PUBLIC

HUTT VALLEY DHB / Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**AGENDA** Held on Wednesday 30 September Level 11 Boardroom, Grace Neill Block, Wellington Regional Hospital Zoom link: **998 0519 8831** Time: 9am
	MEETING

	Item	Action	Presenter	Min	Time	Pg
1	**PROCEDURAL BUSINESS**					
1.1	Karakia		All members	15	9:00am	
1.2	Apologies	**ACCEPT**	Chair			
1.3	Public Participation -	**VERBAL**	Public			
1.4	Continuous Disclosure 1.4.1 Combined Board Interest Register	**ACCEPT**	Chair			
	1.4.2 Combined ELT Interest Register					
1.5	Minutes of Previous Concurrent Meeting	**ACCEPT**	Chair			
1.6	Matters Arising from Previous Concurrent Meetings	**NOTE**	Chair			
1.7	Chair's Report and Correspondence	**NOTE**	Chair			
1.8	Chief Executive's Report	**NOTE**	Chief Executive			
1.9	Board Work Plan	**NOTE**	Chair			
2	**DHB Performance and Accountability**					
2.1	HVDHB July 2020 Financial and Operational Performance Report 2.1.1 Report	**NOTE**	Chief Financial Officer Director Provider Services	10	9.15am	
2.2	CCDHB July 2020 Financial and Operational Performance Report 2.2.1 Report	**NOTE**	Chief Financial Officer Director Provider Services			
3	**Updates**					
3.1	Major Capital Projects Advisory Committee Update	**NOTE**	MCPAC Chair	40	9.25am	
3.2	Health System Committee Update	**NOTE**	HSC Chair			
3.3	Disability Support Advisory Committee Update 3.3.1 Signing the Disability Charter 3.3.2 Accessibility Charter	**APPROVE**	DSAC Chair			
4	**OTHER**					
4.1	General Business	**NOTE**	Chair	5	10.35am	
4.2	Resolution to Exclude the Public	**ACCEPT**	Chair			

DATE OF NEXT FULL BOARD MEETING:
4 November, Zoom: 973 0468 9420, Location: Level 11 Boardroom, Grace Neill Block, Wellington Regional Hospital

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!

May peace be widespread
May the sea be like greenstone
A pathway for us all this day
Let us show respect for each other
For one another
Bind us all together!

CAPITAL & COAST AND HUTT VALLEY DISTRICT HEALTH BOARDS

Interest Register

27 July 2020

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

	• Member of Capital & Coast District Health Board • Member, Harkness Fellowships Trust Board • Member of the Wesley Community Action Board • Independent Consultant • Brother-in-law is a medical doctor (anaesthetist), and niece is a medical doctor, both working in the health sector in Auckland • Son is Deputy Chief Executive (insights and Investment) of Ministry of Social Development, Wellington
Hamiora Bowkett	• Deputy Chief Executive, Te Puni Kōkiri • Former Partner, PricewaterhouseCoopers • Former Social Sector Leadership position, Ernst & Young
Josh Briggs	• Councillor, Hutt City Council • Wife is an employee of Hutt Valley District Health Board / Capital & Coast District Health Board
Keri Brown	• Councillor, Hutt City Council • Council-appointed Representative, Wainuiomata Community Board • Director, Urban Plus Ltd • Member, Arakura School Board of Trustees • Partner is associated with Fulton Hogan John Holland
'Ana Coffey	• Father, Director of Office for Disabilities • Brother, employee at Pathways, NGO Project Lead Greater Wellington Collaborative • Shareholder, Rolleston Land Developments Ltd
Yvette Grace	• General Manager, Rangitāne Tu Mai Rā Treaty Settlement Trust • Member, Hutt Valley District Health Board • Member, Wairarapa District Health Board • Member, Steering group, Wairarapa Economic Development Strategy • Husband is a Family Violence Intervention Coordinator at Wairarapa District Health Board • Sister-in-law is a Nurse at Hutt Hospital • Sister-in-law is a Private Physiotherapist in Upper Hutt
Dr Tristram Ingham	• Board Member, Health Quality and Safety Commission • Director, Foundation for Equity & Research New Zealand • Director, Miramar Enterprises Limited (Property Investment Company) • Member, Independent Monitoring Mechanism to the United Nations on the United Nations Convention on the Rights of Persons with Disabilities • Chair, Te Ao Mārama Māori Disability Advisory Group • Co-Chair, Wellington City Council Accessibility Advisory Group • Chairperson, Executive Committee Central Region MDA • National Executive Chair, National Council of the Muscular Dystrophy Association • Trustee, Neuromuscular Research Foundation Trust

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

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

CAPITAL & COAST AND HUTT VALLEY DISTRICT HEALTH BOARDS

Interest Register

EXECUTIVE LEADERSHIP TEAM

18 SEPTEMBER 2020

Fionnagh Dougan *Chief Executive Officer*	• Board, New Zealand Child & Youth Cancer Network • Trustee, Wellington Hospital Foundation • Adjunct Professor University of Queensland
Nigel Fairley *3DHB General Manager MHAIDS*	• President, Australian and NZ Association of Psychiatry, Psychology and Law • Trustee, Porirua Hospital Museum • Fellow, NZ College of Clinical Psychologists • Director and shareholder, Gerney Limited
Joy Farley *2DHB Director Provider Services*	• None
Debbie Gell *HVDHB General Manager Quality, Service Improvement and Innovation*	• Member of Consumer Council for Healthy Homes Naenae
Arawhetu Gray *CCDHB Director, Māori Health*	• Co-chair, Health Quality Safety Commission – Maternal Morbidity Working Group • Director, Gray Partners • Chair, Tangata Whenua Advisory Group, Te Hiringa Hauora, Health Promotion Agency
Rachel Haggerty *2DHB Director, Strategy Planning & Performance*	• Director, Haggerty & Associates • Chair, National GM Planner & Funder
Emma Hickson *CCDHB Chief Nursing Officer*	• None
Nicola Holden *Director, Chief Executive's Office*	• None
Dr Sisira Jayathissa *HVDHB Chief Medical Officer*	• Member of the Medicine Adverse Reaction Committee Medsafew (MOH) • Member Standing committee on Clinical trials (HRC) • Member Editorial Advisory Board NZ Formulary • Member of Internal Medicine Society of Australia and New Zealand • Australian and New Zealand Society for Geriatric Medicine • Writer NZ Internal Medicine Research Review • Clinical Senior Lecturer and Module convenor Clinical Skills module (Hutt campus), University of Otago • Company Director of Family Company Strik's Nurseries and Garden Shop 100&1 House and Garden Plans

Friday, 25 September 2020

Christine King *2DHB Chief Allied Health Professions Officer*	• Brother works for Medical Assurance Society (MAS) • Sister is a Nurse for Southern Cross
Helen Mexted *2DHB Director, Communications and Engagement*	• Director, Wellington Regional Council Holdings, Greater Wellington Rail • Board member, Walking Access Commission • Partner owns Mexted Motors (supplies/services vehicles for the CCDBH)
Rosalie Percival *2DHB Chief Financial Officer*	• None
Judith Parkinson *HVDHB General Manager, Finance and Corporate Services*	• Director of Allied Laundry
Tofa Suafole-Gush *HVDHB Director, Pacific Peoples* *Acting CCDHB Director, Pacific Peoples*	• Pacific Member, Board of Compass Health • Director, Pacific Peoples, Wairarapa DHB • Husband is an employee of Hutt Valley DHB
John Tait *CCDHB Chief Medical Officer*	• Vice President RANZCOG • Ex-offico member, National Maternity Monitoring Group • Member, ACC taskforce neonatal encephalopathy • Trustee, Wellington Hospitals Foundation • Board member Asia Oceanic Federation of Obstetrician and Gynaecology • Chair, PMMRC
Tracy Voice *3DHB Chief Digital Officer*	• Secretary, New Zealand Lavender Growers Association
Kiri Waldegrave *HVDHB Acting Director of Māori Health*	• TBC
Declan Walsh *2DHB Director People, Culture and Capability*	• None
Sandy Blake *CCDHB Executive Director, Quality Improvement & Patient Safety*	• Advisor to Patient Safety and Reportable Events programme, Health Quality Safety Commission • Adviser to ACC re adverse events • Son is Associate Director of Deloittes
Chris Kerr *Director of Nursing*	• Member and secretary of Nurse Executives New Zealand (NENZ) • Relative is HVDHB Human resources team leader • Relative is a senior registered nurse in SCBU • Relative is HVDHB Bowel Screening Programme Manager • Adjunct Teaching Fellow, School of Nursing, Midwifery and • Health Practice, Victoria University of Wellington • Auditor for Health Care with the DAA Group Ltd

BOARD MEETING **PUBLIC**

HUTT VALLEY DHB / Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**MINUTES** Held on Thursday 3 September, 9am Level 11 Boardroom, Grace Neill Block, Wellington Via Zoom 980 1222 1912
BOARD MEETING	**PUBLIC**

IN ATTENDANCE

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

Hutt Valley and Capital & Coast DHB

Fionnagh Dougan	Chief Executive
Nicola Holden	Director Office of the Chief Executive
Rachel Haggerty	Director Strategy, Planning and Performance
Joy Farley	Director Provider Services
Rosalie Percival	Chief Financial Officer
Amber Igasia	Board Liaison Officer
Nigel Fairley	GM Mental Health, Addictions and Intellectual Disability Services
Declan Walsh	Director People, Culture and Capability
Tracy Voice	Chief Digital Officer
Helen Mexted	Director of Communications

CCDHB

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

HVDHB

Judith Parkinson	General Manager Finance and Corporate Services

APOLOGIES

Keri Brown
Hamiora Bowkett
Roger Blakeley

1 PROCEDURAL BUSINESS

1.1 KARAKIA

Tristram Ingham opened the meeting with a karakia following which the Chair welcomed everyone to the meeting.

1.2 APOLOGIES

As noted above.

1.3 PUBLIC PARTICIPATION

NIL.

1.4 CONTINUOUS DISCLOSURE

1.4.1 COMBINED BOARD INTEREST REGISTER

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

1.4.2 COMBINED EXECUTIVE LEADERSHIP TEAM INTEREST REGISTER

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

1.5 MINUTES OF PREVIOUS CONCURRENT MEETING

The Combined Board **approved** the minutes of the previous Combined Public Board Meeting held on 29 July 2020.

	Moved	**Seconded**
HVDHB	Prue Lamason	Wayne Guppy
CCDHB	Ayesha Verrall	Chris Kalderimis

1.6 MATTERS ARISING FROM PREVIOUS CONCURRENT MEETINGS

20-P0004: Once the final version is complete it will be sent to the Board members and action removed. Action is now complete.

20-P0005: Update will be provided to Health System Committee on 23 September. Action will be removed.

20-P0006: Once the paper is complete it will be sent to the Board members and action removed.

1.7 CHAIR'S REPORT AND CORRESPONDENCE

The Chair thanked the teams across both DHBs for their continued work.

1.8 CHIEF EXECUTIVE'S REPORT

The Chief Executive provided an update on the following:

Distributed Denial of Service (DDOS) attack
Chief Digital Officer outlined the preparation the digital team are undertaking in the context of a possible DDOS attack and ensuring the appropriate mitigations are in place. A Business Continuity Plan (BCP) is in place to mitigate impact on technology.

Staffing
The CE introduced Rosalie Percival, the newly appointed 2DHB Chief Financial Officer and ensured everyone had also been introduced to Helen Mexted, the 2DHB Director of Communications.

Mental Health, Addiction and Intellectual Disability Services Ombudsman Report
The CE recognized the recently released Ombudsman report on an unannounced follow up inspection of Te Whare o Matairangi Mental Health Inpatient Unit, Wellington Hospital, under the Crimes of Torture Act 1989. The report examines the Unit's progress implementing the nine recommendations made in 2017 along with the conditions of treatment of clients detained at the time of the inspection. One of the issues of concern was the use of seclusion rooms being used as bedrooms when the Unit is over occupancy.

The Board noted it is important to acknowledge staff have the right to a safe workplace and identified there is a clear issue of occupancy which is requiring seclusion rooms to be used as bedrooms. A motion was moved as outlined below.
The CCDHB Board moved to:
Note the Ombudsman's report into Te Whare o Matairangi and
Request the Chief Executive to:

(a) Report in 6 months' time on progress in implementing the recommendations of the report, and
(b) Document revised procedures on the use of seclusion rooms and forward them to the Ombudsman for comment.

	Moved	**Seconded**
CCDHB	Ayesha Verrall	Sue Kedgley

The CE welcomed the clear direction from the Board and assured them it is a key area of focus. Agreed it is a disappointment to only have been able to partially implement the recommendations so far. There is significant work occurring across the whole Mental Health system. There is increasing demand but the DHB us working with Non-Government Organisations (NGOs) to develop their services to be able to prevent people coming into the higher need service as well as being discharged sooner. It was requested a further discussion about the report be had by the Board and it will be added to the Disability Support Advisory Committee (DSAC) on 23 September. The Director of Strategy, Planning and Performance provided a high level strategic overview of the future investment in this area noting it will focus on the continuum of care. Concern was raised about why the issues were raised through an OPCAT report and the Board requested a full report on the facilities in our network.
ACTION: Further discussion on the MHAIDS Ombudsman report to be in the DSAC meeting.
ACTION: The Board requested a report back on the other MHAIDS facilities in our network and the report to include a broad outline of the services and the types of accommodation facilities that are provided in each one (including any seclusion rooms).

1.9 BOARD WORK PLAN 2020

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

2 DHB PERFORMANCE AND ACCOUNTABILITY

2.1 CCDHB JUNE 2020 FINANCIAL AND OPERATIONAL PERFORMANCE REPORTS

This report was taken as **READ.**

	Moved	**Seconded**
CCDHB	Sue	Chris

2.2 HVDHB JUNE 2020 FINANCIAL AND OPERATIONAL PERFORMANCE REPORTS

This report was taken as **READ.**

A question was raised about the number of caesareans and there was nothing further to note than was noted to the Hutt Board previously.

	Moved	**Seconded**
HVDHB	Prue	Wayne

3 UPDATES

3.1 NEW CHILDREN'S HOSPITAL UPDATE

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

(a) There have been no reportable incidents since the last update.

(b) McKee Fehl are forecasting Project Handover on 16 July 2021.

(c) The Electrical Services contractor has been appointed and the work is commencing on site during August.

(d) The Link Bridge & Raised Carpark roof Building Consents are still being reviewed by Wellington City Council.

(e) Grace Neill Block – Level 3 office area has been occupied.

	Moved	**Seconded**
CCDHB	Vanessa	Sue

4 OTHER

4.1 GENERAL BUSINESS

4.2 RESOLUTION TO EXCLUDE THE PUBLIC

	Moved	**Seconded**
HVDHB	Chris	Sue
CCDHB	John	Naomi

5 NEXT MEETING

Wednesday, 30 September 2020. Details to be confirmed.

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

DATED this day of 2020

David Smol
BOARD CHAIR

MATTERS ARISING LOG

Action Number	Date of meeting	Due Date	Assigned	Status	Date Completed	Public or PE	Agenda Item #	Agenda Item title	Description of Action to be taken	How Action to be completed
20-P0005	29-Jul-20	4-Nov-20	Directors of Māori Health	Complete		Public	3.2	Health System Committee Update	Add to future reports any actions taken for Māori Health equity in response to COVID-19.	Reports are quarterly, next report will be in Nov HSC.
20-P0006	29-Jul-20	30-Sep-20	Excutive Director and GM Quality, Innovation and Patient Safety	Complete		Public	4.1	Patient Story	A paper to the Boards around how Board members' are provided an oversight of the DHBs measures and monitoring around patients' adverse events. As governance holders.	Paper to be sent to Boards, not required to go to Board meeting
20-P0007	3-Sep-20	23-Sep-20	Board Secretary	Complete		Public	1.8	Chief Executive Report	Further discussion on the MHAIDS to be in DSAC meeting.	Agenda item 23 Sep
20-P0008	3-Sep-20	18-Dec-20	General Manager MHAIDS	In progress		Public	1.8	Chief Executive Report	Report back on the other MHAIDS facilities in our network and include a broader understanding of the service and rooms.	Paper for DSAC 18 Dec

Chair's Report and Correspondence

Prepared by: Board Liaison Officer on behalf of the Chair

1 Introduction

This report covers the period from 29 August 2020 to 22 September 2020.

2 Correspondence Received

20200916 Email from member of the public, Dawn Clark – Complaint (HVDHB)

From: Dawn Clark <clarkd@stream.school.nz>
Sent: Wednesday, 16 September 2020 11:06 AM
To: CEO [HVDHB] <RES-CEO@huttvalleydhb.org.nz>; news@dompost.co.nz
Subject: Fwd: URGENT - We need urgent help

Good morning

I sent an email to the CEO yesterday at the Lower Hutt Hospital only to be ignored to date. I am sending this to the newspaper because I am so worried about the consequences to my husband due to the lack of care from the medical profession. He is in excruciating pain, he is up through the night every night.

I am very stressed and I have not had any acknowledgement at all from the Hospital CEO. How many other patients are suffering the way my husband is. He had to ring and almost beg as they gave him a two month wait. It was bought forward a month! but he requires urgent attention now not next week!

DHBs accept extra money from the Government, but people are still suffering. I doubt the CEO will care if he loses a hand or finger. She can't even respond that she has received an email, to say she is looking into the matter or whatever, I imagine she carried on with her day.

Regards
Dawn

I would like a copy of my email passed onto the Board of Governors at Lower Hutt Hospital with acknowledgement they have received it.

---------- Forwarded message ---------
From: **Dawn Clark** <clarkd@stream.school.nz>
Date: Tue, Sep 15, 2020 at 11:25 AM
Subject: URGENT - We need urgent help
To: <ceo@huttvalleydhb.org.nz>

My husband is 74 years old, his name is Michael John William Clark
54A Redvers Drive, Belmont, Lower Hutt

He does not deserve the NON treatment from your hospital

He was working at our son's house in Carterton, his hand became irritated, it was very very painful. Later it looked like it was infected and a lump kept growing.

Our Doctor, Dr Tim Ongley referred him to a skin specialist at the same medical centre who sent him immediately to the Hutt Hospital Emergency on 20 August. The Plastic surgeon saw him and booked the theatre for that evening. We were waiting and then the nurse said we want you to look like a patient put this gown on. Then another plastic surgeon came along and cancelled the theatre saying they will give us a call.

Meanwhile the growth keeps him awake at night, every night. It continues to be incredibly painful throughout the day and night. It keeps growing.
He has knocked it so many times. The pain is unbearable and he still waits.

I am absolutely disgusted that my husband is going through so much pain, it is the ugliest growth but the hospital is doing absolutely nothing.

I would like to see something done or I am off to do something else about it.

Why are our people left - is it because of his age?

What happens if he has to lose his finger or hand? They took an xray to make sure it hasn't eaten into the bone! Will the hospital take responsibility for this?

He has been offered no antibiotics. NOTHING

I have given you pictures of this - remember it is very, very painful DAY AND NIGHT - Would you do anything about it if it was your family member?

Regards
Dawn Clark

Phone 0275653336

The first picture was about the time we went to the Doctor - the second picture is what it looks like TODAY.

Acknowledgement and response

From: Kieran Yee [HVDHB] on behalf of Feedback [HVDHB]
Sent: Wednesday, 16 September 2020 3:05 PM
To: 'clarkd@stream.school.nz'
Subject: Complaint acknowledgement

Dear Dawn

Thank you for your email to the Chief Executive outlining your concerns about the delay in treatment provided to your husband by the Plastics Surgery department at Hutt Hospital.

I am very sorry to hear about this experience and the continued pain your husband has had to endure while awaiting treatment.

Your concerns have been directly referred to the service management team for the Plastic Surgery services.

We aim to respond to your complaint within 20 working days. In some instances, additional time is required to fully investigate the matter and we will advise you if this is the case.

You may also like to contact the Nationwide Health and Disability Advocacy service for further support or information. You can contact an advocate on 0800 555 050.

You also have a right to contact the Health and Disability Commissioner directly about your concerns on 04 494 7900 or visit http://www.hdc.org.nz/making-a-complaint/make-a-complaint-to-hdc/

Yours sincerely

Kieran Yee | Quality Advisor | Quality, Service Improvement & Innovation
Hutt Valley DHB
DDI +64 (04) 587 2613
www.huttvalleydhb.org.nz

From: Robyn Fitzgerald [CCDHB]
Sent: Thursday, 17 September 2020 10:21 AM
To: 'clarkd@stream.school.nz' <clarkd@stream.school.nz>
Subject: URGENT - We need urgent help

Dear Mrs Clark

I wish to confirm receipt of your email below, dated 16 September 2020. I understand that our staff did acknowledge receipt of your earlier email (copy attached).

