 1,000 days, exacerbated by ongoing midwifery shortages. Our commissioning team is looking at our learnings from COVID Vaccine Commissioning to see how we can achieve equity using a different commissioning and provider model.
    - Poor control of long term conditions are a driver of ASH rates, in particular cardiovascular and respiratory conditions are the top presenting conditions, particularly for Māori and Pacific peoples. To address these areas we are focusing on access to acute care in primary care practices including the focus for diabetes is on upskilling nurses and GPs with regard to the new funded specialist authority medication Empagliflozin. A hui was held to discuss complex patient management with GPs, nurses and MDTs and CVRA screening in Māori and Pacific (particularly males) continues in PHOs through flexible appointment arrangements and Saturday clinics to support prevention and early intervention. We continue to work with our PHOs on new ways to engage and recall Māori and Pacific.
    - The average general adult bed deficit is 37 at Wellington Regional Hospital in 2020/21. We have analysed data across our 2DHB Hospital Network and identified a number of demographic and clinical drivers that are impacting acute flow and acute demand across our health system (see June update). We are responding through a series of targeted performance based projects including ‘front of whare’ and ‘planned care’.
    - A Mental Health and Addiction Commissioning Forum has been established to steer the redesign and implementation of a whole of population, equitable, MHA system of care to support the wellbeing of the people in the region. The Commissioning Forum will focus on upholding our Te Tiriti o Waitangi obligations developing a kaupapa Māori approach across the continuum of services and designing services that improve wellbeing and achieve equity for our priority populations: Māori, Pacific people and Disabled people.

Funder Financial Statement of Performance

Month			Variance		Capital & Coast DHB Funder Result - $000 Jul 2021	Year to Date			Variance	
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year		Actual	Budget	Last year	Actual vs Budget	Actual vs Last year
76,176	76,176	72,885	(0)	3,291	Base Funding	76,176	76,176	72,885	(0)	3,291
5,625	5,292	4,711	333	914	Other MOH Revenue - Funder	5,625	5,292	4,711	333	914
4,270	0	124	4,270	4,146	COVID Revenue from MOH	4,270	0	124	4,270	4,146
49	46	100	3	(51)	Other Revenue	49	46	100	3	(51)
3,115	2,892	3,253	223	(138)	IDF Inflows PHOs	3,115	2,892	3,253	223	(138)
22,866	23,133	18,517	(266)	4,350	IDF Inflows 20/21 Wash-up Prov	22,866	23,133	18,517	(266)	4,350
112,101	**107,539**	**99,589**	**4,562**	**12,512**	**Total Revenue**	**112,101**	**107,539**	**99,589**	**4,562**	**12,512**
					Internal Provider Payments					
839	839	824	0	(15)	DHB Governance & Administration	839	839	824	0	(15)
62,844	63,033	56,279	189	(6,564)	DHB Provider Arm Internal Costs - HHS	62,844	63,033	56,279	189	(6,564)
11,558	11,558	7,752	0	(3,806)	DHB Provider Arm Internal Costs - MH	11,558	11,558	7,752	0	(3,806)
(201)	(201)	1,940	0	2,141	DHB Provider Arm Internal costs - Corp	(201)	(201)	1,940	0	2,141
637	0	0	(637)	(637)	DHB Provider Arm Internal costs - COVID	637	0	0	(637)	(637)
75,677	**75,229**	**66,795**	**(448)**	**(8,882)**	**Total Internal Provider**	**75,677**	**75,229**	**66,795**	**(448)**	**(8,882)**
					External Provider Payments:					
6,750	6,571	5,703	(180)	(1,047)	- Pharmaceuticals	6,750	6,571	5,703	(180)	(1,047)
7,006	6,932	6,726	(74)	(280)	- Capitation	7,006	6,932	6,726	(74)	(280)
7,405	7,454	7,040	49	(365)	- Aged Care and Health of Older Persons	7,405	7,454	7,040	49	(365)
3,338	3,184	2,996	(154)	(342)	- Mental Health	3,338	3,184	2,996	(154)	(342)
853	879	782	26	(71)	- Child, Youth, Families	853	879	782	26	(71)
834	845	635	11	(200)	- Demand driven Primary Services	834	845	635	11	(200)
2,371	2,440	2,255	69	(116)	- Other services	2,371	2,440	2,255	69	(116)
4,002	4,002	3,828	0	(174)	- IDF Outflows Patients to other DHBs	4,002	4,002	3,828	0	(174)
5,225	5,190	5,334	(35)	109	- IDF Outflows Other	5,225	5,190	5,334	(35)	109
37,784	**37,496**	**35,298**	**(288)**	**(2,486)**	**Total External Providers**	**37,784**	**37,496**	**35,298**	**(288)**	**(2,486)**
3,633	0	516	(3,633)	(3,117)	- COVID in Community PHO, ARC	3,633	0	516	(3,633)	(3,117)
117,094	**112,725**	**102,609**	**(4,369)**	**(11,368)**	**Total Expenditure**	**117,094**	**112,725**	**102,609**	**(4,369)**	**(14,485)**
(4,993)	**(5,186)**	**(3,020)**	**193**	**(1,973)**	**Net Result**	**(4,993)**	**(5,186)**	**(3,020)**	**193**	**(1,973)**

Funder Financials – Variance Explanations

Revenue

SPP Funder Revenue Variances	Mth $000's	YTD $000's
COVID-19 MIQ and Vaccine rollout	637	637
COVID-19 Community funding	3,633	3,633
PHOs volume variances offset	422	422
Mental Health, Aged Care, Family CFAs	102	102
CWD IDF 2021/22 below target	(232)	(232)
Year to Date Revenue Variances	**4,562**	**4,562**

External Revenue Variances

- COVID-19 actual funding and accrued provision of $4.27m in support of GP assessment testing, pharmaceutical costs, vaccine rollout, quarantine hotel staffing & response funding for Maori groups. The DHB will be fully funded for all COVID community, MIQ and Vaccine rollout costs.
- PHO additional wash-ups and volume funding of $0.42m. There are increased costs of ($0.17m) offsetting this revenue. New funding for Mental Health and Child & Youth services of $0.1m has been contracted to NGO Providers.

Internal Revenue Variances

- The Provider Arm has not achieved IDF CWD targets by ($0.23m).

CCDHB Funder Arm total net variance to Budget for the month of July 2021 is $0.19m

Payments to Internal and External Providers

SPP Funder Payment Variances	Mth $000's	YTD $000's
COVID-19 MIQ & Vaccine	(637)	(637)
COVID-19 Community funding	(3,633)	(3,633)
Pharms increased volumes incl COVID	(180)	(180)
PHOs volume variances offset	(169)	(169)
Other Volume driven costs	250	250
Year to Date Payment Variances	**(4,369)**	**(4,369)**

External Provider Payments:

- Community, MIQ and Vaccine rollout COVID-19 response costs ($4.27m) mainly due to ongoing GP test assessment claims and vaccine rollout in support of the COVID-19 response as directed by the Ministry.
- Pharmaceuticals costs are still impacted by COVID-19 with increasing costs and fees unfavourable to budget by ($0.18m).
- PHO Capitation expenses are ($0.17m) unfavourable. Additional costs due to volume changes are offset by additional revenue.
- Other Community NGO contracts have a net YTD variance of $0.06m. New funded NGO contracts offset lower volume trends in NGO contracted services such as immunisations and aged care costs.

Internal Provider Payments:

- Lower targets volumes achieved ($0.19m) to the Provider Arm.

Inter District Flows (IDF)

IDF Inflow Categories Variance to Budget Target	YTD July 2021 $000's
Inpatient CWD	(329)
Outpatient Non DRG	(263)
Uncoded	360
PHO Volume changes	224
Other IDF Inflows	(35)
Total per Financials	**(43)**

Inter District Revenue Inflows

We have recognised changes in IDF inflows which has resulted in an unfavourable variance of ($329k) YTD. Breakdown of the variance commented below:

- The majority of the lower IDF inflows (actuals) are caused by planed care inpatient lower volumes:
  - Acute: ($381k): Neurosurgery ($248k), Cardiology ($228k, followed Vascular Surgery ($129k), Spec Paediatric Surgery ($115k), and Offset by Orthopaedic Surgery $282k, Maternity Service $92k Oncology $89k
  - Planned Care: $52k; Cardiothoracic ($414), Gynaecology ($45k), Neurosurgery ($37k), and offset by Orthopaedic ($292k), Cardiology $77k, Vascular $56k, Ophthalmology $55k, Urology $35k
- Outpatient Non DRG inflow relates to all IDF patient visits that do not require an overnight stay
- PHO Volume change inflows relates to an increase in PHO enrolments through a quarterly wash-up by the Ministry

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

Commissioning: Families & Wellbeing

What is this measure?

- 90% of babies living in a smokefree home at 1st WCTO Contact
- 95% of children fully immunised at 8 months
- 90% of infants receive all WCTO core contacts in first year of life

Why is this important?

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

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

How are we performing?

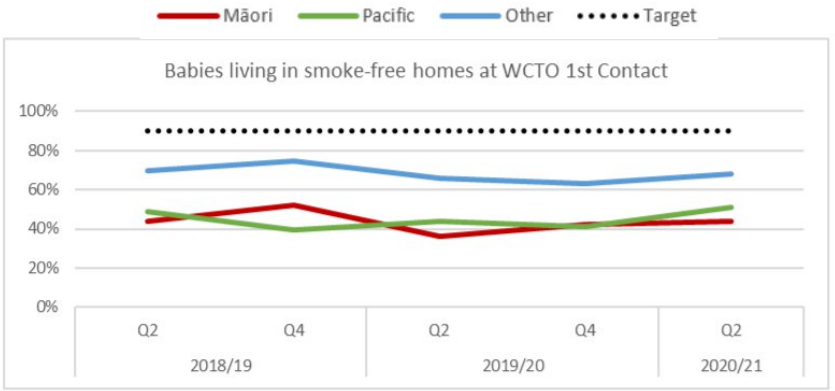
- Performance is below the 90% target for babies living in smoke-free homes at first WCTO Contact for Māori (44%), Pacific (51%) and non-Māori, non-Pacific (77%).
- Performance is below the 95% target for 8 month immunisation coverage for Māori (80%), Pacific (94%). Performance is above target for non-Māori, non-Pacific (96%).
- Performance is below the 90% target for children receiving all WCTO Core Contacts by 1 years old for Māori (52%), Pacific (40%) and non-Māori, non-Pacific (60%).

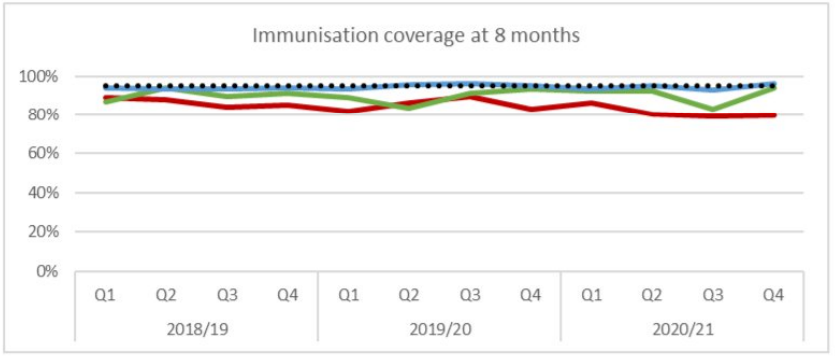
What is driving performance?

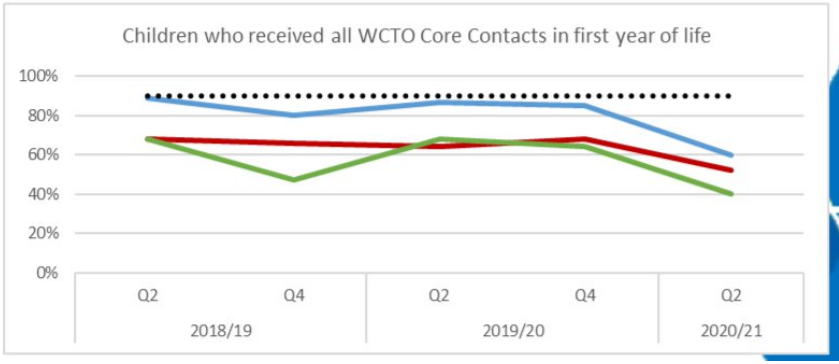
- Engagement with the full set of WCTO visits in the first year of life is challenging. CCDHB is one of the highest performing DHB for this metric across all ethnicities. The factors influencing performance are complex and varied, particularly for Māori and Pacific women. A lack of continuity in support throughout the first 1,000 days, exacerbated by ongoing midwifery shortages,

Management comment

- We are focused on developing a pro-equity commissioning approach adopting the learnings of our COVID vaccine programme. What we know from our COVID Vaccine programme is that commissioning vaccination, with our priority populations (Maori, Pacific & Disability), in addition to the mainstream General Practice system can be more successful. This approach may not be cost neutral but will be developed as the equity gains may be worth a small investment.







Commissioning: Primary & Complex Care

What is this measure?

Management of Long-Term Conditions (LTC):

- 65% of people with diabetes and HbA1c ≤64mmol/mol and no inequity
- ASH admissions rate for cardiovascular conditions (45-64)
- ASH admissions rate for respiratory conditions (45-64)

Why is this important?

- LTCs comprise the major health burden for New Zealand now and into the foreseeable future, and are the leading cause of morbidity. Māori and Pacific people are disproportionately affected by LTC.
- Cardiovascular diseases (CVD) and diabetes are substantially preventable with lifestyle changes for those at moderate or higher risks, and good control of diabetes reduces long-term complications.
- People living with LTC are regarded as leading partners in their own care, and early detection and diagnosis enables treatment and management to begin as soon as possible.

How are we performing?

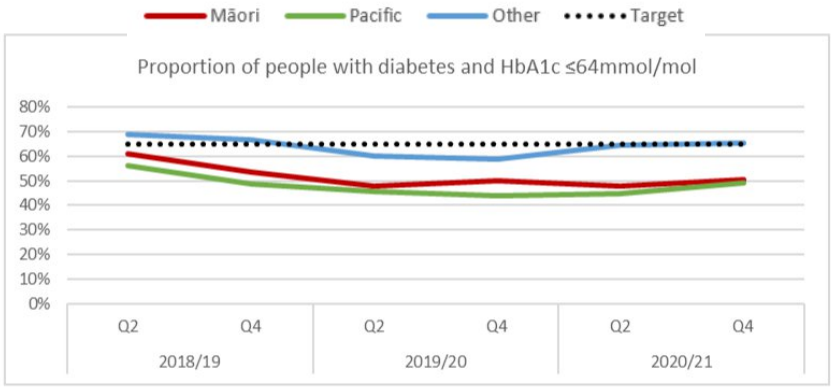
- Performance is below the 60% target for people with diabetes and HbA1c ≤64mmol/mol for Māori (51%), Pacific (49%). Non-Māori, non-Pacific achieved target in Q4 (65%).
- The rate of ASH admissions for CVD conditions for 45-64 year olds was 1,897 for Māori, 2,604 for Pacific, and 1,139 for non-Māori, non-Pacific.
- The rate of ASH admissions for CVD conditions for 45-64 year olds was 1,339 for Māori, 813 for Pacific, and 225 for non-Māori, non-Pacific in Q2.

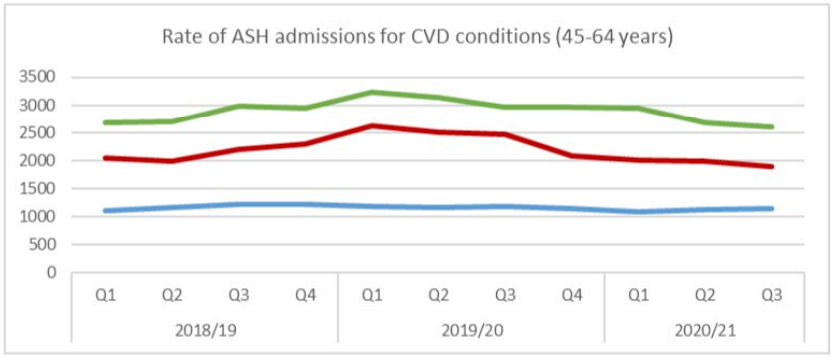
What is driving performance?

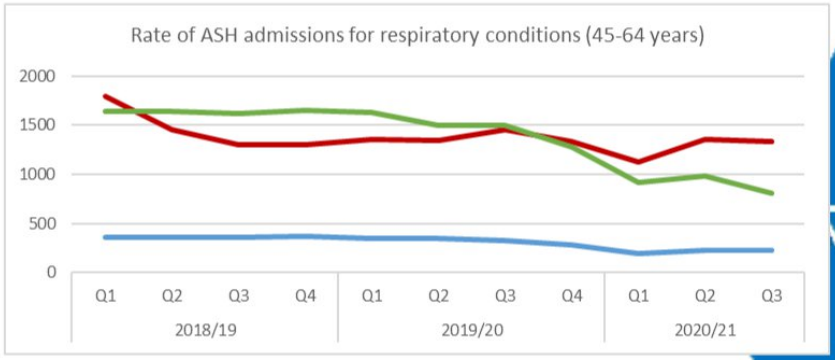
- Poor control of long term conditions are a driver of ASH rates, in particular cardiovascular and respiratory conditions are the top presenting conditions, particularly for Māori and Pacific peoples.

Management Comment

- To address these areas we are focusing on access to acute care in primary care practices:
- The focus for diabetes is on upskilling nurses and GPs with regard to the new funded specialist authority medication Empagliflozin. A hui was held to discuss complex patient management with GPs, nurses and MDTs.
- CVRA screening in Māori and Pacific (particularly males) continues in PHOs through flexible appointment arrangements and Saturday clinics to support prevention and early intervention. We continue to work with our PHOs on new ways to engage and recall Māori and Pacific.
- Vaka Atafaga, the Pacific neighbourhood nursing service in Porirua (similar to PHSHV in HVDHB) , continues to support Pacific families in improving their health and health outcomes. ASH is one of the referral criteria for families, along with diagnosis of long term condition(s) which are high contributors to ASH admissions.







Commissioning: Hospital & Speciality Services

What is this measure?

Acute Flow at Wellington Regional Hospital

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

Why is this important?

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

How are we performing?

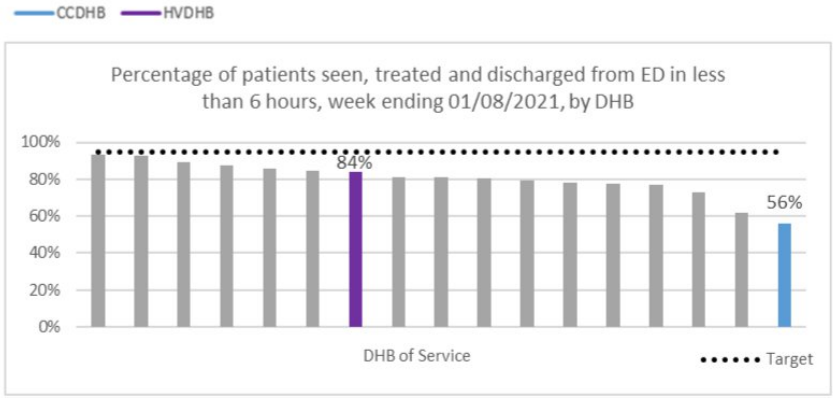
- The proportion of people presenting to ED and seen in under 6 hours was 56% (for the week ending 1 Aug).
- ED occupancy was over 90% in the week ending 1 Aug 100% of the time.
- Hospital occupancy was over 90% in the week ending 1 Aug 95% of the time.

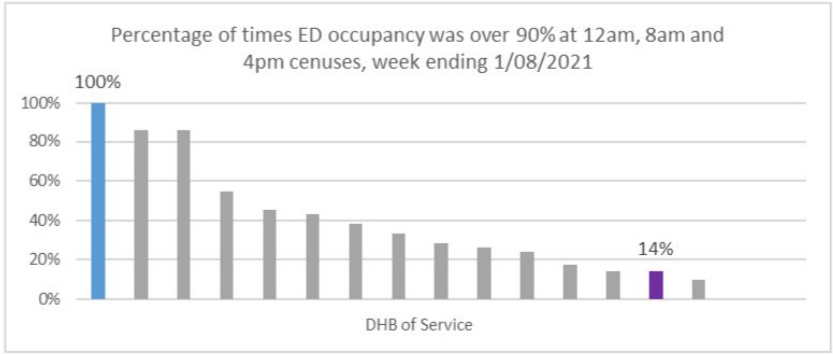
What is driving performance?

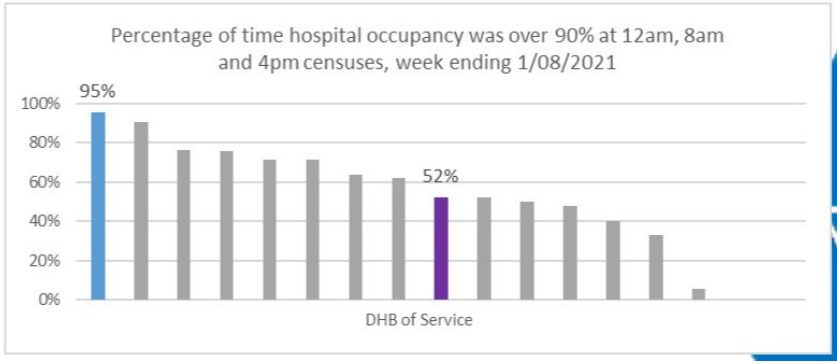
- The average general adult bed deficit is 37 at Wellington Regional Hospital in 2020/21.
- We have analysed data across our 2DHB Hospital Network and identified a number of demographic and clinical drivers that are impacting acute flow and acute demand across our health system (see June update).

Management comment:

- Destravis has been engaged to provide options on the best use of facilities across HVDHB and CCDHB in the 2DHB Hospital Network in the medium to long term.
- In response to capacity constraints we are undertaking the following projects identifying options for increasing **Bed and Theatre Capacity** across our three hospitals within the next two years while optimising use of current capacity. We are identifying options for increasing capacity and flow through Wellington ED and acute assessment areas as part of the **Front of Whare** project.
- A range of strategies underway to manage acute demand in both community and hospital settings, including **Winter Planning** to fund inpatient capacity with the provision of additional beds and physical spaces, and fund improved patient flow; and **community Investments** to deliver more care closer to home.
- These are part of the Hospitals strategic work programme for 2021/22.







Commissioning: Mental Health & Addictions

What is this measure?

- Number of specialist NGO and MHAIDS cultural interventions for Māori and Pacific
- Number of primary mental health and addiction interventions for Māori and Pacific
- ≥30% of mental health presentations to ED seen by an ED mental health nurse within an hour

Why is this important?

- In order to provide a pro-equity system of care, providers need to deliver solutions that are designed with people in mind. One such service is culturally specific interventions which are found throughout MHAIDS and NGO specialist services.
- Primary mental health and addiction services aim to provide timely care for people closer to home. Investment in this area will address people with lower levels of acuity earlier on.
- Emergency departments are under-equipped to resolve mental health presentations in a timely manner. The extensive wait times for mental health consultations often results in increasing distress and readmissions.

How are we performing?

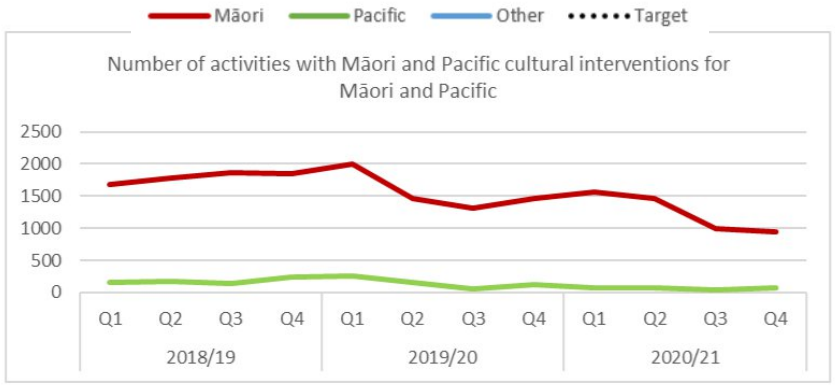
- The number of culturally-specific, specialist mental health and addiction interventions provided in Q4 was 937 for Māori and 65 for Pacific.
- The number of primary mental health and addiction interventions provided in Q4 was 155 for Māori and 73 for Pacific.
- The proportion of presentations to ED for mental health reasons that were seen by a mental health nurse within an hour was below the 30% target for Māori (14%) Pacific (22%), and non-Māori, non-Pacific (25%) in Q4.

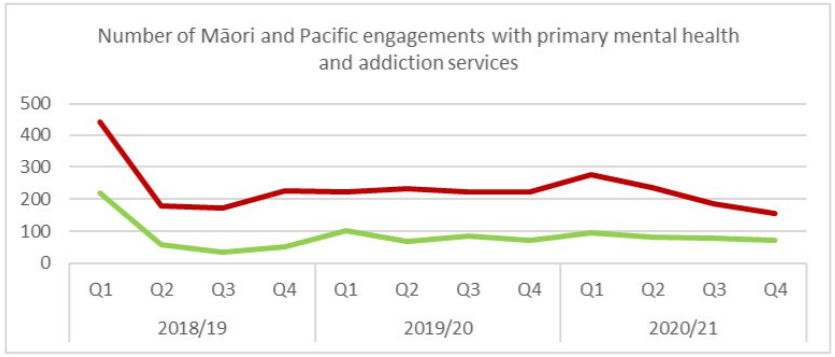
What is driving performance?