I am very sorry to hear of your husband's experience and the continued pain he is experiencing.

We treat all enquiries, such as your own, very seriously and endeavour to do our best to respond as quickly as we can. Your concerns have been referred directly to the service management team for the Plastic Surgery services for response.

As requested I will forward this email to our Board and ask that it be acknowledged and distributed to Board members.

You may wish to contact the Nationwide Health and Disability Advocacy service for further support or information. You can contact an advocate on 0800 555 050.

You also have a right to contact the Health and Disability Commissioner directly about your concerns on 04 494 7900 or visit http://www.hdc.org.nz/making-a-complaint/make-a-complaint-to-hdc/

Yours sincerely

Robyn Fitzgerald
Correspondence Officer
Office of the Chief Executive

20200918 Letter from member of the public, Wes Payne – Compliment (CCDHB)

From: Wesley Payne <paynewesley6@gmail.com>
Sent: Monday, 14 September 2020 2:09 PM
To: Feedback [CCDHB]
Subject: Great team.....

Hi

Please can this be sent to the Chair of the Board.

I would like to take the time to put pen to paper and thanks the staff I had the pleasure of being looked after by. I was transported to Wellington AE on Saturday night with a blocked artery to my left arm. I was met by the nurse in the triage cubicle and she was great to deal with.

It was not long before I was move to a corridor bed.I was met by Devi the nurse. She was really great and you can see it, both passionate and competent in what she does. I later learned she was into her second shift, pulling a double shift on a busy Saturday night. She really made my stay in the ED comfortable and as pleasant as possible.

Due to where I was parked I could hear the staff working with Devi. There were staff working more than their normal shifts and staff working late. One of those working double was also the Dr who first saw me. I think here name was Anneta. She was from the Vascular team. She was really friendly and profesional explaining what the plan was and what could happen, placing me at real ease. I could see she knew what she was talking about.

During the night I had interactions with other nursing staff and they all were willing to stop and help anyone who asked. Their was a young girl who I think had self harmed herself. The young nurse who dealt with her had blue coloured hair. I listened to her when she dealt with this scared young girl. It was extremely busy, however this nurse took the time to stop and talk to her as a young person (21 years old, I think). She really made a difference in this girl's night.

I was finally taken to the ward 7 North. Devi came with and even the young male orderly was friendly and pleasant to be around, talking to us the whole way.

On my arrival we were met by Kiley, the nurse. Friendly, profesional person who is engaged in what she is doing, even at 4am. Nothing was a hassle for her and she did it with a smile. She really had consideration for the other patients as well and helped out where ever she could and with a smile. She was a real pleasure to have around.

Irish was the nurse to take over. She was really great as well, bubbly and really full on, looking after everything. She really went out of her way to settle everyone. Her enthusiasm and humour was commented on by the other patients in the ward.

I had to go for a CT and the 2 orderlies who transported me there and back were happy in what they did and even in the short trip to and from CT I had a good enough chat with them, to say that I at least know am little bit about who they are, and they are assists to your team.

Grace in CT was busy, but took the time to explain everything and was friendly and profesional. She to is an asset to have on your staff.

Mr Richard Evans was the person who oversaw my treatment. When I went in with the cold pale arm I was really worried about what might happen. He explained everything to me. I was concerned when I was told

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that I may not have an operation, as I just wanted the blockage gone. He took the time to explain that the body can self heal and explained how this was possible. It made sense to me that operating was now the last call.

You can be extremely proud of the staff involved in your running on things on the shop front. From the view I got on the other side, they are outstanding. I have been to hospital before and received some really bad experinces and some better treatment, but this was a whole different level of service, hence the email. I thought you and your staff really need to know this, and as a manager myself, they need to hear this from you. They selfishly do things out of love and passion for what they do and it is evident, even when they get the repeat patient who is difficult to deal with (as on this night).

Please pass on my gratitude to them for their tireless dedication and professionalism. It is really appreciated.They are truly and asset to the public services. THANKS.....

Regards

Wes Payne

Chief Executive's Report

Prepared by: Fionnagh Dougan (Chief Executive)

1 Introduction

This report covers the period from 29 August 2020 to 22 September 2020.

2 COVID-19 Update

On 22 September 2020, Wellington went into Alert Level 1 along with most of New Zealand. This is something that had always been planned and which we remained ready for. There is no known community transmission in our area, and screening and testing work at the borders and in our communities is our first line of defence.

Our PHOs have stood up the CBACs to provide testing for all symptomatic people, and mobile testing teams are available for people who cannot leave their homes or residences.

In our hospitals, we continue business as usual with appropriately enhanced protection for visitors, patients and staff. Visitor restrictions are being put in place for our vulnerable areas and COVID-19 screening has been reinstated at the main entrance.

Support for our staff health and wellbeing is an additional continued focus of our response plan.

2.1 Current Cases – 2DHB

Number of COVID-19 cases: 0
Number of days without COVID-19 cases, Hutt Valley DHB: 96
Number of days without COVID-19 cases, Capital & Coast DHB: 153

2.2 Managed Isolation Facilities

Number of COVID-19 cases: 1
Number of guests: 125 as at 0900 22 September

2.3 Testing Statistics

2DHB		HVDHB		CCDHB	
Tests performed to date	65,772	Tests performed to date	18,204	Tests performed to date	47,568
People tested to date	57,531	People tested to date	16,211	People tested to date	41,320
Testing coverage	12.1%	Testing coverage	10.7%	Testing coverage	12.7%
Tests performed last week	2,216	Tests performed last week	547	Tests performed last week	1,669
Test performed since 11 August – Auckland cluster	24,748	Test performed since 11 August – Auckland cluster	6,520	Test performed since 11 August – Auckland cluster	18,228

Source: WSCL
COVID-19 tests by DHB to 22 September 2020

2.4 Testing Statistics by ethnicity

2DHB		HVDHB		CCDHB	
Tests performed to date – Maori | Pacific	8,065 | 5,388	Tests performed to date – Maori | Pacific	2,942 | 1,591	Tests performed to date – Maori | Pacific	5,123 | 3,797
People tested to date – Maori | Pacific	7,048 | 4,729	People tested to date – Maori | Pacific	2,624 | 1,399	People tested to date – Maori | Pacific	4,424 | 3,330
Testing coverage – Maori | Pacific	14.3% | 14.6%	Testing coverage – Maori | Pacific	13.0% | 12.6%	Testing coverage – Maori | Pacific	15.2% | 15.7%
Tests performed last week Maori | Pacific	211 | 298	Tests performed last week Maori | Pacific	84 | 64	Tests performed last week Maori | Pacific	139 | 234
Test performed since 11 August – Auckland cluster Maori | Pacific	2,747 | 2,201	Test performed since 11 August – Auckland cluster Maori | Pacific	937 | 668	Test performed since 11 August – Auckland cluster Maori | Pacific	1,810 | 1,533

Source: WSCL
COVID-19 tests by DHB to 22 September 2020

3 Communications and Engagement

3.1 External Engagement with Key Partners and Stakeholders

As we move down COVID-19 alert levels and into a longer term response, our focus is returning to core business and engagement with key external partners and stakeholders.

Over recent weeks, we have commenced engagement with local government in the region as part of the Chief Executive's stakeholder relationship management programme. We have met with the Mayor and Chief Executive of both Wellington City and Upper Hutt City, and have visits planned to remaining councils over coming months.

Core themes are the wellbeing of our people and places, the provision of health services in hospitals and in the community, our workforce as an important contributor to the region, and our progress towards 2DHB services.

Issues such as mental health, drugs and alcohol, domestic violence, housing and homelessness are commonly mentioned, and it is clear that we share common interests in the health of our population.

We will take the opportunity to present our health system strategies for the region at the Mayoral forum on 9 October, which includes councils from the greater Wellington, Hutt and Wairarapa regions.

Other upcoming stakeholder visits include the Ombudsman, on mental health facilities and services.

3.2 External Communications and Engagement

The past month has seen a continuation of COVID-19 related messages externally, particularly to encourage testing. As focus returns to core health issues, increasingly we are also seeing the addition of public health messages such as rheumatic fever, and cervical and bowel screening.

In addition, we have continued to manage communications with guests and providers behind the scenes in our two managed isolation facilities.

3.3 Social Media and News Stories

We continue to engage with our community on their stories and the work our people do in our hospitals and our communities. A sample of the key messages and performance of our channels is outlined below. Our social media channels, particularly Facebook continue to see strong engagement.

HVDHB impressions

Facebook: 231,183

Hutt Maternity Facebook: 7,912

CE Facebook: 4,659

Twitter: 35,608

Instagram: 16,274

LinkedIn: 10,601

CCDHB impressions

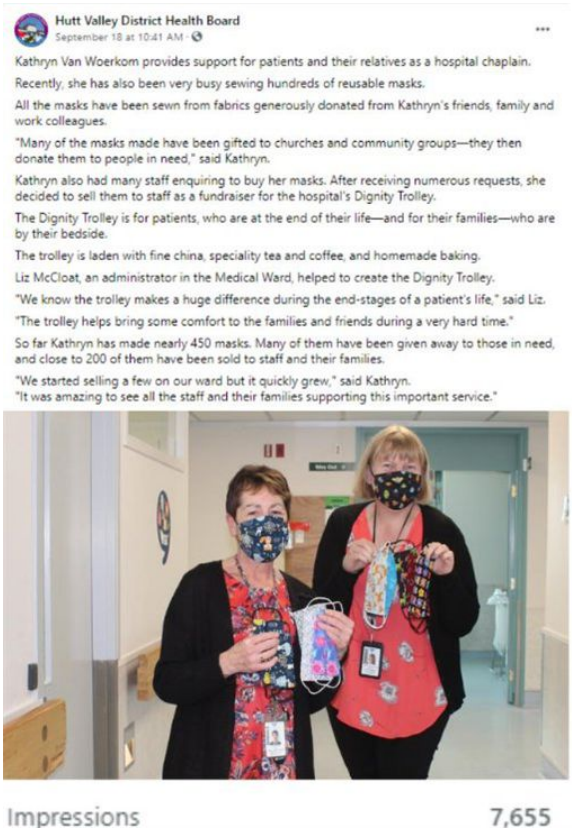
Facebook: 158,933

CE Facebook: 4,659

Twitter: 4,801

LinkedIn: 11,381

Top 4 posts across both DHBs



Capital & Coast District Health Board (CCDHB)
September 4 at 2:09 PM

Capital & Coast District Health Board (CCDHB)'s Board members toured the new Wellington Children's Hospital yesterday.

It is incredibly exciting to see all of the progress being made.

To read the latest update on the new children's hospital visit: https://whf.org.nz/wellington-childrens-hospital/

Impressions 6,899

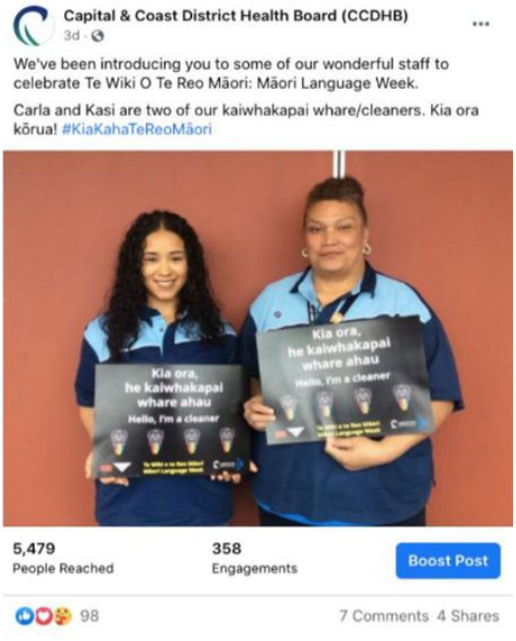
Capital & Coast District Health Board (CCDHB)
September 10 at 9:16 AM

Message from YouthQuake: "We have been working in partnership with CCDHB since June 2019 to integrate youth services for rangatahi in Porirua. Our priority is to establish a youth one stop shop for rangatahi. Culturally relevant to our community, led by youth and accessible to those who need it most. This means a service that provides for Māori and Pacific rangatahi, those living in high deprivation, those living with disability, refugee and migrant families, and the LGBTQI+ community. A service that is confidential offers a whānau-based approach. We want a space in the centre of Porirua that offers us the right mix of health and social services and will improve our outcomes.

The time is now! We are looking for providers to collaborate and help us achieve our goals. An advance notice has been put on the Government Electronic Tender System (GETS) to give you some more information about the process. The RFx ID is 23204276, the Tender name on the GETS system has been called Youth Quake, One Stop Shop – Porirua."
https://www.gets.govt.nz/CCDHB/ExternalTenderDetails.htm...

Impressions 6,831

Te Wiki O Te Reo Māori: Māori Language Week



3.4 Website page views and stories

CCDHB	HVDHB	MHAIDS
115, 761 page views	30,426 page views	11,011 page views

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

Top 5 webpages CCDHB

- Main homepage (www.ccdhb.org.nz)
- Community Based Assessment Centres – locations and hours
- Careers at CCDHB
- Wellington regional hospital information page
- Kenepuru community hospital information page

Top 5 webpages HVDHB

- Main homepage (http://www.hvdhb.org.nz)
- Community Based Assessment Centres – locations and hours
- Contact us
- Hutt Hospital campus maps
- Covid-19 information for visitors

Top 5 webpages MHAIDS

- Main homepage
- Child and adolescent mental health services
- Do you or someone you know need help now? Te Haika contact centre
- Central region eating disorder services
- How to contact our services

Top website stories

Election 2020 – voting from hospital

Published Friday 18 Sep 2020

Due to COVID-19, Electorate Returning Officers will not be collecting votes from patients in hospital either in the lead up to or on Election Day. Hospitals will also not be used as designated voting places.

However, people who cannot get to a voting place because they are in hospital can still vote.

From Saturday 3 October, patients in hospital can use the form below to nominate a friend or family member to collect their voting papers. The patient and nominee must both complete the form to allow the nominee to collect the voting papers, bring them into the hospital, and then return the papers to a voting place.

People who know they will be in hospital prior to Election Day (Saturday 17 October) are encouraged to do this, or to take part in early voting, to ensure their vote can be cast.

People who are scheduled to be in hospital on Election Day will receive a copy of the form with their appointment letter. Copies of the form will also be available in wards in the lead-up to the election, and on Election Day itself.

Please remember that anyone nominated to collect patients' voting papers will need to abide by the DHB's visitors policy .

More information about Election Day and voting is available from the Electoral Commission .

Sewn with love

Kathryn Van Woerkom provides support for patients and their relatives as a hospital chaplain. Recently, she has also been very busy sewing hundreds of reusable masks.

All the masks have been sewn from fabrics generously donated from Kathryn's friends, family and work colleagues.

"Many of the masks made have been gifted to churches and community groups—they then donate them to people in need," said Kathryn.

Kathryn also had many staff enquiring to buy her masks. After receiving numerous requests, she decided to sell them to staff as a fundraiser for the hospital's Dignity Trolley.

The Dignity Trolley is for patients, who are at the end of their life—and for their families—who are by their bedside. The trolley is laden with fine china, speciality tea and coffee, and homemade baking.

Liz McCloat, an administrator in the Medical Ward, help created the Dignity Trolley.

"We know the trolley makes a huge difference during the end-stages of a patient's life," said Liz. "The trolley helps bring some comfort to the families and friends during a very hard time."

So far Kathryn has made nearly 450 masks. Many of them have been given away to those in need, and close to 200 of them have been sold to staff and their families.

"We started selling a few on our ward but it quickly grew," said Kathryn. "It was amazing to see all the staff and their families supporting this important service."

Generation 2 My Health Passport Available Now

Published | Tuesday 22 Sep 2020 | Comms Unit

My Health Passport, the second generation Health Passport, has arrived. It includes an Easy Read version and an Express version to ensure it is appropriate for each person who wants one.

My Health Passport is one of the key tools for ensuring people with disabilities who are accessing services receive effective healthcare. It informs clinicians, nurses and others involved in the delivery of your healthcare services how best to accommodate your needs.

Disabled people can choose to share as much or as little of the information as they wish. It is a mechanism to enable both the disabled person and their support person to communicate the assistance they may require, and is especially useful where a person is unable to describe what they need in times of urgency.

My Health Passport is not a medical record, nor a diagnostic or health management tool. It is a paper document for you to write down any needs you may have or want your health providers to know about you, so you don't have to explain every time.

My Health Passport is free and are available from the office of the Health and Disability Commission (HDC) and the disability team of the 3 DHB'S:

https://www.hdc.org.nz/disability/my-health-passport/

disability@ccdhb.org.nz

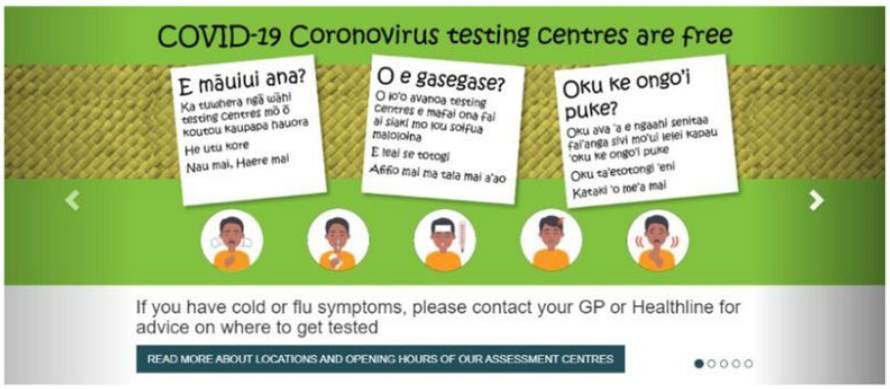
OR

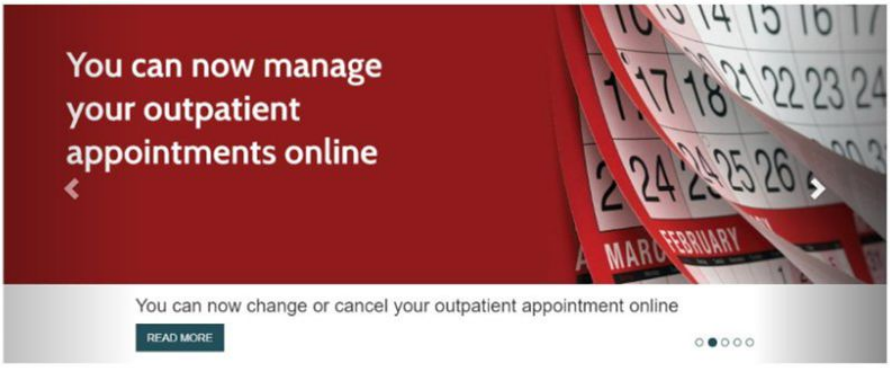
Phone- 0800 Disability (3472245489)

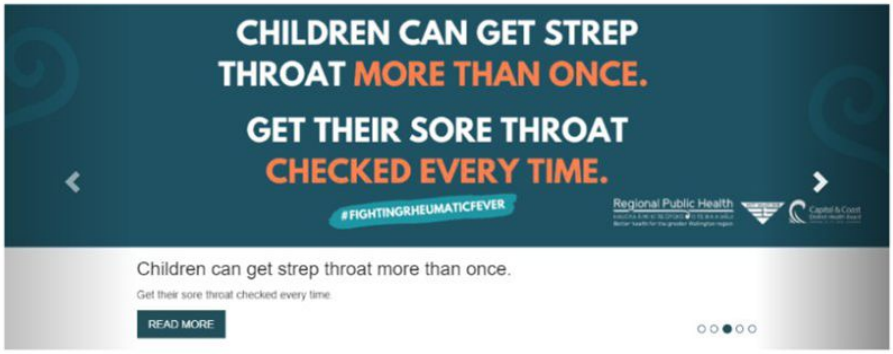
Text - 021 578 307

Website Banners


Visiting restrictions
have been lifted at our
hospitals and health facilities
Manaaki whānau, manaaki tāngata - caring for families, caring for people
General visiting hours are 8.00am - 12.30pm and 2.30pm- 8.00pm.
Find out more


COVID-19 Coronovirus testing centres are free
E māuiui ana?
Ka tuuhere ngā wāhi testing centres mō ō koutou kaupapa hauora
He utu kore
Nau mai, Haere mai
O e gasegase?
O io'o avanoa testing centres e mafai ona fai ai siaki mo lou soifua maloloina
E leai se totogi
Afio mai ma tala mai a'ao
Oku ke ongo'i puke?
Oku ava 'a e ngaahi senitaa fai'anga sivi mo'ui lelei kapau 'oku ke ongo'i puke
Oku ta'etotongi 'eni
Kataki 'o me'a mai
If you have cold or flu symptoms, please contact your GP or Healthline for advice on where to get tested
READ MORE ABOUT LOCATIONS AND OPENING HOURS OF OUR ASSESSMENT CENTRES


You can now manage
your outpatient
appointments online
You can now change or cancel your outpatient appointment online
READ MORE


CHILDREN CAN GET STREP
THROAT MORE THAN ONCE.
GET THEIR SORE THROAT
CHECKED EVERY TIME.
#FIGHTINGRHEUMATICFEVER
Regional Public Health
Children can get strep throat more than once.
Get their sore throat checked every time
READ MORE

3.5 Internal Engagement and Communications

Ongoing internal communications messages to our people continue including the fortnightly Chief Executive update (featured below), COVID-19 updates, the Daily Dose email, intranet stories on our people and successes, and significant a social media presence which reaches our people as well as our communities.