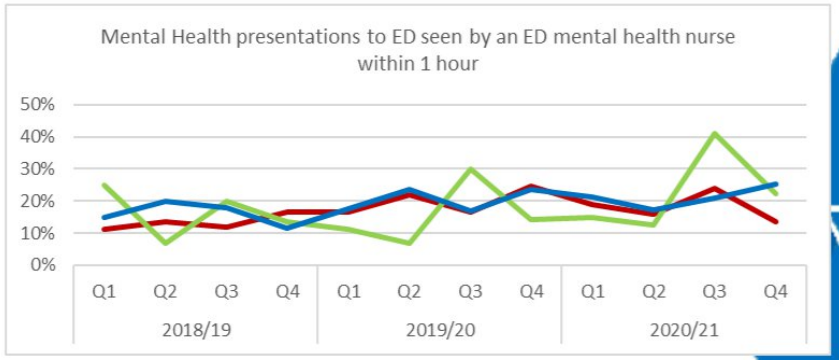
- Despite the current level of investment, we're not getting the outcomes we want for our people, particularly for Māori. There is a need to transform the MHA system to support equitable outcomes.

Management comment

- A Mental Health and Addiction Commissioning Forum has been established to steer the redesign and implementation of a whole of population, equitable, MHA system of care to support the wellbeing of the people in the region. The Commissioning Forum will focus on upholding our Te Tiriti o Waitangi obligations developing a kaupapa Māori approach across the continuum of services and designing services that improve wellbeing and achieve equity for our priority populations: Māori, Pacific people and Disabled people.







2DHB COVID-19 Response

What is this measure?

- COVID-19 vaccination roll-out

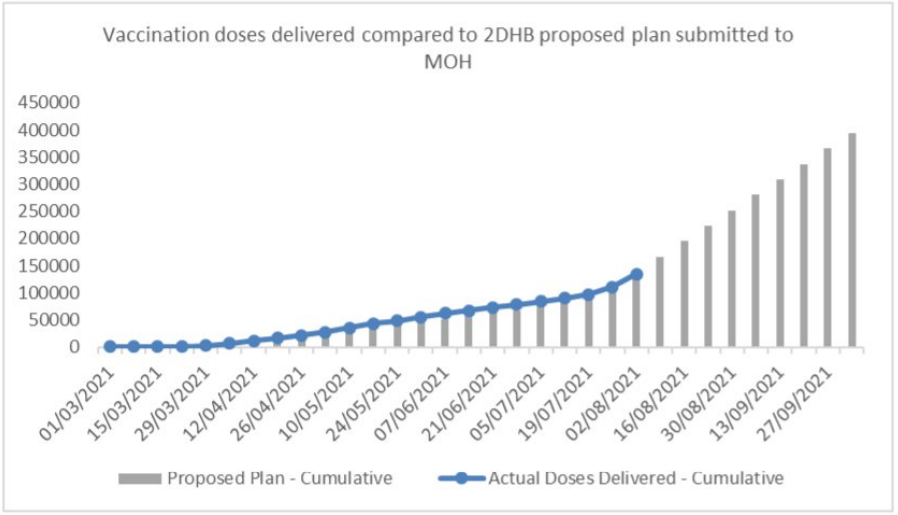
Why is this important?

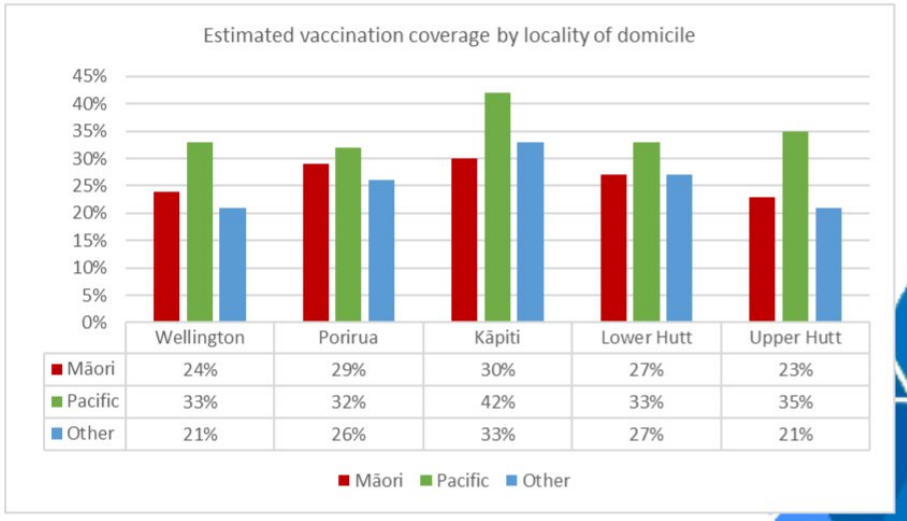
- The COVID-19 vaccine rollout aims to protect Aotearoa by ensuring that everyone over 16 years old receives the two doses. Ensuring equitable access to free COVID-19 vaccines is a priority for New Zealand.
- First we are protecting those most at risk of COVID-19.

How are we performing?

- **Group 1: Protect our border and MIQ workers**
  - Border and MIQ workers and employees and the people they live with
- **Group 2: Protect our high-risk frontline workers and people living in high-risk places**
  - High-risk frontline health care workers (public and private)
  - People living in long-term residential care
  - People working in long-term residential environments
  - Older Māori and Pacific people cared for by their whānau (and their carers and the people they live with)
  - People aged 65+ or with underlying health conditions or a disability living in the Counties Manukau DHB area
- **Group 3: Protect the people who are at risk of getting very sick from COVID-19**
  - People who are 65+
  - People with underlying health conditions1
  - Disabled people
  - People caring for a person with a disability
  - Pregnant people
  - People in custodial settings
- **Group 4: Protect everyone**
  - Everyone in Aotearoa New Zealand aged 16 and over not already eligible for a vaccine

Data and statistics about the rollout of COVID-19 vaccines in CCDHB can be found here.





	Wellington	Porirua	Kāpiti	Lower Hutt	Upper Hutt
Māori	24%	29%	30%	27%	23%
Pacific	33%	32%	42%	33%	35%
Other	21%	26%	33%	27%	21%

Data Sources: COVID-19: Vaccination 2DHB Qlik App
Date Range: 22/02/2021 to 04/08/2021
Data current at: 06/08/2021 @11:00am

Section 2.2

Hospital Performance

Executive Summary – Hospital Performance

- The pressures in July see the principles of our Winter Plan in action. ED and specialities have worked together to consider alternative pathways of care rather than an inpatient stay; Inpatient areas are flexing up in bed numbers in order to better match the needs of our community who are presenting for care. This is the whole of system approach working together to enable shorter stays in ED. The ministry is collating data on a weekly basis to develop a national view about the impact of the increased demand seen across the country.
- Planned care – the delivery of Specialist assessments or Treatment within 120 days continues to be a major challenge in managing this against acute volumes however we are making slow progress against our long wait patients , continuing work is in place to achieve the Recovery wait list trajectories. We continue to liaise weekly with the Ministry planned care team seeking support and advice as we lead out our system improvement project aimed at making progress around all aspects of managing elective flow.
- We continue with the 2D Bed & Theatre Capacity project to identify and deliver solutions for short to medium term improvement in OT capacity across 3 Hospitals (Kenepuru, Wellington & Hutt).
- Workforce shortages across midwifery and nursing, allied health in particular sonographer social work and radiographers are at critical levels in some areas; we are continually refining and reviewing processes to manage demand during busy periods and continue to work closely with our staff and union partners on workforce planning across the region noting this issue as requiring national solutions. The 2D Nursing and Midwifery Recruitment and Retention Strategy, written to assist with the drive we need right now to fill vacancies in both workforces, at both DHBs and seek to retain our existing staff is being led by our Chief Nurse.
- A cautious start to the new financial year – meeting budget.

CCDHB Contract Activity Performance

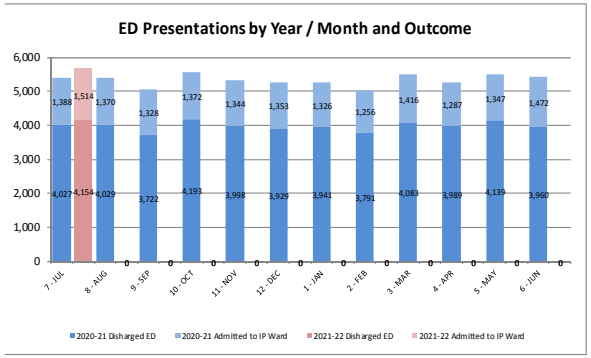
Capital and Coast DHB: July 2021

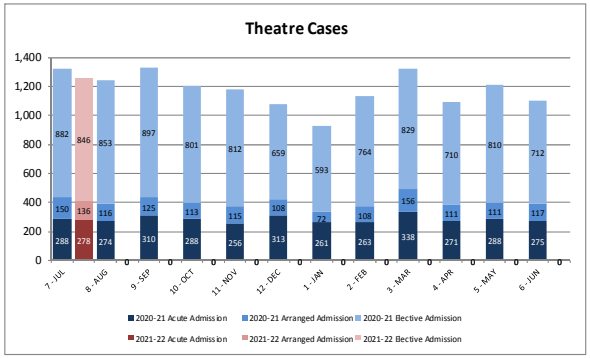
ED Presentations

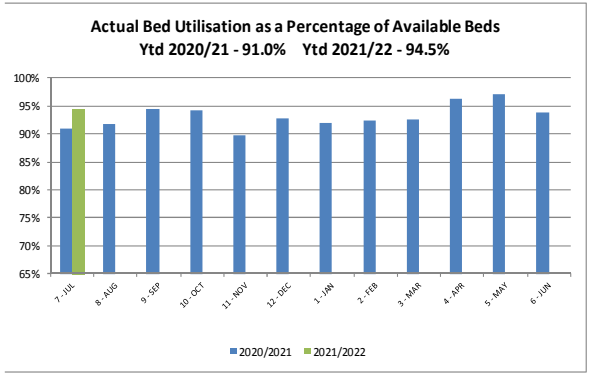
	2020/21	2021/22
YTD Totals	5,415	5,668
Change		253
% Change		5%

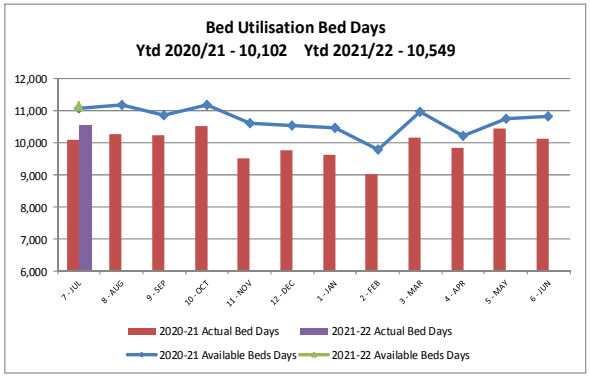
Theatre Cases

	2020/21	2021/22
YTD Totals	1,320	1,260
Change		-60
% Change		-5%









ED

- The total number of presentations to ED in July 2019 was 5,745 (this includes 460 DNWs)
- The total number of presentations to ED in July 2020 was 5,394 (this includes 370 DNWs)
- The total number of presentations to ED in July 2021 was 5,692 (this includes 658 DNWs)
- The overall total in July 2021 was similar to July 2019 but of note the total number of patients with a triage level 1-3 in July 2021 was 3,746 this is over 250 more than the total in 2019.

Bed Utilisation

- The utilisation of available of adult beds in core wards in July 2021 was 94.5% which is higher than the 91.0% rate recorded in July 2020. The number of available beds in July 2021 is higher than in July 2020 with more beds temporarily opened at Kenepuru in July 2021.
- The number of Elective theatre cases has decreased for the month of July 2021 by 4.1% (36 cases) when compared to July 2020. The decreases are spread across a number of specialties in particular Orthopaedics (-35) and Dental (-19) but this could in part be related to the fact there is one less week day in July.

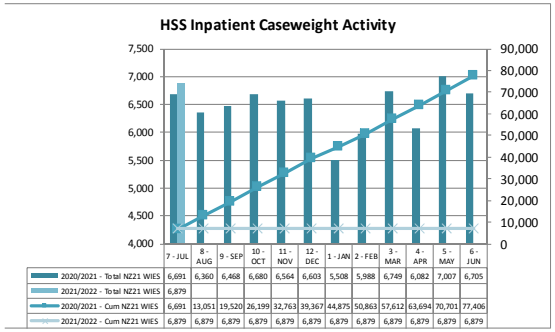
CCDHB Activity Performance

Capital and Coast DHB: July 2021

HSS Inpatient Caseweight Activity

	2020/21	2021/22
YTD Totals	6,691	6,879
Change		188
% Change		2.8%

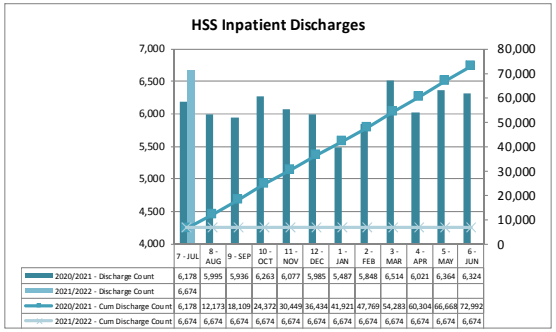
** This includes all Hospital Acitivty including ACC, Non Resident, Non-Casemix but excludes Mental Health*



HSS Inpatient Discharges

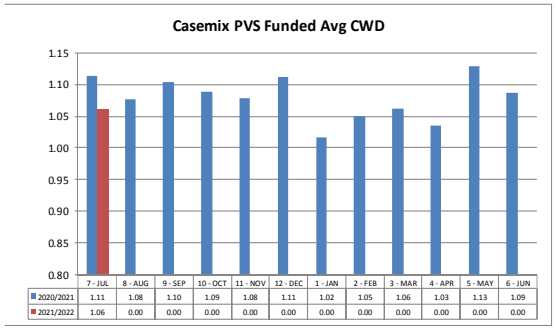
	2020/21	2021/22
YTD Totals	6,178	6,674
Change		496
% Change		8.0%

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



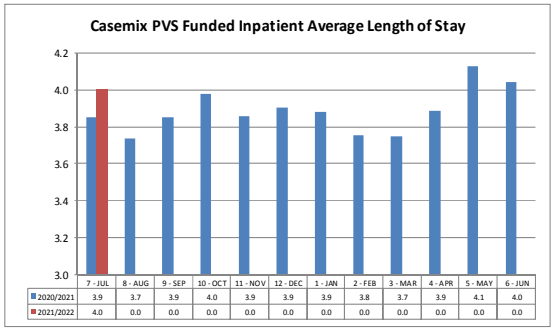
Casemix PVS Funded Avg CWD

	2020/21	2021/22
YTD Totals	1.08	1.06
Change		-0.02
% Change		-2%



Casemix PVS Funded Inpatient Average Length of Stay

	2020/21	2021/22
YTD Totals	3.89	4.00
Change		0.11
% Change		2.9%



Comparisons with same period last year:

- Local acute CWDs are higher than then previous financial year (285 CWDs) with an increase in discharges; a higher ALOS and a similar average CWD. The discharge increase is driven primarily by Paediatric Medicine and Emergency Medicine. The CWD increase is driven primarily by Paediatric Medicine, Neonatal and Orthopaedics.
- Local Elective CWDs are lower than the previous financial year (-10 CWDs) with an increase in discharges; a similar ALOS and average CWD. The discharge increase is driven primarily by Urology and Ophthalmology. The CWD decrease is driven primarily by General Surgery and Cardiothoracic Surgery.
- IDF acute CWDs are higher (88 CWDs) than the previous financial year also with an increase in discharges; a lower ALOS and average CWD. The discharge increase is driven primarily by Emergency Medicine, Gynaecology and Orthopaedics. The CWD increase is driven primarily by Orthopaedics, General Medicine and Radiation Oncology.
- IDF Elective CWDs are higher than the previous financial year (-103 CWDs) with more discharges; a higher ALOS and a lower average CWD. The discharge increase is driven primarily by Urology and Ophthalmology. The CWD decrease is driven by Cardiothoracic Surgery.
- In combination these four admission groups equate to an increase of 261 CWDs compared to the previous year. The services that most significantly impact this shift are Paediatric Medicine (261), Orthopaedics (157) and Neonatal (105).

Discharges:

- The number of publicly funded casemix discharges for the month of July 2021 which has increased by increased by 527 (6.9%) in comparison to the number of discharges recorded in July 2020. This increase can be largely attributed to increases in both Emergency Medicine (199) and Paediatric Medicine (192).
- The increase in Emergency Medicine is related to the increasing amount of time patient are spending in the Emergency Department before being discharged. These longer stays increases the opportunity of the patient reaching the three hour threshold to become a statistical admissions.
- The increase in Paediatric Medicine in July was common trend throughout New Zealand with a surge in emergency department's presentations for RSV (Respiratory syncytial virus) and other similar respiratory illnesses.
- The number of outsourced discharges recorded in July 2021 was 152 which is 20 higher than July 2020. CCDHB in July 2021 has utilised Boulcott Hospital, Bowen Hospital, Southern Cross Hospital and Wakefield Hospital.

HHS Operational Performance Scorecard – period Jul 20 to Jul 21

Domain	Indicator	2021/22 Target	2020-Jul	2020-Aug	2020Sep	2020-Oct	2020-Nov	2020-Dec	2021-Jan	2021-Feb	2021-Mar	2021-Apr	2021-May	2021-Jun	2021-Jul
Care	Serious Safety Events	TBD	15	9	11	5	19	6	12	13	3	9	7	5	9
	Total Reportable Events	TBD	1,168	1,269	1,370	1,359	1,418	1,512	1,424	1,483	1,451	1,418	1,535	1,360	1,481
Patient and Family Centred	Complaints Resolved within 35 calendar days	TBD	86.4%	94.3%	93.9%	94.9%	90.9%	83.0%	93.1%	95.5%	92.3%	93.7%	93.2%	86.6%	89.1%
	% Discharges with an Electronic Discharge summary	TBD													
Access	Emergency Presentations		5,415	5,399	5,050	5,565	5,342	5,282	5,267	5,047	5,499	5,276	5,486	5,432	5,668
	Emergency Presentations Per Day		175	174	168	180	178	170	170	180	177	176	177	181	183
	Emergency Length of Stay (ELOS) % within 6hrs	≥95%	72.6%	68.5%	65.6%	65.1%	67.6%	65.9%	68.6%	62.5%	66.3%	63.3%	66.8%	64.0%	56.2%
	ELOS % within 6hrs - non admitted	TBD	79.8%	76.8%	75.2%	73.6%	73.7%	73.7%	75.8%	70.3%	75.6%	71.7%	76.1%	73.2%	64.5%
	ELOS % within 6hrs - admitted	TBD	53.5%	46.8%	41.3%	42.3%	51.3%	46.0%	49.6%	42.4%	42.7%	40.6%	41.2%	42.1%	37.0%
	Total Elective Surgery Long Waits	Zero Long Waits	247	107	99	184	208	306	491	540	528	526	354	371	464
	Additions to Elective Surgery Wait List		1,520	1,376	1,543	1,397	1,391	1,288	922	1,240	1,452	1,220	1,443	1,332	1,060
	% Elective Surgery treated in time	TBD	73.0%	84.2%	90.3%	89.0%	86.3%	88.4%	75.5%	75.6%	72.2%	72.1%	75.0%	82.3%	83.3%
	No. surgeries rescheduled due to specialty bed availability	TBD	5	9	13	14	1	6	2	6	11	7	13	21	16
	Total Elective and Emergency Operations in Main Theatres	TBD	1,237	1,192	1,254	1,130	1,118	1,002	878	1,076	1,270	1,063	1,190	1,085	1,209
	Faster Cancer Treatment 31 Day - Decision to Treat to Treat	85%	93.0%	85.0%	87.0%	82.0%	85.0%	88.0%	82.0%	90.0%	88.0%	86.0%	82.0%	95.0%	81.0%
	Faster Cancer Treatment 62 Day - Referral to Treatment	90%	94.0%	83.0%	88.0%	88.0%	83.0%	89.0%	88.0%	83.0%	96.0%	79.0%	87.0%	91.0%	71.0%
	Specialist Outpatient Long Waits	Zero Long Waits	1,076	571	314	185	225	314	353	355	302	244	211	265	291
	% Specialist Outpatients seen in time	Zero Long Waits	74.1%	84.9%	90.0%	88.7%	92.1%	92.9%	89.1%	88.2%	85.6%	80.0%	90.5%	90.4%	89.4%
	Outpatient Failure to Attend %	TBD	7.1%	6.7%	7.0%	7.6%	7.7%	7.9%	7.3%	7.5%	7.2%	7.2%	7.4%	7.0%	7.1%
	Maori Outpatient Failure to Attend %	TBD	14.6%	13.8%	15.2%	15.3%	16.0%	16.6%	16.0%	16.1%	15.7%	15.7%	14.9%	15.2%	16.2%
	Pacific Outpatient Failure to Attend %	TBD	17.0%	14.4%	14.6%	16.3%	16.2%	18.8%	19.6%	17.7%	16.8%	15.7%	16.4%	15.6%	15.8%
Financial Efficiency	Forecast full year surplus (deficit) ($million)		($39.8m)	($39.8m)	($62.0m)	($62.0m)	($62.0m)	($62.0m)	($62.4m)	($62.4m)	($62.4m)	($62.4m)	($62.4m)	($46.5m)	$1m
	Contracted FTE (Internal labour)		4,976	5,035	5,237	5,267	5,264	5,257	5,256	5,344	5,346	5,367	5,363	5,340	5,335
	Paid FTE (Internal labour)		5,318	5,369	5,607	5,608	5,651	5,694	5,695	5,813	5,726	5,791	5,783	5,743	5,725
	% Main Theatre utilisation (Elective Sessions only)	85.0%	83.0%	82.0%	82.0%	82.0%	80.0%	78.2%	81.0%	80.0%	83.0%	83.0%	81.0%	80.0%	79.0%
Discharge and Occupancy	% Patients Discharged Before 11AM	TBD	24.0%	22.8%	24.8%	22.2%	25.1%	22.6%	22.3%	21.9%	23.2%	25.3%	23.7%	25.3%	20.6%
	Adult Long Stay Patients Not Yet Discharged (>14 days) WLG	TBD	30	35	51	33	34	37	37	38	41	37	35	38	44
	Adult Overnight Beds - Average Occupied WLG	TBD	362	363	382	378	363	360	355	373	381	381	386	387	383
	Adult Long Stay Patients Not Yet Discharged (>14 days) KEN	TBD	19	19	18	23	18	17	16	14	19	19	22	17	33
	Adult Overnight Beds - Average Occupied KEN	TBD	71	72	74	76	67	64	67	71	69	72	73	73	79
	Child Overnight Beds - Average Occupied	TBD	24	23	22	23	24	22	17	19	22	22	22	25	30
	NICU Beds - ave. beds occupied	36	28	31	38	36	33	35	38	39	44	39	42	36	40
ALOS	Overnight Patients - Average Length of Stay (days)	TBD	3.85	3.74	3.85	3.98	3.86	3.90	3.88	3.75	3.75	3.88	4.13	4.04	4.01
Care	Rate of Presentations to ED within 48 hours of discharge	TBD	3.7%	3.7%	4.3%	4.6%	3.2%	3.2%	4.1%	4.0%	3.5%	4.7%	4.6%	4.0%	4.0%
	Presentations to ED within 48 hours of discharge	TBD	199	201	215	254	171	170	218	202	194	247	253	218	224
Staff Experience	Staff Reportable Events	TBD	140	156	138	179	173	175	147	185	162	154	147	157	148
	% sick Leave v standard	TBD	4.0%	4.0%	3.6%	3.4%	3.4%	3.2%	2.0%	2.7%	3.5%	3.0%	3.6%	3.8%	4.3%
	Nursing vacancy	TBD	248.1	265.3	251.1	247.4	267.4	268.5	267.8	223.4	234.7	235.6	243.0	247.0	245.2
	% overtime v standard (medical)	TBD	1.7%	1.9%	2.1%	1.9%	2.0%	1.8%	1.8%	2.0%	1.9%	1.8%	2.0%	1.9%	2.4%

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

Shorter Stays in ED (SSIED)

What is this measure?

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

Why is this important?

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

How are we performing?

- The proportion of people presenting to ED and seen in under 6 hours was 56% (for the week ending 1 Aug).. Breaches in ED have increased by 1,072 in July 2021 compared to July 2019. The performance for ED treated and discharged patients for July 2021 was 66%, which is a 9% reduction on the result for June 2021. The performance for ED admitted patients for July 2021 was 39%, which is 6% lower than the result for June 2021.
- ED occupancy was over 90% in the week ending 1 Aug 100% of the time.
- Hospital occupancy was over 90% in the week ending 1 Aug 95% of the time. Bed occupancy continues to be one of the most significant contributing factor to SSiED compliance. The occupancy percentage utilisation for June was 94% (optimum occupancy of 95%).
- During the month of July 2021 there were nil presentations where the patient(s) was suspected of having COVID-19.

Performance	MAY	JUN	JUL
2018-19	83%	76%	78%
2019-20	83%	75%	73%
2020-21	67%	64%	56%

Breaches	MAY	JUN	JUL
2018-19	886	1,188	1,149
2019-20	680	1,259	1,358
2020-21	1,673	1,782	2,221

ED Volumes	MAY	JUN	JUL
2018-19	5,204	5,031	5,285
2019-20	4,005	4,952	5,024
2020-21	5,074	4,982	5,034

What is driving performance?