The regular COVID-19 email update provides our people with key information and new operational requirements as they come to hand. Board members have been receiving this too. All information and policies are loaded in the central repository on our intranets. There is an ongoing focus on staff safety and wellbeing. Now we are back in alert level 1 we are likely to reduce the frequency of these updates.

The nominations process has opened for our annual recognition and awards programme for our people, Celebrating Success, which will be held in November across both DHBs, featuring an awards evening (COVID dependent) and a week-long celebration programme.

Health Matters will be published again in late September and has now been extended to the HVDHB team as well as CCDHB, using the same base copy and articles of interest to each DHB.

Kia ora

In delivering effective and excellent healthcare services and outcomes for our patients, whānau and communities, it is important that we continue to focus on opportunities to build and strengthen our services and organisational structures.

Our vision is simple – we know that by working together as one team across two DHBs we can create a better health system with better health outcomes for our communities.

Just over a year ago we took our first steps towards closer collaboration between Hutt Valley and Capital & Coast DHBs with the appointment of a single Chief Executive across both organisations. Since then we have appointed a number of 2DHB roles including Directors of People, Culture and Capability; Provider Services; Strategy, Planning and Performance; Communications and Engagement; and Chief Allied Professions Officer and Chief Financial Officer. Each of these executives has made a substantial and valuable contribution to the operation of our DHBs.

What changes are we making and why

Today, we are moving forward another step with key announcements that further defines and develops our shared structure.

The first is the decision to move to a fully 2DHB executive structure.

Following on from our consultation last month, we will now be moving to an executive

CEO update *31 August 2020*

Kia ora koutou

I hope you have now readjusted to 'business as usual' under alert level 2, albeit with some new challenges. I am keen to ensure we also move forward on our strategic priorities during this time.

Last week I enjoyed getting out and about, and attended a meeting at Takapuwahia Marae, to meet and acknowledge Helmut Modlik, the new CEO of Toa Rangatira. Close relationships with iwi are critical to our ability to address equity.

I also had the chance to visit several wards around the hospitals, as well as a community-based assessment centre (CBAC). It has been great to renew existing ties and create new ones, and hear from you about your challenges.

Lastly, a quick note to welcome Rosalie Percival today as the new 2DHB Chief Financial Officer. Rosalie brings a wealth of experience from both the accounting and healthcare sectors, and her experience will be invaluable to us as we work to make our services more seamless, sustainable, and equitable.

CE Update: We all have a part to play

Published Friday 11 Sep 2020

Learning and speaking Te Reo Māori with our people, communities, patients and whānau is an important way to support our plans for addressing equity, and so I am excited about Te Wiki o Te Reo Māori: Māori Language Week, coming up next week.

One way take part is to join in the Māori Language Moment at 12pm next Monday 14 September - commit to doing one thing, in that one moment, alongside hundreds of thousands of New Zealanders. The action you take in your 'moment' could be as easy as playing a Māori language waiata as you travel to work, or starting your Zoom call with 'mōrena'.

I plan to take up the challenge by ordering my coffee in Te Reo Māori, and using Te Reo Māori greetings throughout the day. Please join me if you can - there are many other ways that you can get involved, either in the 'moment' or any other time throughout the week - check Pūmanawa | Heartbeat for suggestions. I will also start Te Reo Māori lessons this year, to gain a deeper, more meaningful knowledge of the language and of Te Ao Māori.

As you know, Te Pae Amorangi, our Māori Health Strategy has challenged our organisation to achieve health equity for Māori. We all have a part to play in building a pro-equity organisation—'Ehara tāku toa i te toa takitahi, engari he toa takitini'.

Entries open for Ngā Tohu Angitu: Celebrating our Success Awards

Few of us will have experienced a year like this in our lifetimes. While we have been relatively fortunate to avoid spread in Aotearoa, COVID-19 has impacted us all - our lives and our work.

In response to COVID-19 we have adapted and innovated, all while continuing to deliver great care in the hospital and in the community.

I am immensely proud of the fantastic work each of you have done this year – you all deserve recognition. We have the opportunity to recognise this formally soon, so please consider nominating a colleague for an award as part of Ngā Tohu Angitu: Celebrating our Success Awards.

There are awards covering innovation, collaboration, leadership, values, and many more of the things we know are key to forming a resilient, more equitable health system. Please get your nominations in before Friday 2 October.

Top 6 intranet stories

HVDHB

- Nikita Hunter, Integration Lead Māori Health
- Consultation now open on overnight on-site theatre staffing
- Māori cultural safety training inspires clinicians
- Celebrating 30 years of service at Hutt Valley DHB
- Sewn with love
- Send a Shout Out

CCDHB

- Te Wiki O Te Reo Maori
- Celebrating our success 2020
- Keeping staff safe from violence
- Our 3DHB digital strategy
- Communication cards for Deaf people
- Profile: Managed Isolation Facilities nurse

Māori cultural safety training inspires clinicians

Published Monday 7 Sep 2020

A successful homegrown cultural training programme is inspiring Hutt Valley DHB staff to develop better ways to care for Māori patients. Rheumatologist Dr Rebecca Grainger talks about how understanding of the impact of colonisation and themes of racism empowers staff to find ways to address inequity in the health system.

About 100 staff have benefited so far from the first module of the Te Kawa Whakaruruhau Māori cultural safety training programme since its launch by Hutt Valley DHB Pou Tikanga Rawiri Hirini in July.

Te Kawa Whakaruruhau translates as a safe place made from principles.

The programme's first module, Te Tiriti o Waitangi, is an opportunity for staff to learn more about New Zealand from a Māori perspective, through the lens of Te Tiriti o Waitangi (The Treaty of Waitangi).

Rheumatologist Dr Rebecca Grainger praised the training for enabling staff to grow their understanding of the impact of colonisation, themes of racism, and empowering them to find ways to address inequity in the health system.

"If we are going to look at Te Whare Tapa Whā (an holistic Māori health model covering people's physical, spiritual, family and mental wellbeing) - we have to address all those elements to make a difference.

"Within individual patient consultation, you can begin to address different aspects of wellbeing - even simple things like asking: Can we make a time for you to come in with your whānau, and we can have a kōrero at a later date?.

"Those are the hard questions we need to answer when many of us are already faced with limited time.

"Because that's what's going to make a difference."

About 23 per cent of Māori live in the Hutt Valley's most deprived areas compared to 15 per cent of all residents. About a third of all hospital admissions for people under 25 were Māori this year.

Rebecca, who is also an Associate Professor in the University of Otago Wellington's Department of Medicine, said the training helped enable staff to have solution-focussed discussions about what they want to do.

"A few years ago, I printed posters from Te Wiki o Te Reo Māori and stuck them up around our floor because I wanted to signal to Māori people that we value the wealth of Māori culture.

"Some of my colleagues might have wondered why I wanted to do that. But now they might understand that the physical environment can signal that Māori culture is valued."

Hutt Valley DHB Pou Tikanga Rawiri Hirini shared feedback from others about how the training helped them understand the wider context so they understood why Māori initiatives are so important.

"It's been uplifting to know the training's been well-received," Rawiri said. "And that it's enabled positive conversations about service delivery and the value of Māori perspectives within health."

Nikita Hunter, Integration Lead Māori Health

Published Tuesday 15 Sep 2020

My journey to eliminate the inequities our whānau face has lead me to the Māori health unit at Hutt Valley DHB. I now sit within the role of Integration Lead Māori Health.

Ko Tararua te Maunga

Ko Punahau te roto

Ko Kawiu te marae

Ko Mūaupoko te iwi

Ko Nikita Hunter ahau

I was born in Wainuiomata where I was surrounded by my cousins and often picked on! We then journeyed over to Australia for my dad to play league. We moved back to Aotearoa spending some time in the sunny north of Kerikeri. Before settling in Taitoko where we were able to reconnect with our whakapapa and marae, led by our beautiful Maria Lomax.

I spent a year at Hato Hohepa in Napier before completing college at Horowhenua. When my twin girls were born seven weeks early my passion for nursing started and I begun studying my Nursing degree when the girls were one year old. We now have four amazing tamariki.

As a registered nurse I have always worked with our pēpi, tamariki and whānau starting on the paediatric wards of Wellington and Hutt Valley. I then moved out to the community working as a Public Health nurse in our Kura.

My journey to eliminate the inequities our whānau face has lead me to the Māori health unit at Hutt Valley DHB. I now sit within the role of Integration Lead Māori Health. This has moved me from that one whānau at a time approach to helping instil within our systems the visions of Te Pae Amorangi and Pae Ora.

Celebrating 30 years of service at Hutt Valley DHB

Published Wednesday 16 Sep 2020

This month the Toi Ora team celebrate Miriam Coffey's milestone of 30 years of service at Hutt Valley DHB.

Miriam started her career at the DHB as a receptionist in the General Outpatients Department—from the outset she was active in addressing the systematic inequities for whanau Māori.

Miriam is a taonga to the community of Te Awakairangi and a Pou in the Toi Ora team. Her manaaki is her treasure—with a heart of gold, there is nothing that Miriam won't do for someone who needs her.

He taonga rongonui te aroha ki te tangata. Kindness towards people is a great treasure.

Congratulations Miriam and thank you for all that you do.

Te Wiki O Te Reo Māori

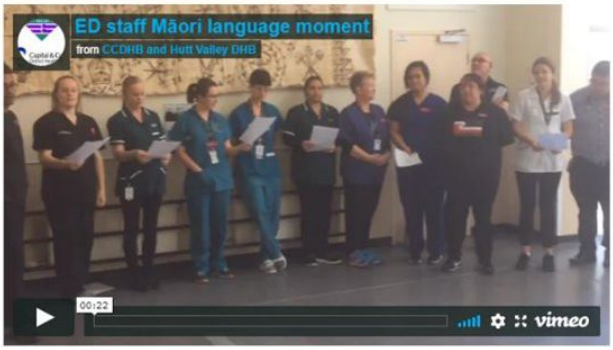
This week is Te Wiki O Te Reo Māori - Māori Language Week

This week is Te Wiki O Te Reo Māori - Māori Language Week, an annual opportunity for celebration, promotion and encouragement o te Reo Māori. The chosen theme for 2020 is again 'Kia Kaha Te Reo Māori' - 'Let's make the Māori language strong'.

Here are some ideas for ways you can take part throughout the week, via Te Kāwanatanga o Aotearoa.

- **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:** Spend your lunch hour reading 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.

This year the first ever 'Māori Language Moment' took place. At 12pm on Monday 14 September, thousands of people did one thing, in that one moment, such as playing a Māori language waiata or starting their Zoom call with 'mōrena'. Our staff in ED got together to sing a waiata.



ED staff Māori language moment from CCDHB and Hutt Valley Vimeo.

Mātauranga / Education

There are plenty of ways to improve your Te Reo Māori at work, from Practice your Pepeha and Tikanga Māori, to Te Tiriti o Waitangi courses.

Keeping staff safe from violence

New tools are available to guide you when you encounter aggressive incidents.

Violence and aggression are challenging to manage and can cause physical or psychological harm. To keep you safer, new tools have been developed to help you report incidents and share information at CCDHB.

Two stickers have been created to help keep staff informed. If a violent incident occurs, a yellow 'Check Incident Sticker' is placed on the front of the patient's file. This alerts staff that an incident has taken place, and tells them there is more information about the incident in the body of the notes.

"The stickers alert others – so that when people pass through the hospital, the next area is aware of the risk," says director of nursing Fiona Houghton, who is part of the preventing workplace violence project group.

"The Keeping Everyone Safe sticker offers information on what to do when an incident occurs and what actions to take after it has happened. It will help staff to be more proactive in planning safe care for the patient, and it is hoped this will help prevent violence and aggression recurring."

The sticker is the latest initiative from the project group, which is formed of representatives from occupational health, capability development, security, and nursing, and is answerable to a workplace violence prevention steering group.

If an incident occurs, Fiona's advice is "first of all, keep yourself safe. Make sure you get help and let people know something's happening."

The capability and development team runs regular workshops (for staff who do not work for MHAIDS) that focus on developing personal safety, communication skills, risk assessment and conflict resolution, to prevent and manage violence and aggression from patients and visitors. Hour and full-day workshop options offer the chance to learn about what's happening at the DHB to help keep you safe. They can be booked via Connect Me.

"You'll learn how to spot someone who is becoming agitated, and get tips on how to intervene before they become violent or aggressive," explains Fiona.

How to keep yourself safe before, during and after an incident

- assess your work area for your own safety
- if an incident occurs, tell others and get help
- try to de-escalate if it's safe to do so
- place a Keeping Everyone Safe Sticker in the patient's medical file and follow the prompts
- create a plan to prevent or manage if a similar event occurs again – this includes identifying what triggered the event if possible. Call a safety huddle with medical staff, allied health, security orderlies, health care assistants, psychiatric liaison, etc. as required – document the plan in the patients file
- raise awareness of the event – place a Check Event Sticker on the PIF and an alert in MAP, write a reportable event (you may need to write two if there was restraint involved).

Find out more here, or contact Fiona Houghton for more information.

Celebrating our Success

Entries are now open for Ngā Tohu Angitu: Celebrating our Success Awards.

It's time to celebrate our shining stars! CCDHB's annual Celebrating our Success Awards recognise and celebrate the work you do to improve the health of our community.

In 2020 we have shown unity, creativity and perseverance to stop the spread of COVID-19. Many of us have innovated, shown excellent teamwork or leadership, and gone the extra mile to deliver fantastic care.

This year we've revised our award categories to encourage more recognition of individuals and teams in clinical and non-clinical roles, as well as recognising our values and embedding equity throughout the categories.

We are accepting nominations from staff, volunteers and our providers for 12 different categories. Those nominating a person or team will need to show who has benefited, and how, by filling in this simple online form. Self-nominations are welcome.

Please get your nominations in by 30 September. The nominations will be collated and judged by a panel, with finalists announced in October. The awards will take place in November.

Fill in this form to nominate a colleague today.

1: Hiranga Haumanu / Clinical Excellence

Recognises teams or individuals who have delivered patient-centred initiatives leading to improvements in health outcomes, patient safety/wellbeing, patient experience, Māori health or equity, outcomes of access, or health literacy for service users.

2: Hautūtanga Taiea / Outstanding Leadership

Recognises teams or individuals whose outstanding leadership has enhanced organisational culture and supported high performance. This could include encouraging workforce development or equity initiatives, improving the capability or wellbeing of employees, leading or driving Māori health or equity, or consistently inspiring and motivating others. Nominees do not have to be in a formal leadership role, and can be clinical or non-clinical.

3: Hiranga i te Wāhi Mahi / Excellence in the Workplace

Recognises teams or individuals who have made a difference to staff experience in the workplace. This could include implementation of sustainable practices that make a difference to the wellbeing of employees, improvement of workplace culture, or enhancement of overall job satisfaction including specific consideration of Māori staff and those of diverse ethnicities. This could include; development of workplace training, recruitment practice improvements, health and safety initiatives, encouraging workplace diversity, fostering inclusion or enhancing staff wellbeing.

4: Toa Ranga i te Tira / Champion of Collaboration and Integration

For teams or individuals who have demonstrated outstanding collaboration or prioritised integration in their approach to care for services across our sub-region and in community and primary health care. This could be developing an initiative to increase system connectedness and cohesion, fostering integration between the primary, secondary or community sectors, demonstrating partnership which builds participation with Māori, using innovative thinking or new approaches which encompass Māori health and equity outcomes.

5: Hiranga Auaha, Whanake me te Anga Whakamua / Excellence in Innovation, Improvement and Future Thinking

For teams or individuals who have either:

The show goes on! School immunisation team on track amongst COVID-19 school closures

Every year the Child Health, School Based Immunisation team at Regional Public Health (RPH) set about the considerable task of immunising 7500 children in years 7 and 8 (ages 10 to 12) in 113 schools across Wellington, Hutt Valley, Porirua and Kapiti. The team deliver the Boostrix and HPV vaccines to these students.

For Maureen Stringer, Child Health Immunisations team leader, 2020 has seen her team lose eight available weeks to administer immunisations due to COVID-19.

"As soon as there were confirmed cases of COVID-19 in New Zealand, we had a number of schools contacting us saying, 'put the immunisations for our school on hold, we don't want any external visitors at the moment.' We could understand why they wanted to take every precaution to keep their tamariki safe," Maureen said.

By late March, under alert level 4 lockdown, all schools closed and the school immunisation programme went on hold. The immunisation team were redeployed within RPH as part of the pandemic response, which included completing daily monitoring of COVID-19 cases and assisting the wider team with contact tracing.

On the other side of the COVID-19 response, the team faced condensing the school immunisation programme into a much shorter timeframe. It was vital that all HPV round one immunisations were completed by the middle of the year, to allow for a minimum of 22 weeks before round two can be administered.

Maureen's "D-Day whiteboard" – the whiteboard used when planning school immunisation visits – suffered through markers and erasers going into overdrive as a number of quick revisions to schedules were made. With great working relationships already established with schools and flexibility shown from both sides, new schedules were completed. "Our team of 5.2 FTE staff wasn't going to get through the workload. Luckily we're a collaborative bunch here at RPH so we called on support from the wider team of public health nurses to help us out," said Maureen.

From there, round one of the HPV vaccine was delivered to all schools. "The team are now working hard to try to deliver HPV round two, on time, by the end of the year," said Maureen.

"The team have continued to go above and beyond, during really challenging times, to ensure that kids get immunised. I have a wonderful team and I am immensely proud how they have risen to the challenges that have been thrown our way this year," she said.