- Our performance being less than target continues to be due to the increase of elective and acute surgical work. A significant increase in the acuity of acutely admitted patients have contributed to very high hospital occupancy and subsequent access block. We also have in place ongoing processes related to COVID-19 screening and precautions.
- We continue to operate parallel processes in our inpatient wards to manage COVID case definition vs. non-COVID patients. The requirement to enhance these processes were a major factor in worsening access blocks during the Wellington Alert level 2 lockdown in late June. Our acute flow programme of work continues as mentioned in the previous report. Unfortunately, these processes have reached breaking point and do not result in any further improvement for patient waiting times and patient flow from ED.

Management Comment

- CCDHB continues to face a significant capacity issue as demonstrated by the consistently high occupancy rate and the bed blockage experienced across hospital flow as a consequence. The average general adult bed deficit is 37 at Wellington Regional Hospital in 2020/21.
- The very small footprint of the Emergency Department cannot tolerate any delays in moving patients from ED to the wards and this, combined with the high hospital occupancy and long waiting list for rest homes placement contributes significantly to the very unsafe level of overcrowding in the ED.
- A range of strategies underway to manage acute demand in both community and hospital settings, including Winter Planning to fund inpatient capacity with the provision of additional beds and physical spaces, and fund improved patient flow; and community Investments to deliver more care closer to home.
- Other work streams continue to be progressed but are unlikely to have any noticeable effect on patient flow unless the capacity issue is addressed. Complexity of cases on the ward is yet another factor to be considered.

Planned Care – Inpatient Surgical Discharges/Minor Procedures

What is this measure?

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

Why is this important?

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

How are we performing?

- Total planned care results for the first month of this financial year, July month end report us unfavourable 28 to our planned target of 949.
- Our in-house elective surgical PUC results were 11 adverse to the planned 561 and outsourcing adverse 35 to the planned 157. Elective non-surgical PUC was 3 ahead of the planned 14 and our arranged group 13 adverse to the planned 128.
- Minor procedures are 111 ahead of the planned 390 for the month of July.

What is driving performance?

- High volumes of cancellations due to acute demand is the main reason we did not meet our planned care targets, coupled with scheduling around planned industrial action and inability to outsource the planned volumes, however the procurement processes to outsource has progressed and we expect our volume to increase once new contracts are in place.

Management Comment

- Our focus remains on scheduling our longest-waiting patients in all specialities, and ensuring our theatre sessions are fully utilised. We are back to full capacity at Kenepuru and resourcing OT 13 in Wellington will provide additional operating time.
- SMOs continue to be involved with planning surgery based on those with greatest clinical urgency and long waiting times.

MRI and CT Waiting Times

What is this measure?

- A percentage measure that shows the proportion of CT or MRI outpatient referrals that are scanned within of a 42-day time period. The 'clock' begins from the date Radiology receives the referral for imaging.

Why is this important?

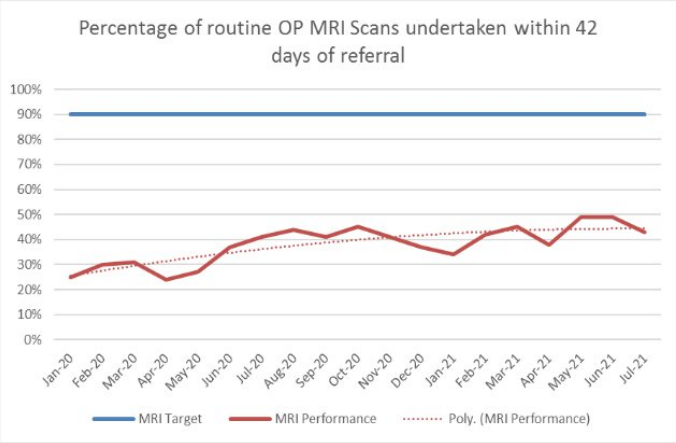
- Delayed diagnosis can lead to poorer health outcomes as a patient's condition may deteriorate while waiting. The period of 6 weeks (i.e. 42 days) is generally accepted as the reasonable clinical timeframe to receive imaging results for non-acute outpatient referrals.

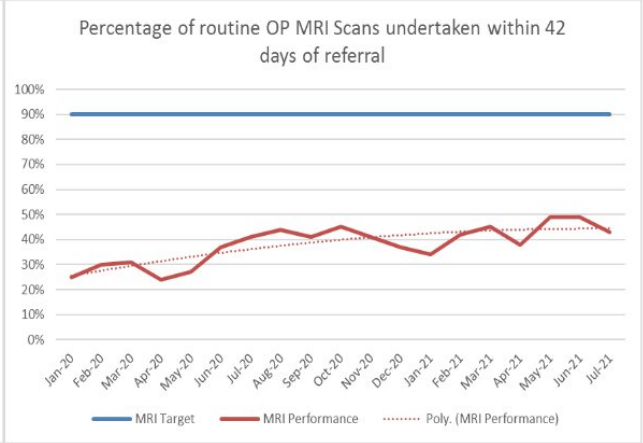
How are we performing?

- Waiting times for CT and MRI remain high as a result of historical insufficient capacity to meet demand. Subsequently, the percentage measure is low and has been for a long time but are slowly trending up, though flattening out in late 2020/early 2021 mainly due to high demand for both services.

What is driving Performance?

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





Management Comment

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

- The Radiology service has received over 12 resignations from within the technical team (MIT – Medical Imaging Technologist) workforce since Easter 2021. This is over 20% of MIT workforce and creates a significant gap in capacity. For CT scanning this has resulted in an approximately 17% reduction in outpatient (OP) booking slots as shifts are unable to be filled.

- Recruitment for the vacant positions continues but due to the specialised nature of the MIT workforce and lack of a timely overseas recruitment process, we are unlikely to see any significant reduction in the MIT vacancy within the department. We do not anticipate a recovery of internal OP capacity until 2022 following the yearly intake of NZ-trained MITs who will graduate in December 2021.

- Unfortunately, we expect waiting times to increase over the next 6 – 8 months. Outsourcing continues at the maximum capacity across service providers available within the region.

Coronary

Coronary Angiography Waiting Times

What is this measure?

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

Why is this important?

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

How are we performing?

- The proportion of patients waiting less than 90 days for angiography is 97.2% this month.

What is driving performance?

- Target has been met this month. Administration/booking have been focusing on ensuring timeframes are met, and interventional session cover has improved

Management Comment

- With the partial return of two interventionists from parental leave session cover is better.

Acute Coronary Syndrome

Key clinical quality improvement indicators

What is this measure?

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

Why is this important?

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

- **How are we performing?**

  <u>Door to cath. <= 3 days June results (Target is ≥70%):</u>

National Performance	75.3% (488/648)
Central Region	82.6% (142/172)
CCDHB	87.1% (27/31)
Hawkes Bay	55.6% (15/27)
Hutt Valley	91.3% (21/23)
Mid Central	80.0% (24/30)

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

What is driving performance?

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

Management Comment

- Staffing capacity is improving due to two SMO's returning from parental leave in June. The underlying issue remains access to beds. This has resulted in less flexibility and impacts on the service's ability to transfer regional patients in a timely manner when busy. This has been particularly problematic with the onset of winter pressures. Additional overnight beds are being used in the transit lounge which will mitigate some of this issue, allowing better patient flow.

Faster Cancer Treatment

What is this measure?

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

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

Why is this important?

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

How are we performing?

- CCDHB is non-compliant with the 62 day target for July at 75% which equates to the aim of 90% of patients receiving their first cancer treatment within 62 days of being referred with a high suspicion of cancer.
- CCDHB is compliant with the 31 day indicator for July at 95% vs the aim of 82% of patients commencing treatment within 31 days from decision to treat.

What is driving performance?

- Of the five patients who breached the 62 day target three experienced delay to surgery, one experienced delays in diagnostic phase, one experienced a delay in accessing a FSA appointment. The breaches occurred in the gynaecological, breast and skin tumour streams. No Māori were covered by the 62 day target and the one Pacifica patient included did not breach (100%). Note acute presentations are excluded from the 62 day target.
- Nine of ten breaches in the 31 day indicator was due to capacity reasons – access to surgery for breast (6), skin (2 at HVDHB) and gynaecological (1) and clinical for urological (1).
- 31 day compliance was 80% for Māori (4/5pts), 100% Pacifica (3/3pts) and 80% for other ethnicities.

Management Comment

- Acute demand and staffing vacancies is having a negative effect upon access to FSA, diagnostic services (imaging & pathology) and surgical services. This was exacerbated in some services due to school holidays in July.
- Overall less patients commenced treatment in July resulting in a few breaches having a significant negative effect on compliance percentage.
- Pleasing to see that the extent of breaches (i.e. average delay) was significantly reduced.
- Work underway includes:
  - Working with gynaecology service to improve compliance -establishment of a bleeding clinic being scoped.
  - Diagnosis via ED presentation pathway improvement project.
  - SMO Forum presentation 16 August.
- The largely manual process for prospectively tracking patients can make it difficult to intervene in a timely manner to enable outsourcing within FCT timeframes.

Figure Eight: FCT 62 day target

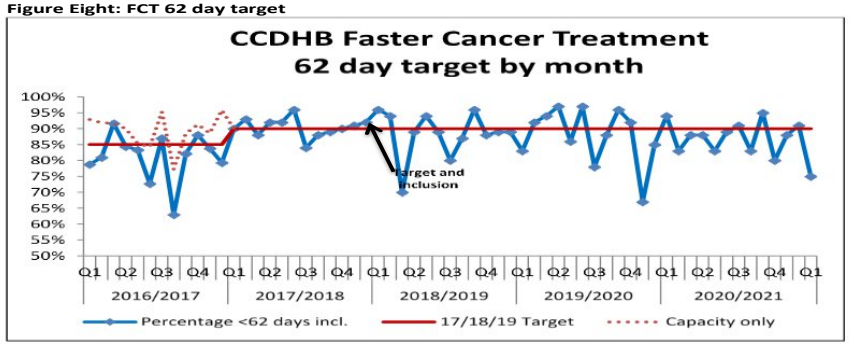
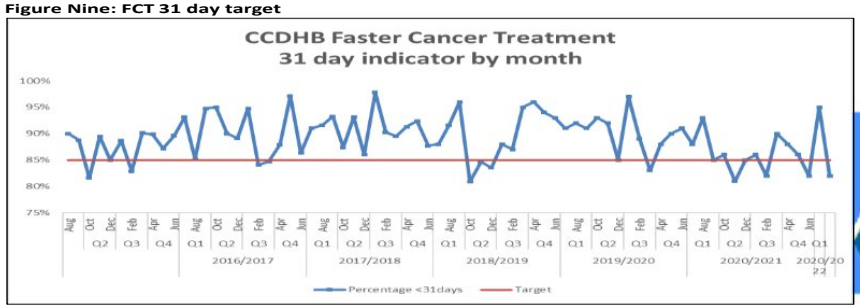


Figure Nine: FCT 31 day target



Colonoscopy

What is this measure?

Diagnostic colonoscopy

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

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

Surveillance colonoscopy

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

Why is this important?

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

How are we performing?

CCDHB achieved the Ministry of Health target for urgent colonoscopies with a performance of 90.9% (target 90%). This was an improvement from the 83.3% achieved in June. For diagnostic waits, we achieved 56.8% (target 70%) in July, which was a small improvement in performance.

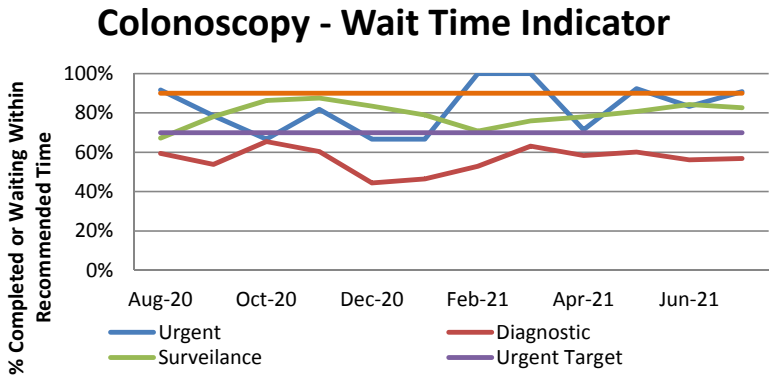
We exceeded the Ministry of Health target for surveillance achieving 82.6 (target 70%). This is a slight reduction from the June return of 84.3%.