2020	2020	2020	2021	2021	2021	2021	2021	2021	2021	2021	2021	2021	2021	2021
October	November	December	January	February	March	April	May	June	July	August	September	October	November	December
No Meeting	4-Nov	3-Dec	No Meeting	No Meeting	3-Mar	7-Apr	5-May	2-Jun	7-Jul	4-Aug	1-Sep	6-Oct	3-Nov	1-Dec
	Hutt Valley Board				Hutt Valley Board		Hutt Valley Board		Hutt Valley Board		Hutt Valley Board		Hutt Valley Board	
		Capital and Coast Board				Capital and Coast Board		Capital and Coast Board		Capital and Coast Board		Capital and Coast Board		Capital and Coast Board
No Meeting	4-Nov	3-Dec	No Meeting	No Meeting	3-Mar	7-Apr	5-May	2-Jun	7-Jul	4-Aug	1-Sep	6-Oct	3-Nov	1-Dec
	Workplace Health and Safety Report	Workplace Health and Safety Report				Workplace Health and Safety Report		Workplace Health and Safety Report		Workplace Health and Safety Report		Workplace Health and Safety Report		Workplace Health and Safety Report
		People, Capability and Culture Report			People, Capability and Culture Report		People, Capability and Culture Report		People, Capability and Culture Report		People, Capability and Culture Report		People, Capability and Culture Report	
		Facilities and Infrastructure Report			Facilities and Infrastructure Report			Facilities and Infrastructure Report			Facilities and Infrastructure Report			Facilities and Infrastructure Report
	ICT Report					ICT Report			ICT Report			ICT Report		
		Pacific Health Report					Pacific Health Report			Pacific Health Report			Pacific Health Report	
	Maternity Review Report (aligned with Hutt Only)						Maternity Review Report (aligned with Hutt Only)			Maternity Review Report (aligned with Hutt Only)			Maternity Review Report (aligned with Hutt Only)	
					Environmental Sustainability			Environmental Sustainability			Environmental Sustainability			Environmental Sustainability
No Meeting	4-Nov	3-Dec	No Meeting	No Meeting	3-Mar	7-Apr	5-May	2-Jun	7-Jul	4-Aug	1-Sep	6-Oct	3-Nov	1-Dec
		Māori Partnership Board (CCDHB)				Māori Partnership Board (CCDHB)		Māori Partnership Board (CCDHB)		Māori Partnership Board (CCDHB)		Māori Partnership Board (CCDHB)		Māori Partnership Board (CCDHB)
	Sub-Regional Pacific Health Strategy Group						Sub-Regional Pacific Health Strategy Group			Sub-Regional Pacific Health Strategy Group			Sub-Regional Pacific Health Strategy Group	
	Wellington Hospital Foundation				Wellington Hospital Foundation			Wellington Hospital Foundation			Wellington Hospital Foundation			Wellington Hospital Foundation
No Meeting	4-Nov	3-Dec	No Meeting	No Meeting	3-Mar	7-Apr	5-May	2-Jun	7-Jul	4-Aug	1-Sep	6-Oct	3-Nov	1-Dec
					Budgets			Budgets				Budgets		
					Annual Plan			Annual Plan				Annual Plan		

Board Information - Public

September 2020

Hutt Valley DHB July 2020 Financial and Operational Performance Report

Action Required

The Hutt Valley DHB Board note:

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

(b) The Financial result for July was a favourable variance to budget of $0.2 million against the annual budget deficit of $10.6 million.

(c) The Funder result for July was $0.5m favourable, Governance $0.1m favourable and Provider ($0.4m) unfavourable to budget.

(d) Total Case Weighted Discharge (CWD) Activity was 7.79% ahead of plan.

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

Executive Summary

As noted to the Board at their last meeting, activity delivered by the Hutt Valley DHB provider arm, ED attendances, surgical procedures, overall discharges, outpatient and community contacts, have returned to pre COVID-19 levels and are consistent with previous years for the month of July.

There is Ministry of Health (MOH) commitment to $2.261 million in year one additional Planned Care Initiative (PCI) funding for HVDHB Improvement Action Plan recovery and we are in discussion with MOH about this and separate initiative including capex funding bid potential. The funding is significantly less than the finances required to close the waiting list ESPI 2 and ESPI 5 gaps. However this is going to be a long slow recovery.

Strategies to address the Hospital provider arm performance include improved access to assessment beds to free up ED and provide a more positive patient journey, expand the capacity of the Early Supported Discharge team to improve efficiency of discharge planning and "pull" patients home from ED and wards, and addressing delays in the Care coordination pathway. Managers are developing annual leave plans with staff and the CCDM programme will be rolled out for this year.

Key areas of funder performance include:

- Maori enrolment in primary care has achieved greater than 92% but remains below other populations.
- Influenza vaccination rates are higher than ever and there is support for Maori and Pacific subsidised vaccination from 55 years.

- Support for older people with long-term conditions and disabilities to remain in their homes for longer.

The surveillance of COVID-19 coordinated through the funder is ongoing. CBACs and primary care are operating at full capacity. MOH funding levels have not been finalised for ongoing COVID-19 work for 2020/21.

For July, the Hutt Valley DHB has a deficit of $1.7m which is $0.2m favourable to budget. Of this deficit $2.2m is in the provider arm services. Activity is 7.79% ahead of that planned. Total FTE are 68 below budget.

Strategic Considerations

Service	Financial performance and funding is a key to delivering the services for the Hutt Valley population.
People	Staff numbers are 68 below plan with additional costs in outsourced personnel if they are employed by CCDHB
Financial	Planned deficit $10.6 million, with no COVID-19 or Holidays Act provision impacts included.
Governance	The committee is accountable for scrutinising the financial and operational performance on behalf of the board, and reporting back to the board on issues as identified by the committee.

Engagement/Consultation

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

Identified Risks

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

Attachment/s

3.2.1 Hutt Valley DHB July 2020 Financial and Operational Performance Report

Monthly Financial and Operational Performance Report

For period ending
30 July 2020

Reported in August 2020

Contents

Section #	Description	Page
❶	Financial & Performance Overview & Executive Summary	
❷	Funder Performance	
❸	Hospital Performance	
❹	Financial Performance & Sustainability	
❺	Additional Financial Information & Updates	

Section 1

Financial and Performance Overview and Executive Summary

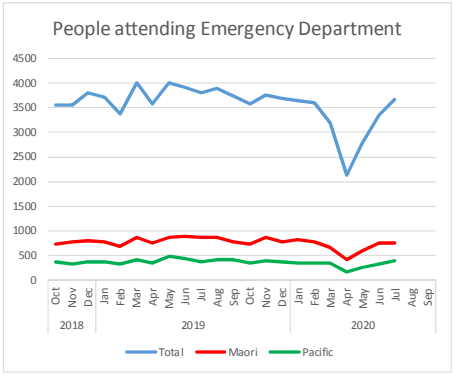
Executive Summary

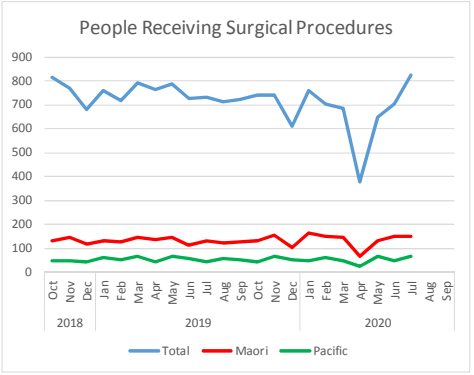
- Activity delivered by the Hutt Valley DHB provider arm - ED attendances, surgical procedures, overall discharges, outpatient and community contacts have returned to pre COVID-19 levels and are consistent with previous years for the month of July.
- There is Ministry of Health commitment to $2.261 million in year one for additional Planned Care Initiative (PCI) funding for HVDHB Improvement Action Plan recovery. We are in discussion with the Ministry about this and a separate initiative including capex funding bid potential. The funding is significantly less than the finances required to close the waiting list ESPI 2 and ESPI 5 gaps. However this is going to be a long slow recovery.
- Strategies to address the Hospital provider arm performance include improved access to assessment beds to free up ED and provide a more positive patient journey, expand the capacity of the Early Supported Discharge team to improve efficiency of discharge planning and "pull" patients home from ED and wards, and addressing delays in the Care coordination pathway. Managers are developing annual leave plans with staff and the CCDM programme will be rolled out for this year.
- Key areas of funder performance include:
  - Maori enrolment in primary care has achieved greater than 92% but remains below other populations
  - Influenza vaccination rates are higher than ever and there is support for Maori and Pacific subsidised vaccination from 55 years
  - Support for older people with long-term conditions and disabilities to remain in their homes for longer
- The surveillance of COVID-19 coordinated through the funder is ongoing. CBACs and primary care are operating at full capacity. MoH funding levels have not been finalised for ongoing COVID-19 work for 2020/21.
- For July, the Hutt Valley DHB has a deficit of $1.7m which is $0.2m favourable to budget. Of this deficit $2.2m is in the provider arm services. Activity is 7.79% ahead of that planned. Total FTE are 68 below budget.

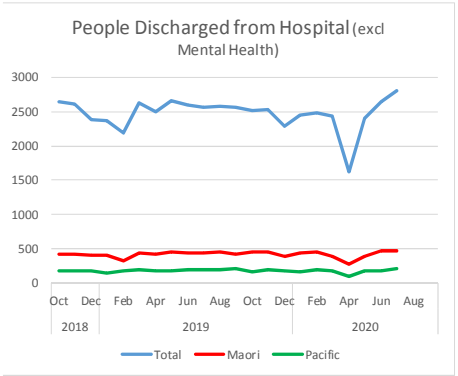
Performance Overview: Activity Context (People Served)

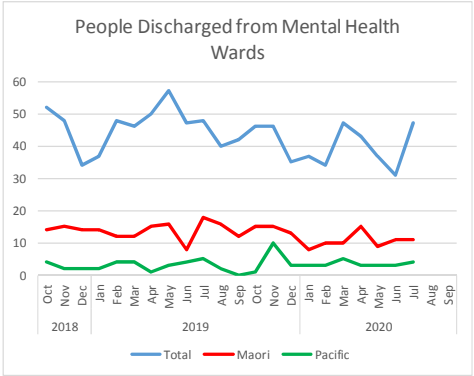
The numbers below count individuals once and are based on Hutt Valley DHB being the DHB of Service. Our services have returned to delivering services to our population without the restrictions due to COVID-19. Services continue to take necessary precautions.

People attending ED	**3,663**	751 Maori, 399 Pacific
People receiving Surgical Procedures	**827**	150 Maori, 64 Pacific
People discharged from Hospital (excl Mental Health)	**2,810**	475 Maori, 215 Pacific
People discharged from Mental Health wards	**47**	11 Maori, 4 Pacific



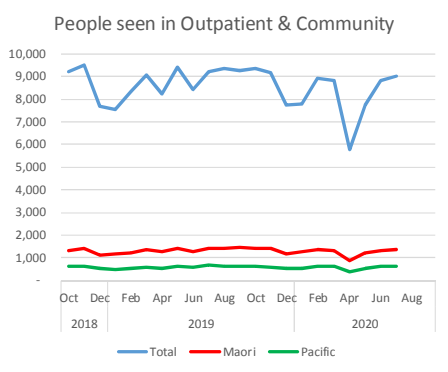


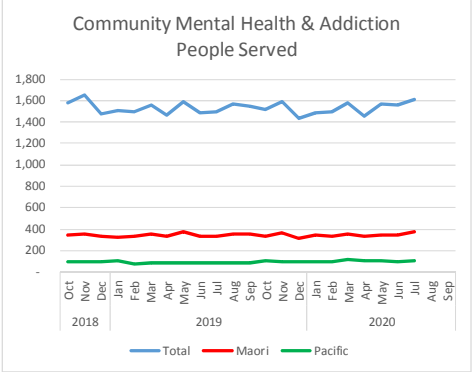


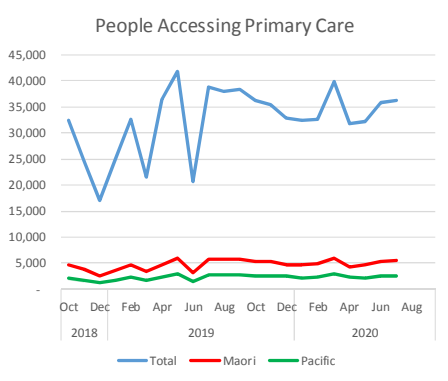


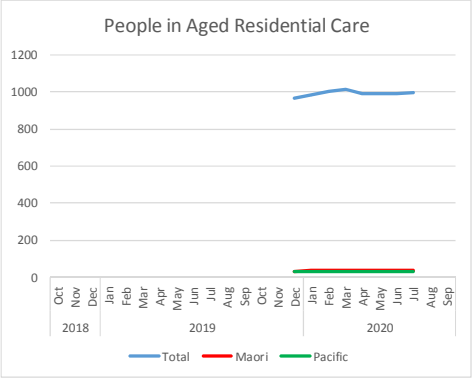
Performance Overview: Activity Context (People Served)

People seen in Outpatient & Community	**9,004** 1,347 Maori, 649 Pacific
Mental Health and Addiction Contacts	**1,607** 370 Maori, 101 Pacific
Primary Care Contacts (shows contacts and the data is 3 months old)	**36,207** 5,414 Maori, 2,516 Pacific
People in Aged Residential Care	**995** 37 Maori, 32 Pacific









Financial Overview – July 2020

YTD Operating Position	YTD Provider Position	YTD Funder Position	YTD Capital Exp
$1.7m deficit	$2.2m deficit	$0.4m surplus	Not available
Against the budgeted deficit of $1.8m.	Against the budget deficit of $1.8m.	Against the budget deficit of $0.1m.	

YTD Activity vs Plan (CWDs)	YTD Paid FTE	Annual Leave Accrual
7.79% ahead	1,997	$21.6m
169 CWDs ahead PVS plan for July. IDFs were 20 CWD above budget for the month	YTD 68FTE below annual budget of 2,065 FTE.	This is an increase of $0.6m on prior period.

Hospital Performance Overview – July 2020

YTD Shorter stays in ED	People waiting >120 days for treatment (ESPI5)	People waiting >120 days for 1st Specialist Assmt (ESPI2)	Faster Cancer Treatment
89.75%	1,086	1,090	100%
6% below the ED target of 95%, 7% below for July 19.	Against a target of zero long waits a monthly movement of -47.	Against a target of zero long waits a monthly movement -147	We achieved the 62 day target. The 31 day target was also achieved 88.2%

YTD Activity vs Plan (CWD)	YTD Standard FTE	Serious Safety Events
7.79% ahead	1,981	3
169 CWDs ahead PVS plan for July. IDFs were 20 CWD above budget for the month	62 below YTD budget of 2,043 FTE. Month FTE was 62 under budget a downwards movement form June of 31 FTE.	An expectation is for nil SSEs at any point.

Section 2

FUNDER PERFORMANCE

Executive Summary – Funder

- Overall the funder has a positive variance of $471k with revenue being slightly behind and most of the underspend driven by an underspend in pharmaceuticals and mental health.
- The overspend in laboratory and capitation investment is expected to return to budget.
- The surveillance of COVID-19 is ongoing. CBACs and primary capacity are operating at full capacity. MOH funding levels have not been finalised for ongoing COVID-19 work in 2020/21 but are behind expected expenditure due to the latest Alert level 2.
- Regional Public Health has returned to ongoing business as usual, but remains ready to respond in the event of an outbreak. Funding sustainability for increased contact tracing capacity is still being reviewed.
- In this report we have also highlighted the below key areas of performance with a focus on our core services and achieving equity.
    - Māori enrolment in primary care and has achieved greater than 92% to improve access to care but remains below the other population. The drive to increase Māori enrolment remains.
    - Engagement with Māori and Pacific whanau needs an approach that maintains high levels of immunisation. There will be a focus on working with the Māori and Pacific team to improve the equity result.
    - Influenza vaccination rates are higher than ever. Driven by greater availability of vaccinations, promotion due to COVID and funding for Māori and Pacific providers to support higher vaccination rates. There is support from our DHBs for Māori and Pacific to be eligible for subsidised vaccination from 55 years rather than 65 years.
    - We are supporting more older people than ever with long-term health conditions and disabilities to remain in their homes for longer. Developing a wider range of services for older people is a current priority.
- The implementation of key whole of system change is progressing slowly at Hutt Valley DHB. New energy will be brought to system transformation as Strategy, Planning and Performance is fully formed.

Funder Financial Statement – July 2020

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

Month					$000s	Year to Date					Annual	
Actual	Budget	Variance	Last Year	Variance		Actual	Budget	Variance	Last Year	Variance	Budget	Last Year
					Revenue							
37,970	37,970	0	34,735	3,235	Base Funding	37,970	37,970	0	34,735	3,235	455,637	416,816
2,435	2,341	94	3,076	(642)	Other MOH Revenue	2,435	2,341	94	3,076	(642)	28,090	38,006
(37)	36	(73)	437	(474)	Other Revenue	(37)	36	(73)	437	(474)	427	619
9,171	9,229	(57)	8,512	660	IDF Inflows	9,171	9,229	(57)	8,512	660	110,742	102,280
49,539	**49,575**	**(36)**	**46,760**	**2,779**	**Total Revenue**	**49,539**	**49,575**	**(36)**	**46,760**	**2,779**	**594,895**	**557,721**
					Expenditure							
416	416	0	383	(33)	DHB Governance & Administration	416	416	0	383	(33)	4,987	4,597
20,861	21,033	172	20,017	(844)	DHB Provider Arm	20,861	21,033	172	20,017	(844)	252,577	241,131
					External Provider Payments							
2,864	3,285	421	3,622	758	Pharmaceuticals	2,864	3,285	421	3,622	758	38,866	37,365
4,637	4,369	(268)	4,232	(405)	Laboratory	4,637	4,369	(268)	4,232	(405)	52,424	50,903
2,704	2,541	(163)	2,532	(173)	Capitation	2,704	2,541	(163)	2,532	(173)	30,495	29,563
1,256	1,235	(21)	885	(371)	ARC-Rest Home Level	1,256	1,235	(21)	885	(371)	14,543	11,877
1,865	1,920	55	1,603	(262)	ARC-Hospital Level	1,865	1,920	55	1,603	(262)	22,604	19,154
2,674	2,688	14	2,491	(183)	Other HoP	2,674	2,688	14	2,491	(183)	32,354	35,108
915	1,081	166	762	(153)	Mental Health	915	1,081	166	762	(153)	13,045	9,580
452	482	30	743	291	Palliative Care / Fertility / Comm Radiology	452	482	30	743	291	5,782	5,788
1,371	1,429	58	1,417	47	Other External Provider Payments	1,371	1,429	58	1,417	47	17,420	19,247
9,106	9,151	45	8,416	(690)	IDF Outflows	9,106	9,151	45	8,416	(690)	109,807	101,298
0	0	0	15	15	Provision for IDF Wash-ups	0	0	0	15	15	0	0
49,121	**49,628**	**507**	**47,118**	**(2,003)**	**Total Expenditure**	**49,121**	**49,628**	**507**	**47,118**	**(2,003)**	**594,905**	**565,610**
418	**(53)**	**471**	**(358)**	**775**	**Net Result**	**418**	**(53)**	**471**	**(358)**	**775**	**(9)**	**(7,889)**

There may be rounding differences in this report

Funder Financials – Revenue

Revenue:

- Revenue is made up of base funding, other MOH revenue, other revenue and inter district flows. The table shows the variance for other MOH revenue.
- Base Funding on target for the month.
- Other MOH revenue is favourable $94k for July, driven by Capitation Funding.
- Other revenue is unfavourable ($73k) for the month, reflecting the reclassification of a prior year accrual.
- IDF inflows are ($57k) unfavourable for the month.

Other MOH Revenue Variance	MTH $000's	YTD $000's
In- Between Travel	16	16
Capitation Funding	146	146
COVID-19 Funding	(38)	(38)
Crown funding agreements		
Other CFA contracts	30	30
Year to date Variance $000's	**94**	**94**

Expenditure:

Governance and Administration are on budget. Provider Arm payments are favourable $172k for the month, mostly related to IDF wash-up payments.

External Provider Payments:

Pharmaceutical costs are favourable $421k for the month. This is expected to be close to budget as the year progresses.

Laboratory costs are unfavourable ($268k) for the month, this is expected to reverse as the year progresses.

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

Aged residential care costs are $34k favourable for the month.

Other Health of Older People costs are favourable by $14k for the month.

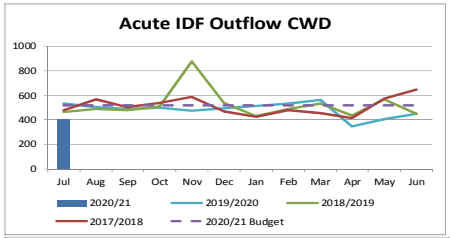
Mental Health costs are favourable $166k for the month reflecting timing of contracts.

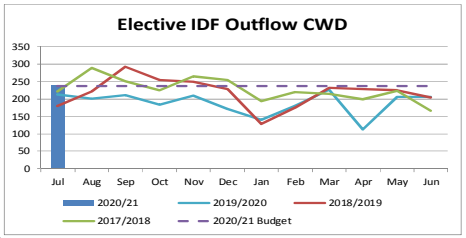
Palliative Care, Fertility and Community Radiology costs are favourable by $30k for the month.

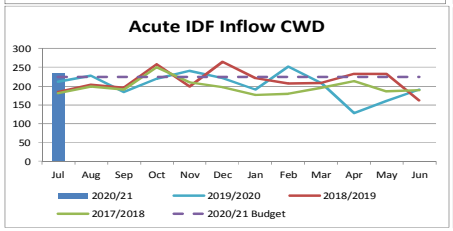
Other external provider costs are favourable to budget $58k for the month.

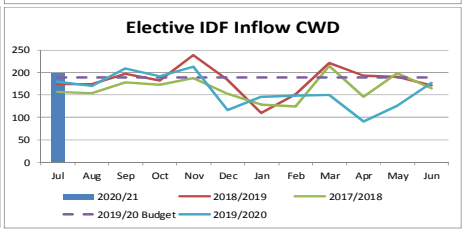
IDF Outflows are favourable $45k, due to Community Pharmacy Wash-up payments.

Inter District Flows (IDF)









IDF Wash-ups and Service Changes Jul 2020		
IDF Outflows $000s	Variance to budget	
	Month	YTD
Base	(0)	(0)
	-	-
Washups		
2019/20 Community Pharmacy	45	45
2019/20 Inpatients	0	0
2019/20 ATR	0	0
2019/20 Non Casemix	-	-
19/20 PCT	-	-
19/20 PHO	-	-
Current year ATR	-	-
	-	-
Rounding (timing) differences	-	-
IDF Outflow variance	**45**	**45**

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 under budget YTD by ($57k), mainly due to other services. This result is likely to change as data is updated. Services have been implementing recovery plans since June to catch up after COVID-19 restrictions.

IDF Outflow (expense):

- Based on the data available, overall IDF outflows are under budget by $45k year to date. This result is likely to change as data is updated. We have one baby currently in Capital & Coast DHB who has had a long stay and is expected to cost at least $300k.

Primary Care Update

What is this measure?

- Target: 90% of Māori are enrolled in a PHO

Why is this important?

- Primary health organisations (PHOs) ensure the provision of essential primary health care services, mostly through general practices, to their enrolled population. People enrolled with a PHO gain the benefits associated with belonging to a PHO, which can include reduced cost for doctors' visits and prescription medicines.

How are we performing?

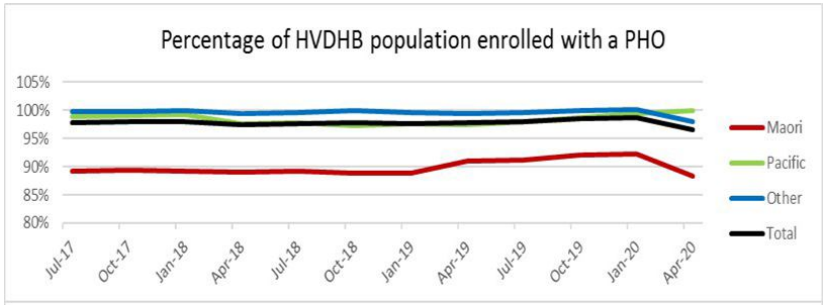
- 96% of HVDHB's estimated population are enrolled with a PHO either in Hutt Valley DHB or elsewhere, however Maori is lower. 24,383 Maori people (92%) were enrolled in Jan 2020 however the percentage decreased in Apr 2020 mainly due to an estimated increase in population.
- All Pacific peoples living in HVDHB are enrolled with a PHO, compared to 98% of non-Māori, non-Pacific peoples.

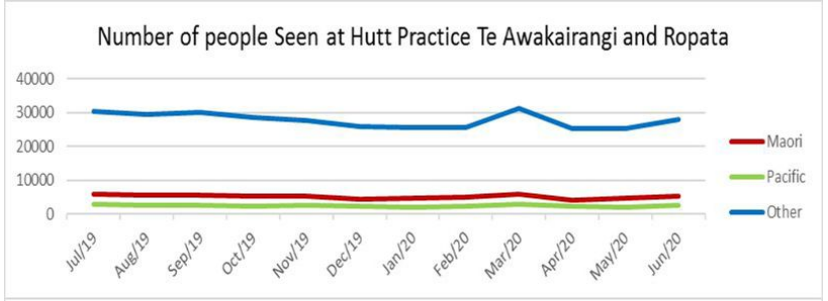
What is driving performance?

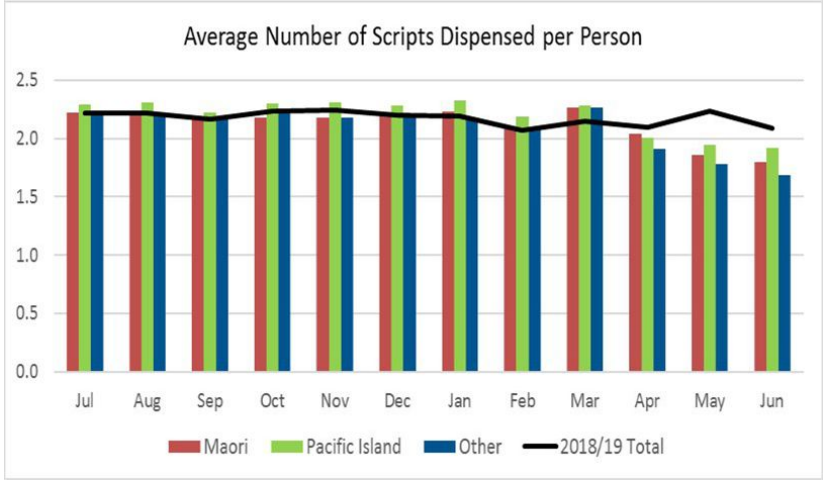
- Prior to lockdown in March, there was sharp increase in the number of people accessing primary care. This activity returned to previous levels during and after lockdown. The numbers of Māori and Pacific accessing primary care have begun to rise slightly, and Other more so.
- In March 2020, there was an increase in the number of prescriptions being dispensed by Pharmacies compared to the same time last year. The drop in scripts after March showed that the COVID-19 lockdown had a protective effect with less people picking up other infectious diseases and going less to ED. Maori and Pacific have continued to receive more scripts on average than people of other ethnicities

Management comment

- The priority focus is on access to pharmaceuticals , improving access to primary care and ensuring Māori remain engaged in primary care.







Immunisation Coverage

What is this measure?

- MOH Target: 95% of children at eight months, 2 years and 5 years of age are fully immunised

How are we performing?

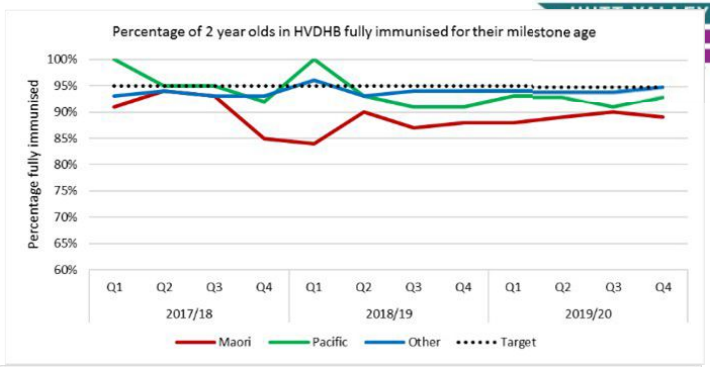
- The percentage of babies that were fully immunised at 8 months old has shown improvement in the second half of 19/20 compared to the first half of 19/20. Maori coverage remains lowest at 85%.
- Maori 2 year old immunisation coverage reached 90% (Q3 2019/20) but has decreased slightly. Pacific have been on average 93% in 2019/20 while other ethnicity groups reached the national target in Q4 19/20.
- Maori and Pacific coverage at age 5 years dropped to 85% since Q3 1819. Other ethnic groups has remained at 90%

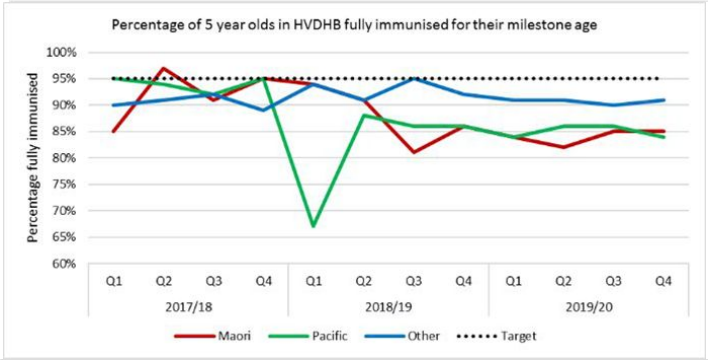
What is driving performance?

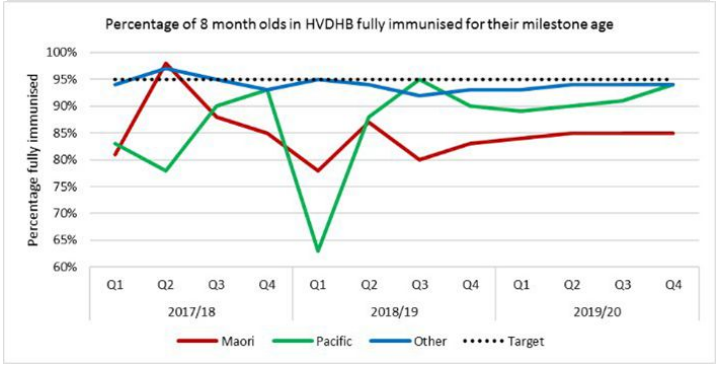
- Engagement with Maori and Pacific whanau needs an approach that maintains high levels of immunisation. This is being developed through the first 1000 days project.
- Greater focus is required in this area.

Management comment

- There will be a focus on working with the Maori and Pacific team to improve the equity result.







Influenza Vaccination Coverage

What is this measure?

- MoH Target: Percentage of eligible population aged 65 years and over immunised against influenza

Why is this important?

- Increasing influenza immunisation reduces influenza-related morbidity and mortality. The indicator of influenza at age 65 years was selected because those aged 65 years and over have the highest rates of hospital admissions for influenza-related severe acute respiratory infections (other than those aged under 5 years). Māori or Pacific people are two to five times more likely to be admitted to hospital for influenza-related severe acute respiratory infections than other ethnicities (ESR. Influenza Surveillance in New Zealand 2015).
- With the COVID-19 pandemic, it was recommended that people received their influenza immunisation for additional protection against infection and to reduce burden on acute health services

How are we performing?

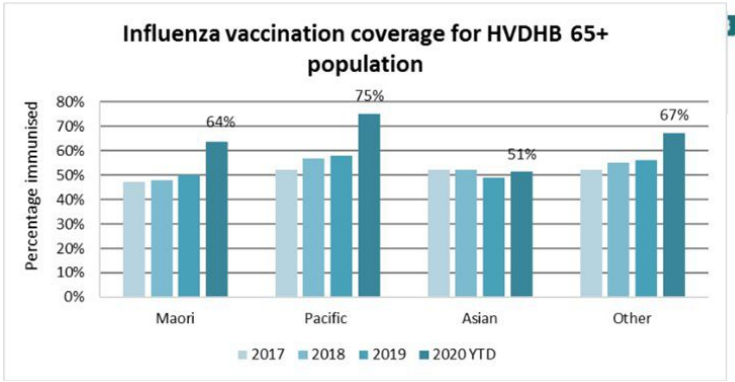
- As at June, 66% of people aged 65+ were immunised, much higher than 55% in 2019. 64% Maori and 75% Pacific older people were immunise much higher than the previous year
- The number of people receiving their immunisation at Pharmacies increased significantly during COVID-19 lockdown March and April. Of our own workforce 76% are immunised

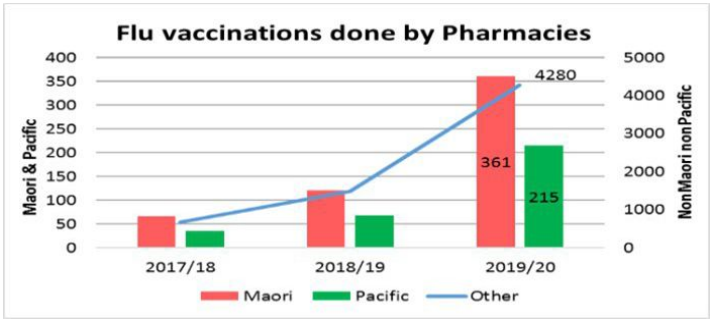
What is driving performance?

- People followed advice during COVID-19 lockdown to be immunised. Funding for Maori and pacific organisations to improve vaccination rates. Immunisations were released earlier by PHARMAC in response to COVID-19 More people went to their Pharmacy to get immunised especially during COVID-19 lockdown March – April as an alternative to their GP practice

Moving forward

- Identifying how to maintain Maori and Pacific vaccinations in 2021 and seek support to reduce the age of eligibility for Maori and Pacific. This requires a PHARMAC decision.





% of HVDHB staff immunised as at Jun 2020	
Nurses	84%
Doctors	75%
Midwives	51%
Allied Health Staff	70%
HCA	68%
Other	76%
Total	**76%**

Health of Older & Frail People

What is this measure?

- DHB Target: % of older people living in own home

Why is this important?

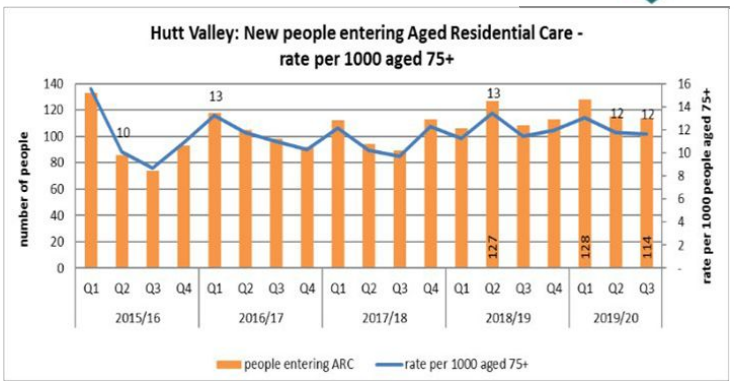
- We are supporting more people than ever with long-term health conditions and disabilities to remain independent in their homes for longer.
- We support models of care that allow older people to maintain their independence, staying healthier for longer with a better quality of life.

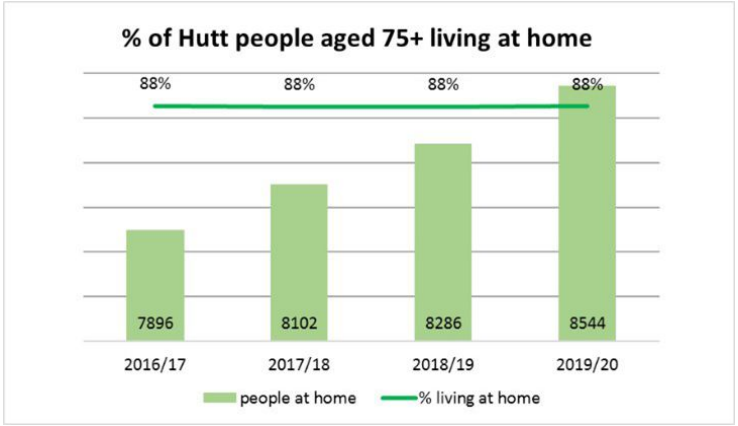
How are we performing?

- An estimated 9,740 people aged 75+ years live in Hutt Valley DHB; 88% live at home. There were 1,196 clients in Aged Residential Care facilities as at March 2020.
- The number of people entering ARC has remained steady in 2018/19 and 2019/20. People are supported to stay healthier and stay at home safely for longer delaying their entry to ARC.
- On average 116 Hutt people entered ARC or 12 per 1000 people aged 75+ in 2018/19 – 2019/20 Q3
- On average, 1156 Hutt people received Home support in Jan-Mar 2020. This dropped during COVID-19 lockdown as the service prioritised essential services to the most frail. HCSS providers delivered on average 6327 rostered home visits per week during April –May COVID-19 level 4 lockdown
- 456 people caring for their frail older family member received support through day programmes, carer support and overnight respite.

What is driving performance?

People are choosing to stay home longer and with more complex conditions because they see that this is possible. Community services such as Home & Community Support services provide support for frail older people to stay home safely and independently and delay entry into aged residential care. Primary Care and DHB services support older people to manage their long term conditions.





Section 3

Hospital Performance

Executive Summary – Hospital Performance

- Activity delivered by the Hutt Valley DHB provider arm - ED attendances, surgical procedures, overall discharges, outpatient and community contacts have returned to pre COVID-19 levels and are consistent with previous years for the month of July.
- The proportion of patients who were admitted from ED in July was higher than budget and the same time last year for the second month in a row. Theatre visits and non-theatre procedures for July were higher than budget as services implement recovery plans after COVID-19 restrictions. Bed days were higher than budget in July but lower than the same time last year. Inpatient ALOS in July was lower than budget and the same time last year. The acute readmission rate is lower lower year to date. Operationally this has meant a busy month across the hospital drawing on additional resources.
- July was an improved month for theatre elective volume. The number of patients waiting more than 120 days for treatment has marginally decreased from last month, likewise we have made inroads into the number of people waiting more than 120 days for assessment. PCI volumes for 2020-2021 have been approved by MOH. There is MOH commitment for $2.261 million in year one of additional PCI funding for HVDHB Improvement Action Plan recovery and we are in discussion with MOH about this and separate initiative and capex funding bid potential. The funding is significantly less than the finances required to close the waiting list ESPI 2 and ESPI 5 gaps. However this is going to be a long slow recovery.
- Three serious Safety events were recorded for the month – these are being reviewed in line with our sentinel event processes.
- The Hospital provider arm is $400K unfavourable to budget – this is driven by personal costs in excess of both Nursing, Allied Health and Support staff and treatment related. The trend for patient activity and acuity and the impact of increasingly older, frailer and more complex patients/increasing one to one care, treatment related costs such as drug, treatment disposables, implants and prostheses have increased above our well ahead of plan for July. Another negative contributor is increasing accrued annual leave.
- Strategies to address the Hospital provider arm performance include improved access to assessment beds to free up ED and provide a more positive patient journey, expand the capacity of the Early Supported Discharge team to improve efficiency of discharge planning and “pull” patients home from ED and wards, and addressing delays in the Care coordination pathway. Managers are developing annual leave plans with staff and the CCDM programme will be rolled out for this year.

Hospital Throughput

Month					Hutt Valley DHB Hospital Throughput YTD Jul-20	Year to Date					Annual	
Actual	Budget	Variance Actual vs Budget	Last year	Variance Actual vs Last year		Actual	Budget	Variance Actual vs Budget	Last year	Variance Actual vs Last year	Annual Budget	Last year
					Discharges							
1,284	1,068	(216)	1,079	(205)	Surgical	1,284	1,068	(216)	1,079	(205)	12,950	12,797
1,876	1,668	(208)	1,940	64	Medical	1,876	1,668	(208)	1,940	64	20,240	19,506
513	410	(103)	469	(44)	Other	513	410	(103)	469	(44)	4,871	5,474
3,673	**3,145**	**(528)**	**3,488**	**(185)**	**Total**	**3,673**	**3,145**	**(528)**	**3,488**	**(185)**	**38,061**	**37,777**
					CWD							
851	1,162	311	1,181	330	Surgical	851	1,162	311	1,181	330	13,889	12,852
867	1,075	208	1,092	225	Medical	867	1,075	208	1,092	225	12,225	11,991
508	362	(145)	454	(54)	Other	508	362	(145)	454	(54)	4,305	4,698
2,225	**2,599**	**374**	**2,727**	**502**	**Total**	**2,225**	**2,599**	**374**	**2,727**	**502**	**30,419**	**29,540**
					Other							
4,039	4,140	101	4,250	211	Total ED Attendances	4,039	4,140	101	4,250	211	48,696	47,491
1,068	1,044	(24)	1,012	(56)	ED Admissions	1,068	1,044	(24)	1,012	(56)	11,386	11,847
862	769	(93)	770	(92)	Theatre Visits	862	769	(93)	770	(92)	9,370	9,271
157	137	(20)	149	(8)	Non- theatre Proc	157	137	(20)	149	(8)	1,500	1,891
7,580	7,034	(545)	7,687	107	Bed Days	7,580	7,034	(545)	7,687	107	82,873	85,515
4.33	4.50	0.17	4.46	0.13	ALOS Inpatient	4.33	4.50	0.17	4.46	0.13	4.50	4.29
1.97	2.18	0.21	2.21	0.24	ALOS Total	1.97	2.18	0.21	2.21	0.24	2.18	2.20
7.23%	8.02%	0.79%	7.68%	0.45%	Acute Readmission	7.23%	8.02%	0.79%	7.68%	0.45%	7.31%	7.36%

For the month of July, Medical and Surgical discharges were over budget but caseweights may increase as the coding process is completed. Other services had higher discharges and caseweights than budget.