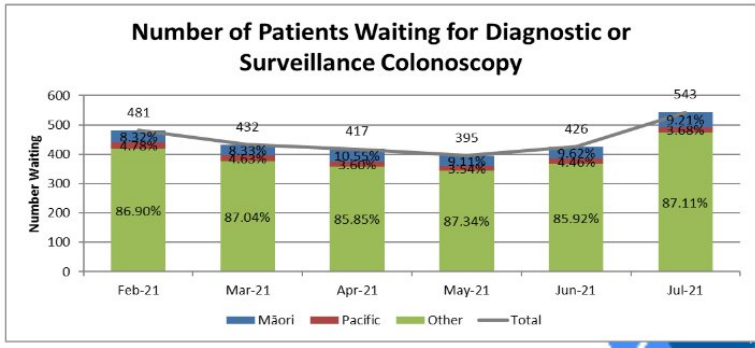
What is driving performance?

As flagged in the May and June reports, we have experienced a high level of RN resignations which has resulted in fewer lists being available. The July performance is slightly better than anticipated, partly as a result of the ability to outsource some cases to the private sector.

Management Comment

Recruitment and training of new staff is ongoing but it will take a number of months before we are back to normal staffing levels. A number of cases have been outsourced and this will continue across August.





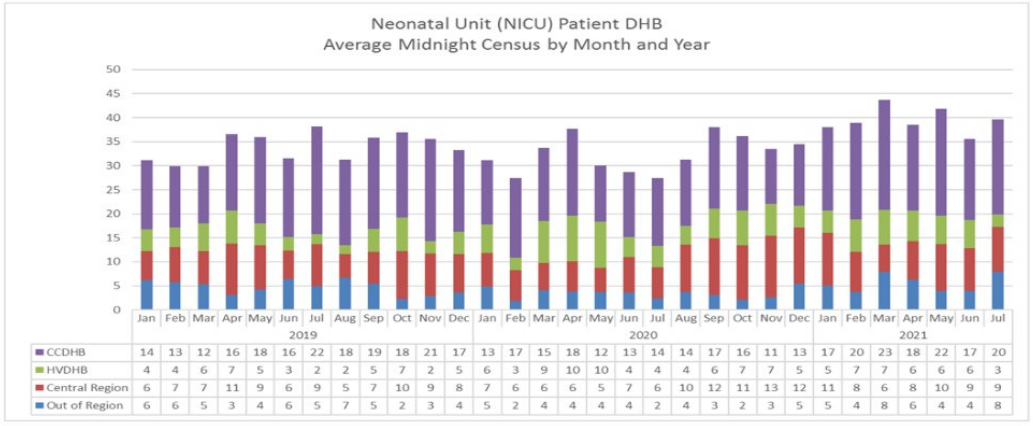
Maternity and Neonatal Intensive Care services

What is the issue?

- CCDHB's NICU has had a sustained high occupancy over the last 3 years and has consistently been above 100% occupancy for the last 12 months (graph below).
- NICU occupancy needs to be at 80-85% to safely manage the required work
- Nationally NICU's are chronically under.

Management Comment

- The NICU has had a sustained high occupancy over the last 3 years and has consistently been above 100% occupancy for the last 12 months (graph below). This is reflected nationally
- Last year CCDM supported an increase of 27FTEs of nursing to support the physical and emotional wellbeing of infants and families - this has been recruited too. This is a very positive response with the current NZ wide nursing shortage.
- The retrieval service is functioning well
- We are working with the region to reduce out of region admissions and are supporting the development of new models of care across the region in particular the need or devilment of transitional care arrangements as mothers and babies move accorss the spectrum of acute neonatal intensive care to discharge

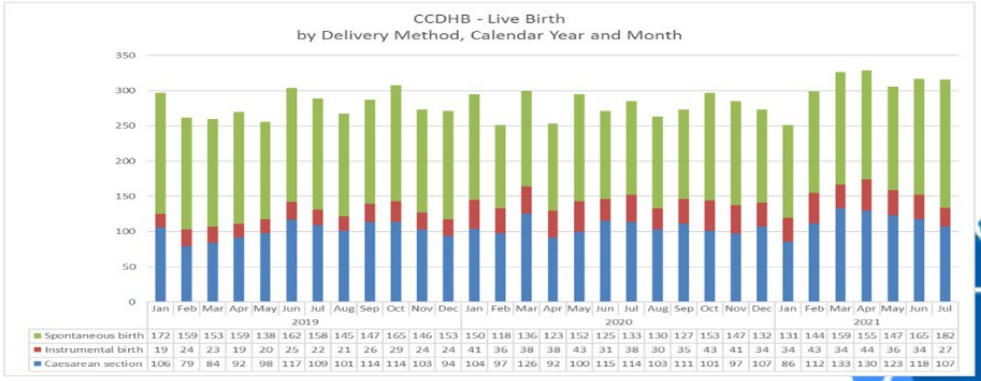


What is the issue?

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

WHS Management Comment

- The service continues to see high volumes of women birthing each month (over 300 births every month since Feb 2021). This results in over occupancy and bed blocking – this along with a high vacancy rate is putting pressure on the service.
- The service has introduced a registered nursing workforce into KMU to support the transfer of women to Kenepuru. This workforce is mostly recruited to. Work needs to be done on the communication to women about expectations of where they may receive their post-natal stay.
- The MoH funded clinical coach roles (1.5 FTE) are being advertised – closing date is 21 August. The service is working with HVDHB and a recruitment agency to support the appointment of overseas and local midwives.



Section 3

Financial Performance and Sustainability

Executive Summary Financial Performance and Position

- The DHB has an annual budgeted surplus of $1m, resulting from the recognition of $60m donation of the new Children's Hospital expected in March 22. The underlying deficit is ($59m) including Holidays Act Provision.
- The responsible deficit YTD was $400k favourable against budget.
- As an extraordinary item COVID-19 is not included within the budget, which the ministry has advised is regarded as outside the DHBs performance assessment:
  - ($441k); COVID-19 additional costs yet to be funded
- The DHB's cash is under pressure for 2021/22 due partly due to MOH guidance on cash funding provided for COVID-19 costs. This was mitigated at year end by significant delays to our capex spend (offset by non cash depreciation). The DHB by the start of July Bank Balance was in overdraft ($28.9m) with $13.4m in special fund balances.
- COVID-19 from the first outbreak continues to incur some additional costs and also disruption to normal BAU for some components of the hospital operation and management. We have put in place tracking and monitoring systems to enable all the costs to be captured and reported to the Ministry, the key items of which are shown on the next slide, this is in addition to the unfunded ($4m) from the prior financial year in which cash has not yet been provided.

COVID-19 Revenue and costs & Holidays Act

Full Last Year			Capital & Coast DHB Operating Results - $000s	Part Year to Date			Total Provision/Expense	
COVID-19 change from Trend - Provider	COVID-19 change from Trend - Funder	Holidays Act [2003]	YTD July 2021	COVID-19 change from Trend - Provider	COVID-19 change from Trend - Funder	Holidays Act [2003]	COVID-19	Holidays Act [2003]
	(31,026)		Devolved MoH Revenue		(4,270)		(35,296)	0
			Non-Devolved MoH Revenue				0	0
693			Other Revenue	0			693	0
			IDF Inflow				0	0
		(44)	Inter DHB Provider Revenue			(75)	0	(119)
693	**(31,026)**	**(44)**	**Total Revenue**	**0**	**(4,270)**	**(75)**	**(34,603)**	**(119)**
			Personnel					
(6,336)		(2,376)	Medical	(10)		(204)	(6,346)	(26,718)
(4,360)		(3,894)	Nursing	(300)		(335)	(4,660)	(43,796)
		(648)	Allied Health	(32)		(56)	(32)	(7,290)
		(174)	Support	(3)		(15)	(3)	(1,956)
		(741)	Management & Administration	(182)		(69)	(182)	(8,278)
(10,696)	**0**	**(7,833)**	**Total Employee Cost**	**(527)**	**0**	**(680)**	**(11,223)**	**(88,038)**
			Outsourced Personnel					
(88)		(16)	Medical	(25)			(113)	(16)
			Nursing				0	0
			Allied Health				0	0
			Support				0	0
			Management & Administration				0	0
(88)	**0**	**(16)**	**Total Outsourced Personnel Cost**	**(25)**	**0**	**0**	**(113)**	**(16)**
(5,088)			Treatment related costs - Clinical Supp	(86)			(5,174)	0
(564)			Treatment related costs - Outsourced	0			(564)	0
(2,028)		(856)	Non Treatment Related Costs	(175)		(28)	(2,203)	(884)
			IDF Outflow				0	0
	(15,828)		Other External Provider Costs (SIP)		(3,899)		(19,727)	0
			Interest Depreciation & Capital Charge				0	0
(7,680)	**(15,828)**	**(856)**	**Total Other Expenditure**	**(261)**	**(3,899)**	**(28)**	**(27,668)**	**(884)**
(18,464)	**(15,828)**	**(8,705)**	**Total Expenditure**	**(812)**	**(3,899)**	**(708)**	**(39,004)**	**(88,938)**
19,157	**(15,198)**	**8,661**	**Net result**	**812**	**(372)**	**632**	**4,400**	**88,819**

- The year to date financial position includes $4.7m additional costs in relation to COVID-19.
- Revenue of $4.3m has been received to fund additional costs for community providers however this has not been sufficient for these costs. The net cost for the month was $0.4m.
- COVID-19 costs are spread across personnel, clinical supplies, outsourced treatment and infrastructure and non-clinical costs.
- Additional personnel costs of $680k have been accrued YTD for the Holidays Act provision.

CCDHB Operating Position – July 2021

Month - July 2021									Capital & Coast DHB Operating Results - $000s	Year to Date									
			Variance		Adjustments			Variance					Variance		Adjustments			Variance
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	COVID-19 change from Trend	Holidays Act [2003]	Actuals exc COVID/HA	Actuals exc COVID vs Budget	YTD July 2021	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	COVID-19 change from Trend	Holidays Act [2003]	Actuals exc COVID-19 / HA	Actuals exc COVID vs Budget
86,071	81,468	77,720	4,603	8,351	4,270		81,801	333	Devolved MoH Revenue	86,071	81,468	77,720	4,603	8,351	4,270		81,801	333
4,890	4,620	3,834	270	1,056			4,890	270	Non-Devolved MoH Revenue	4,890	4,620	3,834	270	1,056			4,890	270
3,002	2,956	3,694	46	(692)	0		3,002	46	Other Revenue	3,002	2,956	3,694	46	(692)	0		3,002	46
25,981	26,024	21,770	(43)	4,211			25,981	(43)	IDF Inflow	25,981	26,024	21,770	(43)	4,211			25,981	(43)
1,549	1,467	812	82	737		75	1,549	82	Inter DHB Provider Revenue	1,549	1,467	812	82	737		75	1,549	82
121,494	**116,536**	**107,829**	**4,958**	**13,664**	**4,270**	**75**	**117,223**	**688**	**Total Revenue**	**121,494**	**116,536**	**107,829**	**4,958**	**13,664**	**4,270**	**75**	**117,223**	**688**
									Personnel									
16,551	16,738	15,239	187	(1,312)	10	204	16,337	402	Medical	16,551	16,738	15,239	187	(1,312)	10	204	16,337	402
22,548	21,590	19,916	(958)	(2,632)	300	335	21,913	(323)	Nursing	22,548	21,590	19,916	(958)	(2,632)	300	335	21,913	(323)
6,793	7,186	5,750	392	(1,043)	32	56	6,705	480	Allied Health	6,793	7,186	5,750	392	(1,043)	32	56	6,705	480
1,003	987	892	(16)	(111)	3	15	985	2	Support	1,003	987	892	(16)	(111)	3	15	985	2
7,697	7,555	6,429	(142)	(1,268)	182	69	7,446	109	Management & Administration	7,697	7,555	6,429	(142)	(1,268)	182	69	7,446	109
54,593	**54,056**	**48,226**	**(536)**	**(6,366)**	**527**	**680**	**53,386**	**670**	**Total Employee Cost**	**54,593**	**54,056**	**48,226**	**(536)**	**(6,366)**	**527**	**680**	**53,386**	**670**
									Outsourced Personnel									
710	530	504	(180)	(206)	25	0	685	(155)	Medical	710	530	504	(180)	(206)	25	0	685	(155)
11	101	60	90	48			11	90	Nursing	11	101	60	90	48			11	90
196	143	134	(53)	(62)			196	(53)	Allied Health	196	143	134	(53)	(62)			196	(53)
5	22	45	17	40			5	17	Support	5	22	45	17	40			5	17
240	234	386	(6)	146			240	(6)	Management & Administration	240	234	386	(6)	146			240	(6)
1,162	**1,029**	**1,128**	**(133)**	**(34)**	**25**	**0**	**1,137**	**(108)**	**Total Outsourced Personnel Cost**	**1,162**	**1,029**	**1,128**	**(133)**	**(34)**	**25**	**0**	**1,137**	**(108)**
11,521	11,793	11,134	273	(387)	86		11,435	359	Treatment related costs - Clinical Supp	11,521	11,793	11,134	273	(387)	86		11,435	359
2,573	2,630	1,868	57	(705)	0		2,573	57	Treatment related costs - Outsourced	2,573	2,630	1,868	57	(705)	0		2,573	57
8,262	7,690	6,287	(572)	(1,975)	175	28	8,059	(369)	Non Treatment Related Costs	8,262	7,690	6,287	(572)	(1,975)	175	28	8,059	(369)
9,227	9,192	9,059	(35)	(167)			9,227	(35)	IDF Outflow	9,227	9,192	9,059	(35)	(167)			9,227	(35)
32,191	28,305	26,755	(3,886)	(5,435)	3,899		28,292	13	Other External Provider Costs (SIP)	32,191	28,305	26,755	(3,886)	(5,435)	3,899		28,292	13
4,585	4,423	5,161	(162)	575			4,585	(162)	Interest Depreciation & Capital Charge	4,585	4,423	5,161	(162)	575			4,585	(162)
68,359	**64,033**	**60,264**	**(4,326)**	**(8,095)**	**4,160**	**28**	**64,171**	**(138)**	**Total Other Expenditure**	**68,359**	**64,033**	**60,264**	**(4,326)**	**(8,095)**	**4,160**	**28**	**64,171**	**(138)**
124,113	**119,118**	**109,618**	**(4,995)**	**(14,495)**	**4,711**	**708**	**118,694**	**424**	**Total Expenditure**	**124,113**	**119,118**	**109,618**	**(4,995)**	**(14,495)**	**4,711**	**708**	**118,694**	**424**
(2,619)	**(2,583)**	**(1,789)**	**(37)**	**(831)**	**(441)**	**(632)**	**(1,471)**	**1,112**	**Net result**	**(2,619)**	**(2,583)**	**(1,789)**	**(37)**	**(831)**	**(441)**	**(632)**	**(1,471)**	**1,112**
(4,993)	(5,186)	(3,020)	193	(1,973)					Funder	(4,993)	(5,186)	(3,020)	193	(1,973)				
27	(0)	62	27	(35)					Governance	27	(0)	62	27	(35)				
2,346	2,604	1,169	(257)	1,177					Provider	2,346	2,604	1,169	(257)	1,177				
(2,619)	**(2,583)**	**(1,789)**	**(37)**	**(831)**					**Net result**	**(2,619)**	**(2,583)**	**(1,789)**	**(37)**	**(831)**				