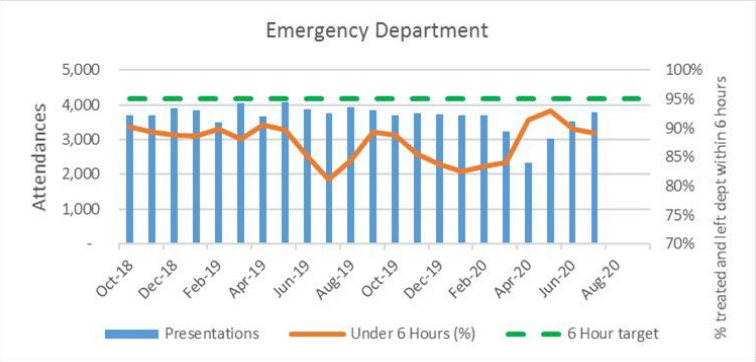
ED volumes for the month were lower than budget and lower than the same time last year. The proportion of patients who were admitted from ED in July (26%) was higher than budget and the same time last year. Theatre visits and non-theatre procedures for July were higher than budget as services implement recovery plans after COVID-19 restrictions. Bed days were higher than budget in July but lower than the same time last year. Inpatient ALOS in July was lower than budget and the same time last year. The acute readmission rate is lower than plan.

Operational Performance Scorecard – Period July 2019- July 2020

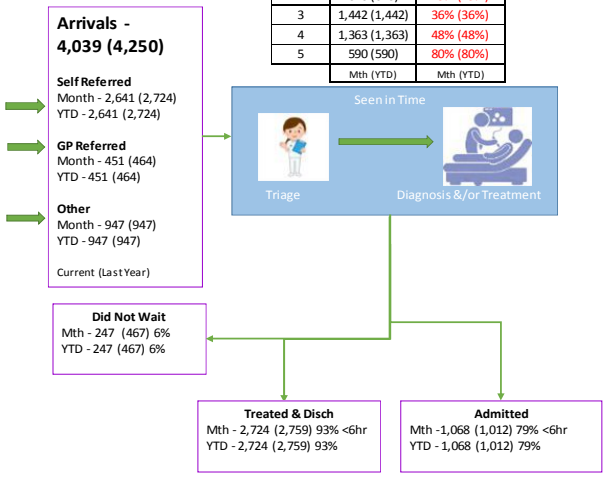
			13 Months Performance Trend													Last Four Weeks			
Domain	Indicator (MoH KPIs highlighted yellow)	2019/20 Target	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	6/07/20	13/07/20	20/07/20	27/07/20
Safe	Serious Safety Events[1]	Zero SSEs	2	4	1	6	3	0	1	4	1	2	2	2	3				
	SABSI Cases [2]	Zero	0	0	0	0	0	0	1	0	0	0	0	0	0				
	C. difficile infected diarrhoea cases	Zero	1	2	1	2	2	1	2	2	4	0	2	0	2				
	Hand Hygiene compliance (quarterly)	≥ 80%	86%			84%			83%			87%							
	Seclusion Hours- average per event (MH Inpatient ward TWA)[3]		25.3	0.0	14.5	81.0	126.8	36.4	21.8	14.0	31.1	39.1	16.3	13.8	27.7				
Patient and Family Centred	Complaints Resolved within 35 calendar days[4]	≥90%																	
	Patient reported experience measure[5] (quarterly)	≥80%	85.3%			N/a			N/a			N/a							
Timely	Emergency Presentations	49,056	4,251	4,348	4,166	4,054	4,239	4,133	4,053	4,028	3,558	2,405	3,104	3,721	4,039	832	881	968	955
	Shorter Stays in ED (SSiED) % within 6hrs	≥95%	81.2%	84.4%	89.3%	88.7%	84.6%	83.7%	82.6%	83.5%	83.9%	91.4%	93.0%	89.9%	89.2%	92.5%	89.8%	89.1%	82.6%
	SSiED % within 6hrs - non admitted	≥95%	88.6%	90.4%	94.1%	92.7%	90.1%	90.9%	89.5%	90.1%	90.1%	95.7%	97.0%	94.7%	93.3%	95.6%	93.9%	92.7%	89.3%
	SSiED % within 6hrs - admitted	≥95%	61.0%	67.9%	75.2%	77.7%	71.0%	64.5%	63.1%	64.4%	66.6%	81.1%	82.4%	76.1%	78.6%	84.6%	80.8%	79.3%	63.8%
	Total Elective Surgery Long Waits -ESPI 5	Zero Long Waits	227	275	304	435	535	625	726	719	821	1,013	1,079	1,130	1,086	1,135	1,131	1,080	1,035
	No. Theater surgeries cancelled (OP 1-8)		180	143	162	169	137	116	134	98	194	50	72	98	143	36	19	38	33
	Total Elective & Acute Operations in MainTheatres 1-8[6]		770	752	744	788	769	664	784	743	704	389	673	733	862	204	183	189	170
	Specialist Outpatient Long Waits- ESPI 2	Zero Long Waits	466	495	571	594	637	895	1,136	1,194	1,265	1,372	1,365	1,226	1,090	1,253	1,234	1,147	1,076
	Outpatient Failure to Attend %	≤6.3%	7.2%	6.3%	6.6%	6.8%	6.9%	7.6%	7.1%	7.6%	6.9%	6.1%	7.4%	8.2%	6.7%	6.4%	5.8%	7.7%	5.6%
	Full Year Forecast surplus / (deficit) $m - Provider (1) (2)	($2.03)	($2.03)	($2.03)	($4.48)	($6.90)	($5.21)	($5.21)	($6.57)	($8.19)	($10.37)	($13.04)	($13.59)	($14.20)	TBC					
	Full Year Forecast surplus / (deficit) $m - DHB (1) (2)	($8.14)	($8.14)	($8.14)	($8.97)	($8.14)	($8.58)	($8.58)	($8.76)	($10.39)	($13.04)	($14.64)	($15.64)	($21.45)	TBC					
	% Theatre utilisation (Elective Sessions only)[7]	≤90%	88.1%	88.5%	87.9%	87.1%	86.5%	85.5%	87.9%	89.6%	86.4%	74.5%	85.2%	87.6%	84.9%	84.1%	85.6%	86.6%	82.9%
	Overnight Patients - Average Length of Stay (days)	≤4.3	4.46	4.38	4.36	4.82	4.52	4.37	4.34	4.35	5.31	4.90	4.26	4.44	4.40	4.29	3.83	4.95	4.59
	Long Stay Patients Not Yet Discharged (>14 days)	≤5	15	14	21	13	10	23	15	16	7	12	15	14	16	10	10	11	21
	Overnight Beds (General Occupancy) - Average Occupied	≤130	139	140	140	135	138	137	131	136	129	105	118	136	141	128	140	148	153
	Overnight Beds (General Occupancy) - % Funded Beds Occupied	≤85%	86.1%	85.9%	86.2%	87.9%	89.5%	89.0%	87.2%	88.2%	79.5%	65.1%	73.1%	84.2%	86.8%	79.3%	86.4%	91.1%	94.2%
	All Beds - ave. beds occupied[8]	≤250	248	253	250	242	244	232	231	244	223	179	207	241	245	230	247	249	248
	% sick Leave v standard	≤3.5%	4.0%	3.9%	3.7%	3.5%	2.9%	2.7%	2.0%	2.5%	3.6%	7.5%	6.9%	3.1%	4.3%				
	% Nursing agency v employee	≤1.49%	2.3%	2.0%	3.8%	2.6%	2.3%	1.7%	3.9%	3.0%	2.6%	2.3%	3.3%	2.0%	TBC				
	% overtime v standard (medical)	≤9.22%	7.6%	9.6%	7.4%	8.7%	11.2%	5.9%	11.6%	9.3%	7.6%	9.2%	9.7%	9.2%	TBC				
	% overtime v standard (nursing)	≤5.47%	12.9%	12.6%	12.8%	12.4%	13.8%	11.5%	17.9%	14.1%	10.6%	13.2%	12.6%	12.3%	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	28 (28)	100% (100%)
2	616 (616)	49% (49%)
3	1,442 (1,442)	36% (36%)
4	1,363 (1,363)	48% (48%)
5	590 (590)	80% (80%)
	Mth (YTD)	Mth (YTD)

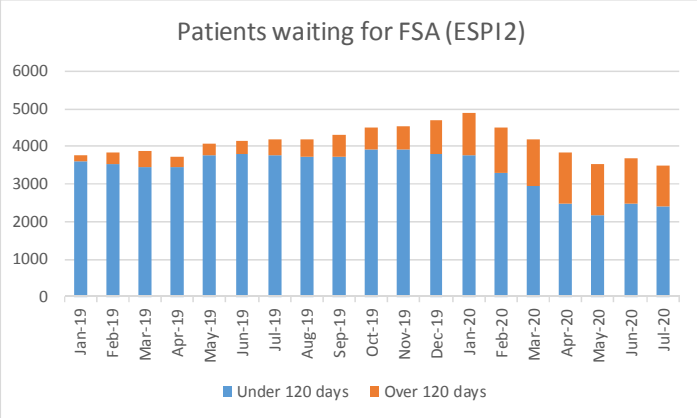


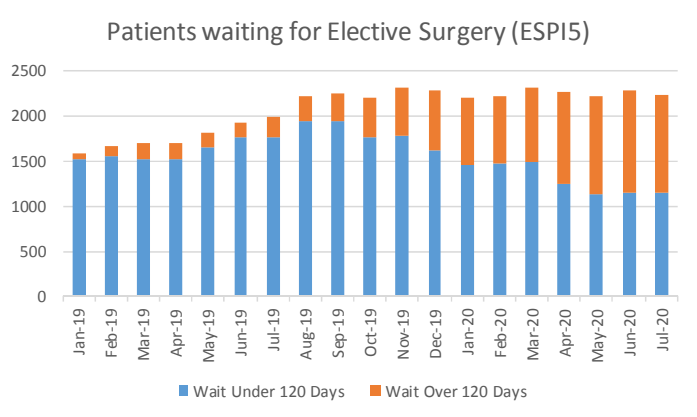
- **What is this Measure**
  - The percentage of patients admitted, discharged and transferred from an Emergency Department within 6 hours.
- **Why is it important**
  - This indicator measures flow through the whole system it is impacted by the number of people arriving at ED, how fast ED treats them, availability of beds in the hospital and community service availability.
- **How are we performing**
  - Performance of the target improved during April with lower numbers through the ED however then dropped further in July to 89%.
- **What is driving Performance**
  - A higher volume of presentations and people being admitted to the hospital has driven the performance down. Admissions from ED to general medicine and general surgery are more likely to wait longer
  - Delays in the Care coordination pathway - overall referral numbers, both in the community and from hospital, are higher than corresponding months in previous years, and have an increased level of complexity. A stock take at the end of July showed 18 patients waiting at various stages of assessment, clients / family to determine a facility, no legal framework to support entry to residential care (whether permanent or short term care) as inpatients across medical and elderly services. This drives bed access issues, nursing costs and quality of care.
- **Management Comment**

The following work streams are being rolled out:

- MAPU – from 8 July, we have rolled out Medical, General Surgery and Gynaecology admissions to MAPU. This gives access for more services to use these assessment beds to free up ED and provide a more positive patient journey. June was our busiest month in MAPU ever and July continued in the same way. The new model is embedding well.
- The Early Supported Discharge team continues to work from MAPU, and is now integrated with community allied health and older peoples services. Patients can be seen at home within 4 hours of discharge by the District Nursing and short-term home and community support services. Next steps planned are to expand the capacity of the ESD team, improve efficiency of discharge planning and "pull" patients home from ED and wards, and implement hospital avoidance and prevention strategies in the community.
- A key focus area is the Care coordination pathway – a rapid improvement process supported by project resources is in development to remove any barriers that can be addressed – this will be updated next month.

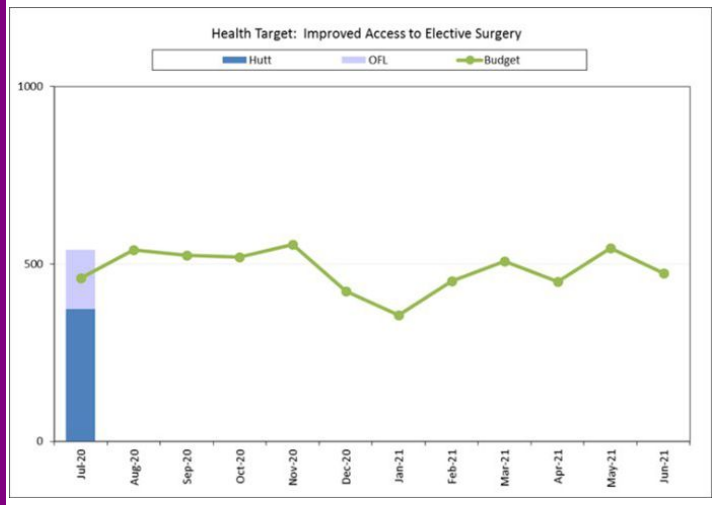
Waiting times - Planned Care





- **What is this measure?**
  - The delivery of Specialist assessments or Treatment within 120 days
- **Why is it important?**
  - It is important to ensure patients receive care at the most appropriate time to support improved health.
- **How are we performing?**
  - The total waiting for an FSA has reduced this month along with the number waiting over 120 days
  - The number waiting for elective surgery fell by 39 to 2,236 and the number waiting over 120 days fell by 47 to 1,086
- **What is driving performance?**
  - A number of staffing issues and the close down during the COVID-19 lock down have resulted in an increase in patients waiting
- **Management Comment**
  - July was an improved month for theatre elective volume; the number of patients waiting more than 120 days for treatment has marginally decreased from last month, likewise we have made inroads into the number of people waiting more than 120 days for assessment. However this is going to be a long slow recovery.
  - We are exploring a number of innovations to address i) the Orthopaedic FSA waiting list and ii) the elective surgical waiting list with support and expertise being shared across the two DHBs.

Planned Care – Inpatient discharges and Minor procedures

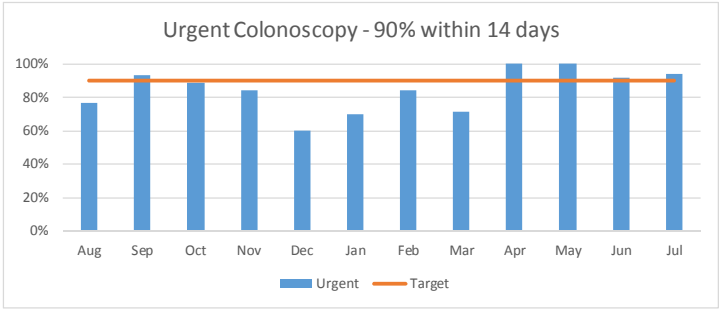


- **What is this measure?**
  - The delivery of an agreed number of inpatient surgical discharges and minor procedures to the Hutt Valley Population
- **Why is it important?**
  - It is important to ensure patients are receiving the planned care procedures required.
- **How are we performing?**
  - Phasing of budgets are not yet confirmed with the Ministry of Health however we are over the draft volumes submitted
  - Minor procedures exceeded target
- **What is driving performance?**
  - A number of staffing issues and the close down during the COVID-19 lock down have resulted in an increase in patients waiting
  - There continued to be a number of minor procedures completed during the lockdown both in the hospital and community
- **Management Comment**
  - July planned care target was met reflecting significant work undertaken by the clinical and booking Teams over the month.
  - We continue working with our SMO's to schedule surgery and utilising private providers to reduce our surgical waiting list. Based on those with greatest clinical urgency and risk of deterioration.
  - PCI volumes for 2020-2021 have been approved by MoH. There is MOH commitment to $2.261 million in year one additional PCI funding for HVDHB Improvement Action Plan recovery and we are in discussion with the Ministry about this and separate initiative and capex funding bid potential. The funding is significantly less than the finances required to close the waiting list ESPI 2 and ESPI 5 gaps.
  - Capex proposal for procedure suite build in 2020-2021 is in development to Board next month. The Suite will cover off i) deliver minor procedures under LA outside of main OT ii) support us to deliver greater volumes of complex elective surgery in main OT in replacement of minor procedures iii) Plastics Service significant clinical risks (as presented in May 2020 to the Board) (iv) maintain our strategy of increasing access for acute surgery to reduce bed block.

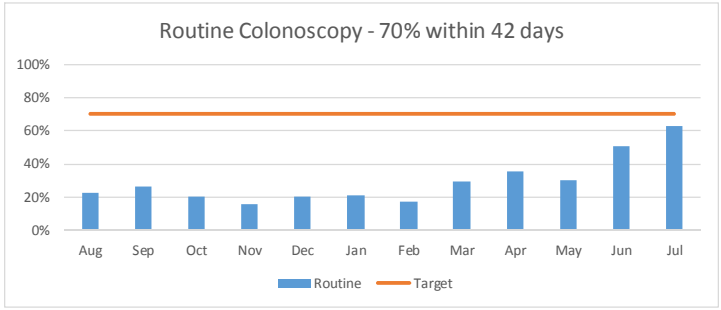
CT & MRI wait times

- **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 continues to increase.
  - CT wait times remain close to target although performance fell a little in July.
- **What is driving performance?**
  - There is insufficient staffing capacity to meet demand. and Some level of reduced capacity will continue for the foreseeable future but is difficult to model with confidence.
- **Management comment**
- We are also supporting CCDHB by scanning all Hutt Valley domicile patients even if they are under care at CCDHB.
- Actions currently underway:
  - Working with Strategy Planning & Performance and HVDHB to maximise and plan best outsourcing approach moving forwards in light of radiologist shortages.
  - Maximise opportunities in the Radiology workforce to extend “elective” hours to weekends – Currently discussing with staff and unions
  - Reviewing current workflow within Radiology to maximise flexibility of bookings and acute imaging response.

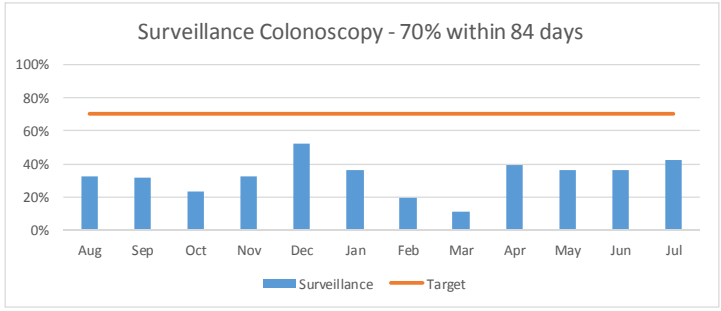
Colonoscopy Wait Times



Urgent
94% YTD



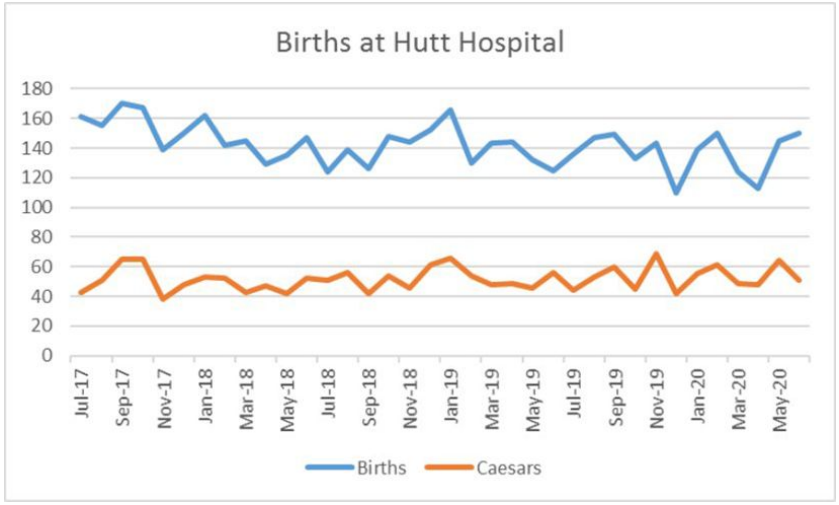
Routine
63% YTD

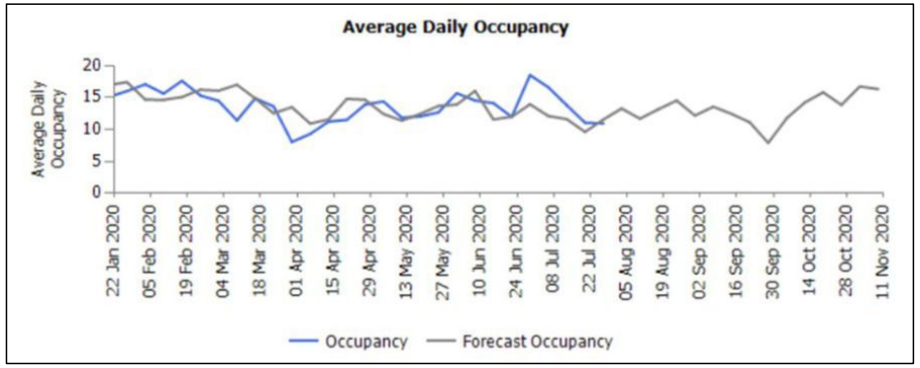


Surveil
42% YTD

- **What is this measure?**
  - The delivery of Colonoscopy, urgent within 14 days, routine 42 days and surveillance within 84 days of being due.
- **Why is it important?**
  - Delayed diagnostic results can negatively affect health outcomes.
- **How are we performing?**
  - We are close to meeting the urgent colonoscopy target however we continue to struggle with both routine and surveillance
- **What is driving performance?**
  - There is insufficient staffing capacity to meet demand. Some level of reduced capacity will continue for the foreseeable future but this is difficult to model with confidence.
- **Management comment**
  - We have recruited 2 additional SMO's to assist with the number of procedure lists per week. A Fellow has also been employed for 6 months (June – December 2020).
  - Covid-19 has resulted in a reduction of new referrals which has enabled our lists to be booked with additional surveillance patients.
  - We are still investigating a nurse endoscopist to provide further procedure lists without the increase in clinics or other SMO work that is not required at present.
  - We are making inroads into the waiting lists and we are tracking in line with our production plan.