Note one adjustments are made for

1. COVID-19

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

Executive Summary – Financial Variances

- The DHB deficit year to date is ($2.6m).
- Included within this result is recognition of the adjustment to the holiday Act provision ($632k) and an estimated impact of COVID-19 of ($400k).
- Excluding the COVID-19 net costs this brings the deficit for the month to ($2.2m) being $400k favourable to budget.
- Revenue is favourable by $5m YTD, after excluding COVID-19, this is on budget.
- Personnel costs including outsourced is ($672k) YTD, excluding COVID-19 related costs of ($590k) incurred the net unfavourable variance is ($82k) Currently they DHB has a large number of vacancies which has been offset by ($1.9m) of vacancy savings targets for July.
- Treatment related clinical supplies are $273k favourable with increased costs associated with drugs & catheters offset by a favourable movement in prostheses and grafts, bloods and outreach clinics.
- Outsourced clinical services is favourable YTD by $57k; favourable movement due to outsourced surgical service delayed compared to budget.
- Non treatment related costs ($734k) YTD unfavourable, after excluding COVID-19 ($440k) unfavourable, the variance was due to an Increase in Patient meal costs and increase in deferred maintenance costs.

Analysis of the Operating Position – Revenue and Personnel

Revenue

- Revenue is $5m favourable YTD.
- The variance is due to revenue for special MHAIDS additional funding $285k, The funder arm is also favourable by $4.2m revenue however with offsetting community cost and COVID-19 related costs in the Provider.

Personnel (including outsourced)

- Medical Personnel is $7K favourable for the month, the favourable position for the month is driven by vacancies across other services, most notably MHAIDS & Hospital Flow offset by centrally held vacancy savings targets.
- Nursing Personnel is ($868k) unfavourable to budget for the month. Operationally nursing across the hospital is on budget, however the variance is a result of front loading of vacancy savings as recruitment of additional roles is expected in the second half of the year.
- Allied Personnel labour is $339k favourable to budget for the month, as a result of vacancies.
- Support Personnel labour for the month is on budget.
- Management/Admin Personnel is unfavourable in the month by ($148k). Operationally across the hospital Management/Admin is favourable to budget, however the variance is a result of front loading of vacancy savings as roles are expected to be recruited in the second half of the year.

Section 4

Financial Position

Cash Management – July 2021

Month : Jul 2021					Capital & Coast DHB Statement of Cashflows	Year to Date				
			Variance						Variance	
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	YTD Jul 2021	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year
					Operating Activities					
121,896	116,074	110,833	5,822	11,064	Receipts	121,896	116,074	110,833	5,822	11,064
					Payments					
54,134	54,654	62,364	520	8,230	Payments to employees	54,134	54,654	62,364	520	8,230
72,060	61,939	58,571	(10,122)	(13,490)	Payments to suppliers	72,060	61,939	61,464	(10,122)	(10,597)
0	11,102	12,110	11,102	12,110	Capital Charge paid	0	11,102	12,110	11,102	12,110
258	0	1,446	(258)	1,188	GST (net)	258	0	(1,446)	(258)	(1,705)
126,452	127,695	134,492	1,243	8,039	Payments - total	126,452	127,695	134,492	1,243	8,039
(4,556)	(11,621)	(23,659)	7,065	19,103	Net cash flow from operating Activities	(4,556)	(11,621)	(23,659)	7,065	19,103
					Investing Activities					
37	16	96	(22)	59	Receipts	37	16	96	(22)	59
					Payments					
7,720	11,255	4,610	3,534	(3,111)	Purchase of fixed assets	7,720	11,255	4,610	3,534	(3,111)
7,720	11,255	4,610	3,534	(3,111)	Payments - total	7,720	11,255	4,610	3,534	(3,111)
(7,683)	(11,239)	(4,513)	3,512	(3,052)	Net cash flow from investing Activities	(7,683)	(11,239)	(4,513)	3,512	(3,052)
					Financing Activities					
0	39,815	0	(39,815)	0	Equity - Capital	0	39,815	0	(39,815)	0
11,597	7,730	0	3,867	11,597	Other Equity Movement	11,597	7,730	0	3,867	11,597
0	0	0	0	0	Other	0	0	0	0	0
11,597	47,545	0	(35,947)	11,597	Receipts	11,597	47,545	0	(35,947)	11,597
					Payments					
0	0	0	0	0	Interest payments	0	0	0	0	0
0	0	0	0	0	Payments - total	0	0	0	0	0
11,597	47,545	0	(35,947)	11,597	Net cash flow from financing Activities	11,597	47,545	0	(35,947)	11,597
(642)	24,685	(28,172)	(25,370)	27,648	Net inflow/(outflow) of CCDHB funds	(642)	24,685	(28,172)	(25,370)	27,648
(15,452)	(24,134)	18,236	(8,682)	33,688	Opening cash	(15,452)	(24,134)	18,236	(8,682)	33,688
133,531	163,634	110,929	(30,147)	22,720	Net inflow funds	133,531	163,634	110,929	(30,147)	22,720
134,173	138,950	139,101	4,777	4,928	Net (outflow) funds	134,173	138,950	139,101	4,777	4,928
(642)	24,685	(28,172)	(25,370)	27,648	Net inflow/(outflow) of CCDHB funds	(642)	24,685	(28,172)	(25,370)	27,648
(16,094)	550	(9,936)	(16,644)	(6,158)	Closing cash	(16,094)	550	(9,936)	(16,644)	(6,158)

RECONCILIATION OF CASH FLOW TO OPERATING BALANCE

	YTD Jul 2021		
	Actual $000	Budget $000	Variance $000
Net Cashflow from Operating	(9,177)	(11,621)	2,444
Non operating financial asset items	8	-	8
Non operating non financial asset items	(284)	-	(284)
Non cash PPE movements	(3,077)	(3,558)	481
Working Capital Movement			
Inventory	(133)	-	(133)
Receipts and Prepayments	17,724	-	17,724
Payables and Accruals	(7,679)	10,265	(17,944)
Total Working Capital movement	**9,912**	**10,265**	**(353)**
Operating balance	**(2,619)**	**(4,914)**	2,295

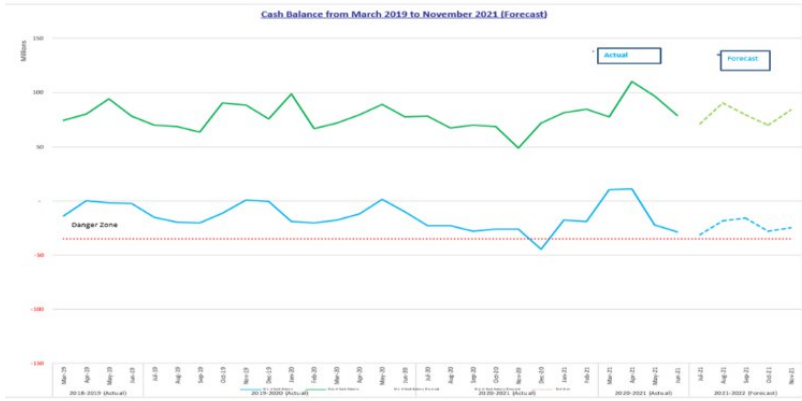
Net inflow cash: Jun $25.4m (Unfavourable)

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

Debt Management / Cash Forecast – Jul 2021

Accounts Receivable
31-Jul-21

Aged Debtors report ($'000)	Total	Current	1-30	31 - 60	61 - 90	91+	Previous Period
Ministry of Health	22,430	20,041	129	290	253	1,717	8,000
Other DHB's	5,058	1,476	936	399	242	2,005	8,793
Kenepuru A&M	217	19	31	14	153		219
ACC	196	402	- 356	- 15	45	120	215
Misc Other	4,612	2,546	311	31	26	1,698	3,347
Total Debtors	32,513	24,484	1,051	719	719	5,540	20,574
less : Provision for Doubtful Debts	(4,093)						(4,075)
Net Debtors	28,420						16,499



Debt Management

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

2. The single largest debtor in 'Other DHB's' outstanding is HVDHB with $1.0m.

3. Kenepuru A&M includes significant number of low value patient transactions. Provision for the overdue debts is $134k

4. 'Misc Other' debtors includes non resident debt of approx. $1.92m. About 86% of the non resident debt have payment arrangements in place. The balance will be referred to collection agencies if unpaid.

Cash Management

We have projected our cash position based on the proposed capital budget and a forecast deficit of $59m for 2021/22. However any deterioration in these forecasts may put the facility limit at risk and we continue to monitor this closely.

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

Balance Sheet / Cashflow – as at 31 July 2021

Jun-21	Month : Jul 2021			Variance		Capital & Coast DHB Balance Sheet
Actual	Actual	Budget	At Jul 2020	Actual vs Budget	Actual vs Jul 2020	YTD Jul 2021
31	31	31	31	0	0	Bank
3	50	824	(5)	(774)	55	Bank NZHP
13,391	13,177	13,561	12,369	(384)	808	Trust funds
60,022	77,167	63,930	53,018	13,237	24,149	Accounts receivable
9,393	9,261	9,466	9,434	(205)	(173)	Inventory/Stock
7,141	7,745	7,902	6,369	(158)	1,375	Prepayments
89,982	**107,430**	**95,714**	**81,216**	**11,716**	**26,214**	**Total current assets**
505,931	504,875	516,712	522,017	(11,837)	(17,143)	Fixed assets
16,058	5,875	5,875	14,796	0	(8,920)	Work in Progress - CRISP
95,166	106,062	103,005	56,797	3,056	49,265	Work in progress
617,155	**616,812**	**625,593**	**593,610**	**(8,781)**	**23,202**	**Total fixed assets**
1,150	1,150	1,150	1,150	0	(0)	Investment in Allied Laundry
1,150	**1,150**	**1,150**	**1,150**	**0**	**(0)**	**Total investments**
708,287	**725,392**	**722,457**	**675,977**	**2,935**	**49,416**	**Total Assets**
28,877	29,352	13,865	22,331	(15,486)	(7,021)	Bank overdraft HBL
91,559	80,462	72,575	66,411	(7,887)	(14,051)	Accounts payable, Accruals and provisions
0	1,508	1,850	1,641	342	133	Capital Charge payable
593	593	593	593	0	0	Insurance liability
16,759	9,895	123,911	100,827	114,016	90,932	Current Employee Provisions
179,786	178,617	67,997	61,401	(110,619)	(117,216)	Accrued Employee Leave
5,682	14,324	22,515	8,468	8,191	(5,856)	Accrued Employee salary & Wages
323,256	**314,751**	**303,307**	**261,672**	**(11,444)**	**(53,080)**	**Total current liabilities**
90	90	92	100	3	10	Restricted special funds
605	605	605	605	0	0	Insurance liability
6,222	6,222	6,564	6,563	343	342	Long-term employee provisions
6,916	**6,916**	**7,262**	**7,268**	**345**	**352**	**Total non-current liabilities**
330,172	**321,668**	**310,569**	**268,940**	**(11,099)**	**(52,728)**	**Total Liabilities**
378,115	**403,724**	**411,888**	**407,037**	**(8,164)**	**(3,313)**	**Net Assets**
829,962	829,962	829,962	809,740	0	20,222	Crown Equity
0	0	0	0	0	0	Capital repaid
0	28,229	0	0	28,229	28,229	Capital Injection
130,659	130,659	130,659	130,659	0	0	Reserves
(582,507)	(585,126)	(596,279)	(537,797)	11,151	(47,329)	Retained earnings
378,114	**403,724**	**411,888**	**407,036**	**(8,165)**	**(3,312)**	**Total Equity**

Balance Sheet

1. The DHB's cash overdraft balance at the end of July 2021 is unfavourable to budget due to higher payment of suppliers entered in the system at year end;
2. Accounts receivable is high than budget due to timing differences;
3. Accounts payable, accruals and provisions is higher than the budget mainly due to timing differences but a large drop on the end of June figures;
4. Employee liabilities is slightly lower than budget due to Actuarial valuations in the opening balance being lower than budgeted;

Cash flow

1. The net cash flow from operating activities is unfavourable, but better than budget due to increased revenue for the month. This is mainly due to more than expected Crown funding received in December and other timing differences;
2. The net cash flow from investment activities is favourable to budget due to less spend on Capital activity then budgeted;

Financial ratios

1. The net cash flow from operating activities is unfavourable, but better than budget due to increased revenue for the month. This is mainly due to more than expected Crown funding received in December and other timing differences;
2. The net cash flow from investment activities is favourable to budget due to less spend on Capital activity then budgeted;

Note

1. Balance Sheet subject to change due to Revaluation of Land and Buildings currently in progress as at 30 June, which will be reflected through Comprehensive Income

Capital Expenditure Summary on Prior Year Approved July 2021

			Actual spend on live projects				Forecast spend on approved projects						
Asset Category	Approved Capex Budget	PY Spend to 30 June 2021	July actual spend	Actual YTD Spend	Actual LTD Spend	To spend	August forecast spend	September forecast spend	December Quarter forecast	March Quarter forecast	June Quarter forecast	Forecast cash spend to June 22*	Carry forward to FY22-23
Buildings	27,456,044	16,017,443	318,706	318,706	16,336,150	11,119,894	1,104,987	1,603,606	4,986,368	2,004,523	1,024,932	10,724,416	395,478
Clinical Equipment	58,062,831	42,615,125	2,346,010	2,346,010	44,961,135	13,101,696	1,235,909	1,428,914	5,654,748	2,327,005	1,054,568	11,701,145	1,400,551
ICT	11,882,523	9,546,425	556,583	556,583	10,103,007	1,779,516	277,367	275,277	657,344	53,286	-	1,263,275	516,241
Prior Year projects	**97,401,398**	**68,178,993**	**3,221,299**	**3,221,299**	**71,400,292**	**26,001,106**	**2,618,263**	**3,307,797**	**11,298,460**	**4,384,814**	**2,079,500**	**23,688,835**	**2,312,270**

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

- $29.2m in approved but incomplete projects was carried forward from the previous year to FY2020/21
- Total cash spend in July 2021 was $3.2m with a further $23.7m is forecasted to be spent by 30 June 2022, leaving an estimated $2.3m to be carried forward to FY2022/23
- The forecast is based on cash phasing with the December 2021 quarter expected to be high due to the high spending in ICT and Clinical Equipment
- The cash spending forecast will be reviewed monthly and adjusted to reflect changes from both internal and external factors (workforce, logistics, supply chain)

Capital Expenditure Summary 2021/22 July 2021

				Quarterly forecast					
Row Labels	Capital Plan 2021/22	Approved	Actual LTD	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Forecast cash spend to June 22	Carry forward
Clinical Equipment/Non Clinical Equipment	15,280,105	120,346	-	83,318	2,765,987	3,090,111	6,308,215	12,247,631	3,032,474
Facilities or Building	37,378,945	8,736,015	138,742	935,370	2,481,847	3,517,126	11,769,680	18,842,764	18,536,181
ICT	5,199,917	3,100,000	-	876,404	2,038,199	1,487,077	726,237	5,127,917	72,000
Small capex pool	10,796,925	1,291,179	22,006	1,799,488	2,699,231	2,699,231	2,699,231	9,919,187	877,738
Grand Total	68,655,892	13,247,540	160,748	3,694,579	9,985,264	10,793,545	21,503,363	46,137,499	22,518,393

Key highlights to FY2021/22 Capital plan:

- $68.7m was approved by the Board in the FY2021/22 Capital Plan
- The development of business cases from the 2021/22 Capital Plan are at various stages with $13.2m having been approved by July 2021
- Spend to July 2021 $160k and reflects the changes
- Business units have indicated when business cases will be submitted and a high level cash forecast has been projected from this with $46m to be spent by 30 June 2022, and $22.5m carried forward to next financial year
- The cash spending forecast will be reviewed on a monthly basis and adjusted to reflect our capacity to submit business cases for approval, procure and install projects

Board Information – Public

6 October 2021

Health System Committee (HSC) update from Committee meeting dated 29 September 2021

Action Required

The Boards note:

(a) The papers are in the Diligent Board book for the HSC meeting dated 29 September 2021.

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

Item 2.1: Planned Care Performance and Impact of COVID-19 Lockdown in 2021

(a) the increasing service delivery and financial risks within Planned Care services at both Capital & Coast and Hutt Valley DHBs

Item 3.1: Ministry of Health Non-Financial Performance Report – 2020/21 Quarter 4

(a) that this report provides a summary from two key reports:

i. CCDHB and HVDHB's Ministry of Health (MoH) Non-Financial Quarterly Monitoring Report for Q4 2020/21 (April to June 2021).

ii. CCDHB and HVDHB's Q4 2020/21 Health System Plan and Vision for Change dashboard.

(b) that for the 56 indicators rated by MoH this quarter, CCDHB received 1 'Outstanding' rating, 30 'Achieved' ratings, 18 'Partially Achieved' ratings and 7 'Not Achieved' ratings. This is an improvement on CCDHB's Q3 result.

(c) that for the 56 indicators rated by MoH this quarter, HVDHB received 1 'Outstanding' rating, 28 'Achieved' ratings, 19 'Partially Achieved' ratings and 8 'Not Achieved' ratings. This is similar to HVDHB's Q3 result.

(d) that specific action plans are in place to improve performance against the 'Not Achieved' performance measures, including strategies to improve our immunisation and smoking cessation advice results.

(e) that the recommissioning of immunisation services is now being considered, alongside quality improvement initiatives.

(f) overall results for CCDHB and HVDHB demonstrate:

i. performance deterioration in immunisation targets reflecting the impact of a timing change in the age for MMR immunisations and a greater number of declines to vaccination offerings;

ii. a community health system delivering well for the majority of indicators with a persistent pressure points posing challenges; and,

iii. a hospital system working hard under the pressures of increased seasonal acute demand and bed pressures.

(g) that both CCDHB and HVDHB received 'Outstanding' ratings for the 'Engagement and obligations as a Treaty partner' indicator, which is recognition of our efforts in this area.

(h) that both CCDHB and HVDHB improved their performance rating for the 'Shorter Stays in Emergency Departments' indicator, which moved from a 'Not Achieved' rating in Q3 to a 'Partially Achieved' rating in Q4.

(i) that the recent Alert Level 3 and 4 lockdown period is likely to impact performance in the Q1 2021/22 results, as some activities cannot be performed during lockdown and resources have also been temporary diverted into swabbing and vaccination efforts.

Item 4.2: Central Region Eating Disorder Service

(a) the contents of this report

Item 4:3: Homelessness, health and COVID-19

(a) This update on homelessness and how the 2DHBs contribute to addressing this important issue.

(b) Homelessness is part of a wider issue in a housing continuum that faces significant challenges. Working towards a solution requires coordinated cross agency collaboration.

(c) A strategic priority project around emergency housing is a priority this year. Emergency housing is considered a subset of homelessness

Endorsed by	Fionnagh Dougan, Chief Executive Health System Committee
Presented by	Sue Kedgley, Health System Committee
Purpose	Provide the Boards with an update regarding the content of the meeting
Contributors	As noted in the HSC papers
Consultation	As noted in the HSC papers

Executive Summary

The Chair of the Health System Committee will provide an overview of the meeting agenda items and discussion. The papers can be located on the DHB websites or in the HSC Diligent Book for 29 September 2021. The slides for presentations given at the meeting are located in the Resource Centre on Diligent.

Strategic Considerations

As noted in the HSC papers

Engagement/Consultation

As noted in the HSC papers

Identified Risks

As noted in the HSC papers

Attachment/s

n/a

Board Information – Public

4 August 2021

Disability Support Advisory Committee (DSAC) Items for Board Approval and Noting from Committee meeting dated 29 September 2021

Action Required

The Boards note:

(a) The papers are in the Diligent Board book for the HSC meeting dated 29 September 2021.

(b) DSAC received reports and noting recommendations on the following:

Item 2.1 Locality Community Mental Health Development (Strategic Priority: Community Mental Health Networks)

(a) the purpose of the Community Mental Health and Addiction (MHA) Change Programme (the Programme) is to design, and implement integrated, place-based, MHA services for the Hutt Valley, Wellington, Kāpiti and Porirua that are operational by 30 June 2022.

(b) the Programme is part-funded by Ministry of Health investment and is one of three MHA strategic priorities for delivery in the 2021/2022 financial year, as our DHBs transition to a new health and disability system.

(c) the first stage of the Programme is the MHAIDs-led 3-month Te Haika/Crisis Response project to address immediate pressures in our 24 hour call centre and intake/triage services and will consider our community mental health teams' structure.

(d) Te Rangapū Ahikaaroa, our memorandum of understanding with Ngāti Toa Rangatira and Te Āti Awa ki te Upoko o te Ika a Māui, is our platform for partnering to design and develop community MHA services for Māori.

(e) the Mental Health and Addiction Commissioning Forum will provide Programme governance and the design process will implement the Pro-Equity, People-based Commissioning Policy to understand and address inequities for our priority populations.

the enablers for the Programme design and implementation – our evolving partner, provider and stakeholder MHA networks, including the Lived Experience Advisory Group.

Item 3.1 - MHAIDS Service Performance Update

(a) the attached report from MHAIDS.

Item 3.2 – 3DHB Sub Regional Disability Strategy 2017 – 2022 Update

(a) This report provides DSAC with an update on the implementation of the Sub Regional Disability Strategy 2017 – 2022.

Strategic Alignment	Annual Plans, Te Pae Amorangi, Taurite Ora and Sub Regional Disability Strategy 2017-2022, Pacific Health and Wellbeing Strategy for the Greater Wellington Region. Suicide Prevention Postvention Annual Action Plan 2021/2022.
Endorsed by	Fionnagh Dougan, Chief Executive Disability Support Advisory Committee
Presented by	'Ana Coffey, Chair Disability Support Advisory Committee
Purpose	Gain Board approval for decisions endorsed by DSAC, noting any discussions or areas of concern, and provide an update on the meeting of the Committee.
Contributors	As noted in the DSAC papers
Consultation	As noted in the DSAC papers

Executive Summary

The Chair of the DSAC will provide an overview of the meeting agenda items and discussion. The papers can be located on the DHB websites or in the DSAC Diligent Book for 29 September 2021. The slides for the presentations are located in the Resource Centre on Diligent.

The Chair of DSAC will update the Boards on the discussion on recommendation (d) of Item 2.1 and in particular the feedback from the Chair of Te Upoko o Te Ika a Maui Māori Council.

Strategic Considerations

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

Engagement/Consultation

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

Identified Risks

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

Attachment/s

n/a

Capital and Coast DHB and Hutt Valley DHB

CONCURRENT Board Meeting

Meeting to be held on 6 October 2021

Resolution to exclude the Public

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

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

TABLE

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

Service Spotlight – ENT Patient Story Presentation	As above	As above and section 9(2)(a)
Annual Plan 2021/2022	As above	As above
Annual Report 2020/2021	As above	As above
2DHB Strategic Priorities Deliverables and Update	As above	As above
Te Wao Nui Project: Data and Digital Foundations	As above	As above
Te Wao Nui – Playscape	As above	As above
Replacement of Hutt Valley DHB Integrated Pulmonary Function Diagnostic System	As above	As above
People and Culture Report	As above	As above
Chair's Report and Correspondence	As above	As above
Chief Executive's Report and Chief Executive only time	As above	As above
General Business	As above	As above

NOTE

The Act provides that every resolution to exclude the public shall be put at a time when the meeting is open to the public, and the text of that resolution (or copies of it) must:

- be available to any member of the public who is present; and
- form part of the minutes of the board or committee.