Maternity





- **What is the issue?**
  - In 2019 a number of clinical and community concerns around Hutt hospital's maternity services were identified.
- **Why is it important?**
  - An external review of the service and HDC investigations showed a number of areas where improvements needed to be made.
- **How are we performing?**
  - We are receiving an increase in positive feedback from women using our maternity service
  - The number of births at Hutt hospital remained relatively stable
  - The Caesarian rate for the 12 months to June 2020 was an average of 39% which is an increase on the previous 12 months average of 38%. During alert level 4 and 3 less caesarean sections were done and this change in practice reduced high risk surgical intervention during the pandemic.
  - Bed Occupancy rose in June but fell towards the end of July
- **Management comment**
  - Concept plans and costings have been completed for the single stage business case to upgrade maternity and special care baby unit facilities.
  - The Ministry of Health Manager for infrastructure investment projects visited the maternity facility and provided advice on the business case which is on track for a final draft to the CEO before 18 August.
  - The Ministry require the final business case on 1 September.
  - Our maternity hui on 23 July was well attended with positive feedback.
  - Progress continues to be made to meet the review recommendations.

Section 4

Financial Performance & Sustainability

Summary the Financial Performance for July 2020

Month					Hutt Valley DHB Operating Report for the month of July 2020	Year end Result					Annual		
Actual	Budget	Variance	Last Year	Variance	$000s	Actual	Budget	Variance	Last Year	Variance	Budget	Last Year	
					Revenue								
40,404	40,313	92	37,811	2,593	Devolved MoH Revenue	40,404	40,313	92	37,811	2,593	483,750	454,822	
1,998	1,624	374	1,651	348	Non Devolved MoH Revenue	1,998	1,624	374	1,651	348	20,049	19,272	
596	575	21	619	(24)	ACC Revenue	596	575	21	619	(24)	7,219	6,457	
604	530	74	972	(368)	Other Revenue	604	530	74	972	(368)	6,309	6,074	
9,171	9,229	(57)	8,512	660	IDF Inflow	9,171	9,229	(57)	8,512	660	110,742	102,288	
472	303	169	295	178	Inter DHB Provider Revenue	472	303	169	295	178	3,637	4,507	
53,246	**52,573**	**673**	**49,860**	**3,386**	**Total Revenue**	**53,246**	**52,573**	**673**	**49,860**	**3,386**	**631,707**	**593,420**	1
					Expenditure								
					Employee Expenses								
5,367	5,498	131	5,140	(227)	Medical Employees	5,367	5,498	131	5,140	(227)	63,312	60,010	
6,968	6,759	(209)	6,167	(801)	Nursing Employees	6,968	6,759	(209)	6,167	(801)	76,768	75,339	
2,929	2,982	53	2,600	(330)	Allied Health Employees	2,929	2,982	53	2,600	(330)	34,601	32,175	
832	723	(109)	813	(19)	Support Employees	832	723	(109)	813	(19)	8,330	8,676	
2,735	2,716	(18)	2,683	(52)	Management and Admin Employees	2,735	2,716	(18)	2,683	(52)	30,876	28,166	
18,831	**18,679**	**(153)**	**17,403**	**(1,428)**	**Total Employee Expenses**	**18,831**	**18,679**	**(153)**	**17,403**	**(1,428)**	**213,888**	**204,366**	2
					Outsourced Personnel Expenses								
226	247	22	52	(174)	Medical Personnel	226	247	22	52	(174)	2,965	3,763	
113	91	(22)	142	30	Nursing Personnel	113	91	(22)	142	30	1,093	2,002	
32	87	55	34	1	Allied Health Personnel	32	87	55	34	1	1,049	583	
74	20	(54)	68	(6)	Support Personnel	74	20	(54)	68	(6)	244	522	
116	89	(27)	92	(24)	Management and Admin Personnel	116	89	(27)	92	(24)	1,765	1,671	
560	**535**	**(25)**	**388**	**(173)**	**Total Outsourced Personnel Expenses**	**560**	**535**	**(25)**	**388**	**(173)**	**7,116**	**8,541**	2
839	696	(143)	920	80	Outsourced Other Expenses	839	696	(143)	920	80	8,363	9,845	3
2,789	2,366	(423)	2,469	(320)	Treatment Related Costs	2,789	2,366	(423)	2,469	(320)	28,666	27,169	4
1,838	1,583	(255)	1,623	(215)	Non Treatment Related Costs	1,838	1,583	(255)	1,623	(215)	18,463	19,886	5
9,106	9,151	45	8,416	(690)	IDF Outflow	9,106	9,151	45	8,416	(690)	109,807	101,298	6
18,739	19,029	290	18,302	(437)	Other External Provider Costs	18,739	19,029	290	18,302	(437)	227,534	218,583	7
2,211	2,377	166	2,194	(17)	Interest, Depreciation & Capital Charge	2,211	2,377	166	2,194	(17)	28,517	25,186	8
54,914	**54,416**	**(498)**	**51,714**	**(3,200)**	**Total Expenditure**	**54,914**	**54,416**	**(498)**	**51,714**	**(3,200)**	**642,352**	**614,874**	
(1,668)	**(1,843)**	**175**	**(1,854)**	**186**	**Net Result**	**(1,668)**	**(1,843)**	**175**	**(1,854)**	**186**	**(10,645)**	**(21,454)**	
					Result by Output Class								
418	(53)	471	(358)	775	Funder	418	(53)	471	(358)	775	(9)	(7,889)	
110	14	96	35	75	Governance	110	14	96	35	75	(25)	634	
(2,196)	(1,804)	(392)	(1,531)	(665)	Provider	(2,196)	(1,804)	(392)	(1,531)	(665)	(10,611)	(14,198)	
(1,668)	**(1,843)**	**175**	**(1,854)**	**186**	**Net Result**	**(1,668)**	**(1,843)**	**175**	**(1,854)**	**186**	**(10,645)**	**(21,454)**	

There may be rounding differences in this report

Executive Summary – Financial Position

Financial performance year to date

- Total Revenue favourable $673k
- Personnel and outsourced Personnel unfavourable ($178k)
  - Medical favourable $153k; Nursing unfavourable ($231k); Allied Health unfavourable ($108k), Support Staff unfavourable ($163k); Management and Admin unfavourable ($45k); Annual leave Liability cost has increased $2,926k since July 2019
- Outsourced other expenses unfavourable ($143k)
- Treatment related Costs unfavourable ($423k)
- Non Treatment Related Costs unfavourable ($255k)
- IDF Outflow favourable $45k
- Other External Provider Costs favourable $290k
- Interest depreciation and capital charge favourable $166k

Analysis of Operating Position – Revenue

- **Revenue:** Total revenue favourable $673k for the month
  - Devolved MOH revenue $92k favourable, driven by Capitation.
  - Non Devolved revenue $374k favourable driven largely by the recognition of Public Health contract Revenue, originally deferred due to COVID-19.
  - ACC Revenue $21k favourable driven by Older Person Rehabilitation.
  - Other revenue $74k favourable for the month reflecting adjustments to Community Pharmacy.
  - IDF inflows unfavourable ($57k) for the month reflecting prior month adjustments.
  - Inter DHB Revenue favourable $169k, reflecting the use of shared 2 & 3DHB services.

Analysis of Operating Position – Personnel

- **Total Personnel** including outsourced unfavourable ($178k) for the month
  - Medical personnel incl. outsourced favourable $153k. Outsourced costs are $22k favourable Medical Staff Internal are $131k favourable.
  - Nursing incl. outsourced ($231k) unfavourable. Employee costs are ($209k) unfavourable, driven by Registered Nurses ($56k), Internal Bureau Nurses and Health Care Assistants ($302k), partly offset by Registered Nurses $138k and Senior Nurses $34k.
  - Allied Health incl. outsourced $108k favourable, with outsourced favourable $55k, internal employees favourable $53k driven by Regional Public Health.
  - Support incl. outsourced unfavourable ($163k), with Outsourced ($54k) unfavourable, and employee costs ($109k) unfavourable, driven by Orderlies ($41k), Cleaners ($18k) and Sterile Supply Assistants ($22k).
  - Management & Admin incl. outsourced unfavourable ($45k); internal staff unfavourable ($18k), Outsourced unfavourable ($27k), the later includes savings targets.
  - Sick leave for July was 4.3%, which is higher than the same time last year, which was 4.0%.

FTE Analysis

Month					FTE Report	Year To Date					Annual	
Actual	Budget	Variance	Last Year	Variance	Jul-20	Actual	Budget	Variance	Last Year	Variance	Budget	Last Year
					FTE							
284	285	1	307	24	Medical	284	285	1	307	24	287	294
824	839	15	789	(35)	Nursing	824	839	15	789	(35)	837	818
398	416	18	384	(14)	Allied Health	398	416	18	384	(14)	417	402
143	137	(6)	138	(5)	Support	143	137	(6)	138	(5)	137	143
348	388	40	376	28	Management & Administration	348	388	40	376	28	388	365
1,997	**2,065**	**68**	**1,995**	**(2)**	**Total FTE**	**1,997**	**2,065**	**68**	**1,995**	**(2)**	**2,066**	**2,023**
					$ per FTE							
18,923	19,299	376	16,728	(2,194)	Medical	18,923	19,299	376	16,728	(2,194)	219,997	215,103
8,456	8,058	(398)	7,815	(641)	Nursing	8,456	8,058	(398)	7,815	(641)	91,990	93,880
7,358	7,165	(193)	6,763	(595)	Allied Health	7,358	7,165	(193)	6,763	(595)	82,842	86,026
5,821	5,293	(528)	5,887	66	Support	5,821	5,293	(528)	5,887	66	61,759	58,105
7,850	6,996	(854)	7,136	(714)	Management & Administration	7,850	6,996	(854)	7,136	(714)	79,552	84,523
9,429	**9,046**	**(383)**	**8,724**	**(705)**	**Average Cost per FTE all Staff**	**9,429**	**9,046**	**(383)**	**8,724**	**(705)**	**103,600**	**105,731**

Medical over budget for the month by (1). SMOs under budget by 10 FTE, MOSS under budget by 1 FTE, offset by RMO's & House Officers combined.

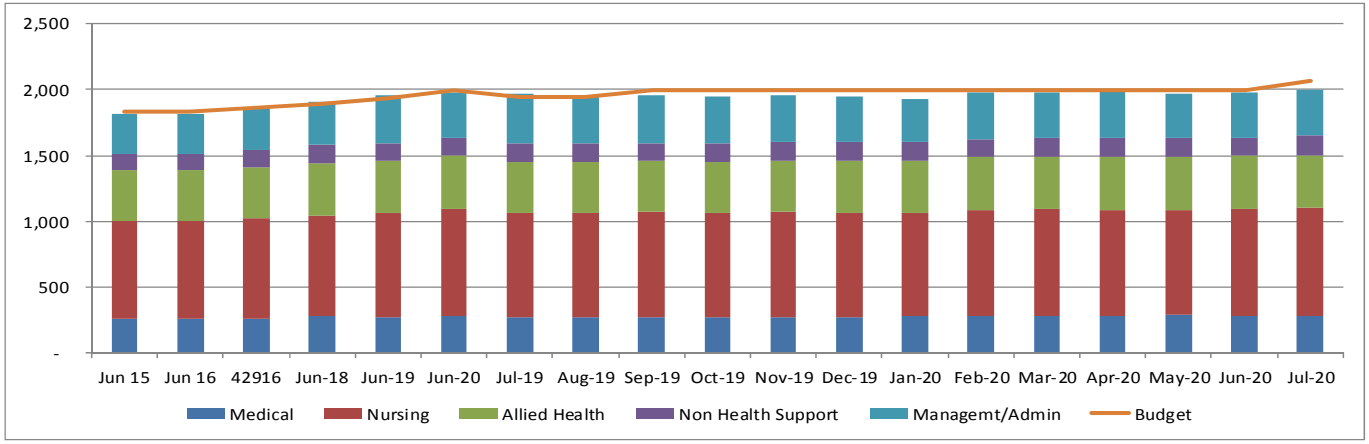
Nursing under by 15 FTE for the month. Internal Bureau Nurses and HCA's are over budget (31) FTE mostly driven by ED (5), Maternity (3), Older Person Rehab (8), General Surgery (4) and other variances. This is largely offset by Registered Nurses and Health Care Assistants under budget 32 FTE, mostly in the central New Initiatives Budget pool, reflecting the ongoing implementation of CCDM. Registered Midwives are under budget by (13) FTE, also reflecting a centrally held provision to complete the implementation of the Maternity Review.

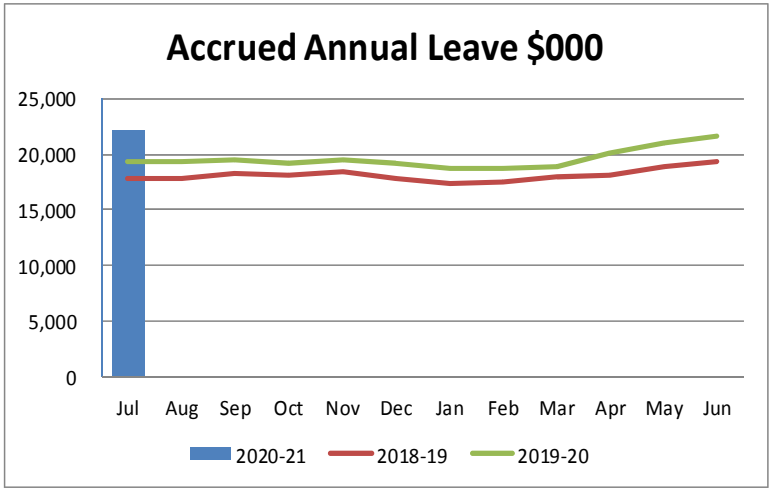
Allied FTEs are under by 18 FTEs for the month due in the main to, favourable variances in Health promotion officers 5 FTE, Other Allied Health 3 FTE, Pharmacists 3 FTE, and other variances.

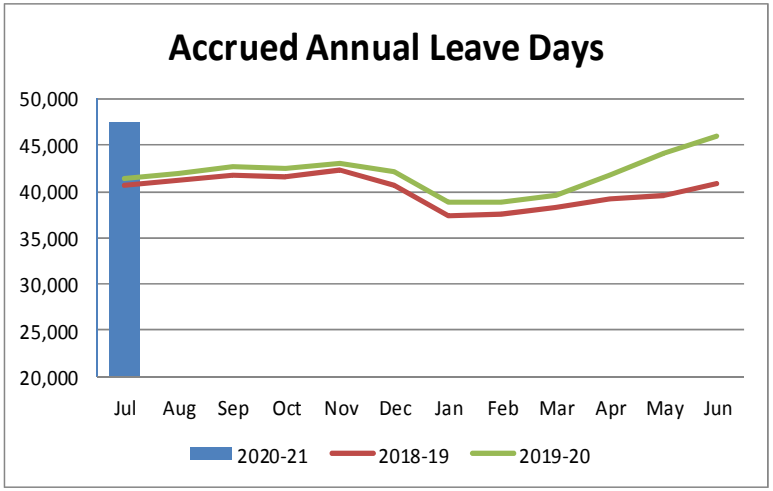
Support FTEs are (6) FTEs over budget driven by Food services (3) FTE and Orderlies (2) FTE, and other minor variances.

Management & Admin are under budget by 40 FTEs. Driven by administrative support staff vacancies and includes the capitalisation of 10 FTE's in June. Some roles are under outsourced personnel if they are now on the CCDHB payroll which do not show in this report as FTEs.

FTE Analysis







Analysis of Operating Position – Other Expenses

- **Other Operating Costs**
  - Outsourced other unfavourable ($143k) for the month, driven by Outsource Clinical Services ($133k), reflecting to high volumes.
  - Treatment related costs ($423k) unfavourable, Pharmaceuticals ($250k) and implants and prosthesis ($87k).
  - Non Treatment Related costs unfavourable ($255k) driven by the provision for Holidays Act Settlement ($233k), which was not budgeted for as advised by the Ministry of Health.
  - IDF Outflows $45k favourable for the month.
  - Other External Provider costs favourable $290k, driven by driven by Adolescent Dental $70k, Palliative Care $28k, General Medical Subsidy $24k, Primary Health $50k and Laboratory and Pharmaceutical Payments combined $153k.
  - Interest, Depreciation & Capital Charge favourable $166k, driven by depreciation $165k, a result in the delay in the capitalisation of assets.

Section 5

Additional Financial Information & Updates

Financial Position as at 31 July 2020

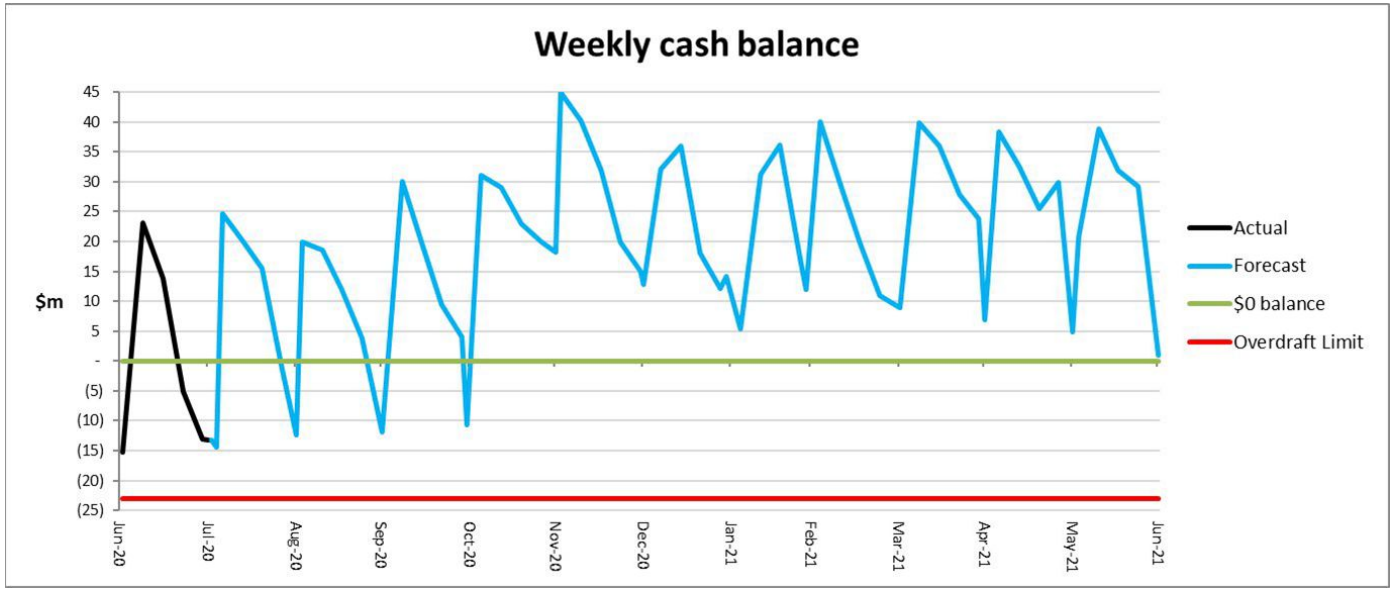
$000s	Actual	Budget	Variance	Jun 20	Variance	Explanation of Variances Between Actual and Budget
Assets						
Current Assets						
Bank - Non DHB Funds *	3,109	4,927	(1,818)	4,927	(1,818)	Payments from NHMG to DHB's paid earlier than budgeted
Accounts Receivable & Accrued Revenue	27,701	27,577	124	27,577	124	
Stock	2,271	2,200	71	2,199	72	
Prepayments	558	815	(257)	815	(257)	
Total Current Assets	**33,639**	**35,519**	**(1,880)**	**35,518**	**(1,879)**	
Fixed Assets						
Fixed Assets	228,647	230,227	(1,580)	229,790	(1,143)	
Work in Progress	14,894	14,001	893	14,001	893	
Total Fixed Assets	**243,541**	**244,228**	**(688)**	**243,791**	**(251)**	
Investments						
Investments in Associates	1,150	1,150	0	1,150	0	Allied Laundry
Trust Funds Invested	1,248	1,347	(99)	1,347	(99)	Restricted trusts
Total Investments	**2,398**	**2,497**	**(99)**	**2,497**	**(99)**	
Total Assets	**279,577**	**282,244**	**(2,667)**	**281,806**	**(2,229)**	
Liabilities						
Current Liabilities						
Bank	13,136	22,189	9,053	10,986	(2,150)	Average bank balance in Jul-20 was $7.5m
Accounts Payable and Accruals	71,042	47,654	(23,387)	56,285	(14,756)	Includes Holidays Act Provision of $27.7m
Crown Loans and Other Loans	42	42	0	42	0	
Capital Charge Payable	1,035	0	(1,035)	0	(1,035)	
Current Employee Provisions	27,273	26,018	(1,256)	26,518	(756)	
Total Current Liabilities	**112,528**	**95,903**	**(16,625)**	**93,831**	**(18,697)**	
Non Current Liabilities						
Other Loans	178	180	2	178	0	
Long Term Employee Provisions	8,972	8,972	0	8,972	0	
Non DHB Liabilities	3,109	4,927	1,818	4,927	1,818	Payments from NHMG to DHB's paid earlier than budgeted
Trust Funds	1,237	1,347	110	1,347	110	
Total Non Current Liabilities	**13,496**	**15,426**	**1,930**	**15,424**	**1,928**	
Total Liabilities	**126,024**	**111,329**	**(14,695)**	**109,255**	**(16,769)**	
Net Assets	**153,554**	**170,916**	**(17,362)**	**172,552**	**(18,998)**	
Equity						
Crown Equity	123,916	124,123	(207)	123,916	0	
Revaluation Reserve	146,289	146,289	0	146,289	0	
Opening Retained Earnings	(114,982)	(97,653)	(17,330)	(76,199)	(38,784)	
Net Surplus / (Deficit)	(1,668)	(1,843)	175	(21,454)	19,786	
Total Equity	**153,554**	**170,916**	**(17,362)**	**172,552**	**(18,998)**	

* NHMG - National Haemophilia Management Group

Statement of Cash Flows to 31 July 2020

$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	41,434	41,973	42,072	41,955	41,966	41,981	41,882	41,900	42,091	41,991	41,998	42,054
Receipts from Other DHBs (Including IDF)	9,112	9,532	9,532	9,532	9,532	9,530	9,532	9,532	9,532	9,532	9,532	9,532
Receipts from Other Government Sources	721	759	767	753	834	710	683	750	638	677	638	750
Other Revenue	1,833	379	379	383	380	380	388	380	380	383	380	380
Total Receipts	**53,100**	**52,644**	**52,751**	**52,622**	**52,712**	**52,600**	**52,484**	**52,561**	**52,640**	**52,583**	**52,547**	**52,715**
Payments for Personnel	(21,092)	(17,669)	(18,488)	(18,634)	(17,820)	(19,473)	(17,826)	(17,043)	(19,524)	(18,709)	(17,889)	(18,714)
Payments for Supplies (Excluding Capital Expenditure)	(4,686)	(4,623)	(4,324)	(4,616)	(4,529)	(2,561)	(4,543)	(6,701)	(4,410)	(4,704)	(4,662)	(4,692)
Capital Charge Paid	0	(0)	(0)	(0)	(0)	(6,210)	(0)	(0)	(0)	(0)	(0)	(6,210)
GST Movement	(710)	350	350	350	350	350	350	(2,000)	(2,000)	(1,000)	(2,500)	3,350
Payments to Other DHBs (Including IDF)	(9,106)	(9,151)	(9,151)	(9,151)	(9,151)	(9,151)	(9,151)	(9,151)	(9,151)	(9,151)	(9,151)	(9,151)
Payments to Providers	(18,833)	(19,079)	(18,820)	(19,026)	(18,978)	(19,148)	(18,907)	(18,092)	(18,814)	(19,187)	(19,366)	(19,088)
Total Payments	**(54,427)**	**(50,171)**	**(50,433)**	**(51,076)**	**(50,128)**	**(56,193)**	**(50,077)**	**(52,987)**	**(53,899)**	**(52,751)**	**(53,568)**	**(54,505)**
Net Cashflow from Operating Activities	**(1,327)**	**2,472**	**2,318**	**1,546**	**2,584**	**(3,593)**	**2,407**	**(427)**	**(1,259)**	**(168)**	**(1,021)**	**(1,790)**
Investing Activities												
Interest Receipts	0	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	**0**	**25**	**25**	**25**	**25**	**25**	**25**	**25**	**25**	**25**	**25**	**25**
Capital Expenditure	(913)	(1,772)	(5,772)	(1,272)	(8,772)	(1,772)	(1,272)	(1,772)	(5,772)	(14,772)	(1,472)	(1,773)
Increase in Investments and Restricted & Trust Funds Assets	99	0	0	0	0	0	0	0	0	0	0	0
Total Payments	**(814)**	**(1,772)**	**(5,772)**	**(1,272)**	**(8,772)**	**(1,772)**	**(1,272)**	**(1,772)**	**(5,772)**	**(14,772)**	**(1,472)**	**(1,773)**
Net Cashflow from Investing Activities	**(814)**	**(1,747)**	**(5,747)**	**(1,247)**	**(8,747)**	**(1,747)**	**(1,247)**	**(1,747)**	**(5,747)**	**(14,747)**	**(1,447)**	**(1,748)**
Financing Activities												
Equity Injections - Capital	0	0	4,000	1,000	0	0	0	0	4,000	13,000	0	0
Equity Injections - Deficit Support	0	0	0	0	35,000	0	0	0	0	0	0	0
Total Receipts	**0**	**0**	**4,000**	**1,000**	**35,000**	**0**	**0**	**0**	**4,000**	**13,000**	**0**	**0**
Interest Paid on Finance Leases	(9)	(7)	(7)	(6)	(6)	(6)	(6)	(6)	(6)	(5)	(5)	(5)
Total Payments	**(9)**	**(7)**	**(7)**	**(6)**	**(6)**	**(6)**	**(6)**	**(6)**	**(6)**	**(5)**	**(5)**	**(5)**
Net Cashflow from Financing Activities	**(9)**	**(7)**	**3,993**	**994**	**34,994**	**(6)**	**(6)**	**(6)**	**3,994**	**12,995**	**(5)**	**(5)**
Total Cash In	53,100	52,669	56,776	53,647	87,737	52,625	52,509	52,586	56,665	65,608	52,572	52,740
Total Cash Out	(55,250)	(51,950)	(56,211)	(52,354)	(58,906)	(57,971)	(51,355)	(54,765)	(59,677)	(67,529)	(55,046)	(56,283)
Net Cashflow												
Opening Cash	(10,986)	(13,136)	(12,417)	(11,853)	(10,560)	18,271	12,924	14,078	11,899	8,887	6,967	4,494
Net Cash Movements	(2,150)	719	564	1,293	28,831	(5,346)	1,154	(2,179)	(3,012)	(1,920)	(2,473)	(3,543)
Closing Cash	**(13,136)**	**(12,417)**	**(11,853)**	**(10,560)**	**18,271**	**12,924**	**14,078**	**11,899**	**8,887**	**6,967**	**4,494**	**951**

Weekly Cash Flow – Actual to 31 July 2020



Note

- the overdraft facility shown in red is set at $23 million as at July 2020
- the lowest bank balance for the month of July was $15.3m overdrawn
- the cash forecast assumes an equity injection of $35m in November

Summary of Leases – as at 31 July 2020

		Original Cost	Monthly Amount	Annual Amount	Total Lease Cost	Start Date	End Date	Lease type
Rental Property Leases	**Occupants**							
Wainuiomata Health Centre	District Nurses		1,149	13,787		1/11/2017	31/10/2020	Operating
Public Trust House Lower Hutt	Community Mental Health		21,887	262,643		1/09/2017	1/09/2023	Operating
CREDS - Johnsonville	Eating Disorders		5,370	64,435		1/01/2015	Rolling lease	Operating
RPH - Porirua Public Health	RPH School Health - Promotional Health		9,088	109,055		15/03/2015	14/03/2021	Operating
Criterion Lane Upper Hutt	Lagans Pharmacy - Physiotherapy		2,363	28,359		5/01/2019	31/12/2020	Operating
CBD Towers Upper Hutt	Community Mental Health		9,854	118,247		8/06/2015	7/06/2021	Operating
Upper Hutt Health Centre	District Nurses		974	11,688		24/01/2015	1/02/2022	Operating
			50,685	**608,214**				
Car Park Leases								
CBD Towers Upper Hutt			542	6,500		8/06/2015	7/06/2021	Operating
Public Trust House Lower Hutt			1,603	19,240		1/09/2017	1/09/2023	Operating
			2,145	**25,740**				
Motor Vehicle Leases								
Motor Vehicle Lease plus Management Fees (115 Vehicles)			41,002	492,023		Ongoing	Ongoing	Operating
			41,002	**492,023**				
Equipment Leases	**Supplier**							
MRI Ingenia 1.5T	De Lage Landen (paid monthly in arrears)		22,498	269,981	1,349,905	19/09/2019	19/08/2024	Operating
Fluoroscopy Combi Diagnost	De Lage Landen (paid monthly in arrears)		9,753	117,037	585,185	1/08/2019	31/07/2024	Operating
Plastics Micro Power Tools	Stryker New Zealand Ltd	293,188	3,490	41,884	125,652	1/10/2018	30/09/2025	Finance
Orthopaedic Tools	Stryker New Zealand Ltd		9,024	108,292	758,044	1/09/2016	31/08/2023	Operating
3 x Ultrasounds (Equigroup)	GE Healthcare Ltd		7,303	87,641	438,205	28/06/2017	28/06/2022	Operating
1 x Ultrasound (Equigroup)	Philips NZ Commercial Ltd		1,758	21,099	105,495	28/08/2017	28/07/2022	Operating
CT Scanner (Equigroup)	Toshiba Medical Systems		25,187	302,244	1,511,220	28/05/2017	28/05/2022	Operating
Philips Digital Diagnost C90	De Lage Landen (paid monthly in arrears)		7,265	87,186	435,930	31/01/2020	31/01/2025	Operating
Philips Digital Diagnost C90	De Lage Landen (paid monthly in arrears)		6,184	74,214	371,070	31/01/2020	31/01/2025	Operating
Philips Diagnost R2	De Lage Landen (paid monthly in arrears)		3,932	47,186	235,930	1/06/2020	1/06/2025	Operating
		293,188	**96,394**	**1,156,764**	**5,916,636**			
Total Leases			**190,226**	**2,282,741**				

Treasury as at 31 July 2020

1) Short term funds / investment ($000)

NZHP banking activities for the month	Current month ($000)	Last month ($000)
Average balance for the month	$7,488	$9,404
Lowest balance for the month	($15,294)	($15,827)
Average interest rate	(0.97%)	(0.37%)
Net interest earned/(charged) for the month	($6)	($3)

2) Hedges

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

3) Foreign exchange transactions for the month ($)

No. of transactions involving foreign currency	5
Total value of transactions	$40,477 NZD
Largest transaction	$34,350 NZD

	No. of transactions	Equivalent NZD
AUD	4	$6,127
GBP		
SGD		
USD	1	$34,350
Total	**5**	$40,477

4) Debtors ($000)

Top 10 Debtors	Outstanding	Current	1-30 Days	31-60 Days	61-90 Days	91-120 Days	121-180 Days	181+ Days
Capital & Coast District Health Board	$2,751	$199	$181	$26	$42	$118	$305	$1,880
Ministry of Health	$2,377	$809	$853	$14	$176	$0	$127	$398
Wairarapa District Health Board	$1,304	$83	$92	$290	$0	$0	$62	$776
Accident Compensation Corporation	$784	$446	($74)	$11	$14	$50	$51	$286
Whanganui District Health Board	$347	$347	$0	$0	$0	$0	$0	$0
Health Workforce NZ Limited	$154	$0	$97	$0	$0	$57	$0	$0
Boulcott Pulse Health Ltd	$150	$150	$0	$0	$0	$0	$0	$0
Auckland District Health Board	$74	$67	$0	$0	$0	$5	$2	$0
Wellington Southern Community Laboratories	$73	$3	$2	$2	$3	$62	$0	$0
Non Resident	$53	$0	$0	$0	$0	$0	$0	$53
Total Top 10 Debtors	**$8,067**	**$2,104**	**$1,151**	**$344**	**$235**	**$292**	**$547**	**$3,393**

BOARD Information - Public

September 2020

Capital & Coast DHB July 2020 Financial and Operational Performance Report	
Action Required **The Capital & Coast DHB Board note:** (a) The release of this report into the public domain. (b) The DHB had a $1m surplus for the month of July 2020 after excluding COVID-19 and Holidays Act (2003) being $3.8m favourable against budget. (c) In addition for July we have incurred $2m additional net expenditure for COVID-19 and $756k against provision for Holidays Act [2003] (d) These above expenses and provisions are outside the performance monitoring by Ministry of Health	
Strategic Alignment	Financial Sustainability
Authors	Michael McCarthy, Chief Financial Officer Joy Farley, Director of Provider Services Rachel Haggerty, Director Strategy Planning & Performance
Endorsed by	Fionnagh Dougan, Chief Executive
Purpose	To update the Board and FRAC on the financial performance and delivering against target performance for the DHB
Contributors	Finance Team, Mental Health and 2DHB Hospital Services, GM MHAIDS, Director Strategy Planning & Performance

Executive Summary

As noted to the Boards in their previous meeting, there is an ongoing significant cost due to the COVID-19 response into the 20/21 fiscal year. We have been advised by the Ministry that unfunded COVID-19 costs for this year and next are outside our responsible deficit and budgets. We have also been advised that any adjustments to the Holidays Act remediation are outside our responsible deficits and budgets.

The DHB has achieved for the first month of 2019/20 a $1 million surplus underlying result excluding COVID-19 unfunded costs and Holidays Act, this is against a July 2020 budget of 2.8m deficit.

In addition we have incurred an additional net expenditure for COVID-19 related expenses of $2 million

We have made a further provision for the Holidays Act and will continue to do so on a monthly basis, totalling $756k. The COVID-19 expenses and Holidays Act (2003) provision are outside the performance monitoring by the Ministry of Health

The DHB has advised the Ministry of a budget of $39.8 million deficit. The Ministry requires us to forecast COVID and Holidays act expenses from July 2020 This is challenging giving fluctuating alert levels and other response actions decided by the government to address COVID-19.

Capital Expenditure was $4.3 million indicating, which is above our capital performance in recent times.

We had a negative cash Balance at month-end of $21.6 million offset by positive "Special Funds" of $11.7 million (nett $9.9 million overdraft). It should be noted that there is a significant amount of the COVID response that has not been funded by the crown at this time.

The DHB continues to have a target to pay commercial creditors within 10 days of the invoice being received in the payments office.

Activity delivered by the CCDHB provider arm - ED attendances, surgical procedures, overall discharges, outpatient and community contacts have returned to pre COVID levels and are consistent with previous years for the month of July. Improvements in performance are seen across a number of services – faster cancer times, Radiology MRI and CT, Colonoscopy with marginal improvements in planned care targets - elective theatre cases have increased for the month of July 2020 by 3.5% (30 cases) when compared to July 2018. A recovery plan is in development which will need continued support from the private sector however DHBs consider at least a year will be required to address the backlog.

However our ED wait times have declined significantly due to combination of factors – the on-going processes in place related to COVID-19 screening and precautions and our increased the elective and acute surgical work that was delayed during our COVID response. This exacerbates flow given the mismatch between inpatient activity and the existing bed base. A number of work streams continue to be rolled out within the Acute Demand and Bed Capacity Programme – notable highlights are the expansion of the Advancing Wellness at Home Initiative (AWHI) project to a wider catchment and other inpatient wards; increasing the opening hours of the Children's Assessment Unit which has been relocated to the "Pink Zone" in ED; establishment of a Project group to review patients who have been in hospital more than 10 days, to identify barriers to patients being discharged; a work group established to identify space to create additional acute assessment beds.

Strategic Considerations

Service	Financial performance and funding is a key to delivering the services for the Wellington population and Tertiary services for the region.
People	Staff numbers are 137 FTE below our annual budget.
Financial	The monthly result for the DHB was $1m surplus from normal operations, against our DHB budget of ($2.8m). An additional ($2m) was spend on unfunded COVID-19 costs largely in the provider arm, and ($756k) 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	Michael McCarthy, Chief Financial Officer	Currently on track but will be impacted by current events	Major (but no payment impacts)	Major (no operational impacts)

Attachment/s

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

Capital & Coast District Health Board

Monthly Financial and Operational Performance Report

For the period ending 31 July 2020

Presented in August 2020

Capital & Coast
District Health Board

Contents

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❸	Financial Performance & Sustainability	39
❹	Appendices Financial Position	50

Section 1

Performance Overview and Executive Summary

Executive Summary

- There is an ongoing significant cost due to the COVID response into the 20/21 fiscal year. We have been advised by the Ministry that unfunded COVID costs for this year and next are outside our responsible deficit and budgets. We have also been advised that any adjustments to the Holidays Act remediation are outside our responsible deficits and budgets.
- The DHB has achieved for the first month of 2019/20 a $1 million surplus underlying result excluding COVID-19 unfunded costs and Holidays Act, this is against a July 2020 budget of 2.8m deficit.
- In addition we have incurred an additional net expenditure for COVID related expenses of $2 million
- We have made a further provision for the Holidays Act and will continue to do so on a monthly basis, totalling $756k
- The COVID-19 expenses and Holidays Act [2003] provision are outside the performance monitoring by the Ministry of Health
- The DHB has advised the Ministry of a budget of $39.8 million deficit. The Ministry requires us to forecast COVID and Holidays Act expenses from July 2020. This is challenging given fluctuating alert levels and other response actions decided by the government to address COVID-19.
- Capital Expenditure was $4.3 million, which is above our capital performance in recent times.
- We had a negative cash Balance at month-end of $21.6 million offset by positive “Special Funds” of $11.7 million (net $9.9 million overdraft). It should be noted that there is a significant amount of the COVID response that has not been funded by the crown at this time.

Executive Summary continued

- The DHB continues to have a target to pay commercial creditors within 10 days of the invoice being received in the payments office.
- Activity delivered by the CCDHB provider arm - ED attendances, surgical procedures, overall discharges, outpatient and community contacts have returned to pre COVID levels and are consistent with previous years for the month of July.
- Improvements in performance are seen across a number of services – faster cancer times, Radiology MRI and CT, Colonoscopy with marginal improvements in planned care targets - elective theatre cases have increased for the month of July 2020 by 3.5% (30 cases) when compared to July 2018. A recovery plan is in development which will need continued support from the private sector however DHBs believe at least a year will be required to address the backlog.
- Our ED wait times have declined significantly due to a combination of factors – the on-going processes in place related to COVID-19 screening and precautions and our increased the elective and acute surgical work that was delayed during our COVID response. This exacerbates flow given the mismatch between inpatient activity and the existing bed base.
- A number of work streams continue to be rolled out within the Acute Demand and Bed Capacity Programme. Notable highlights are the expansion of the Advancing Wellness at Home Initiative (AWHI) project to a wider catchment and other inpatient wards, increasing the opening hours of the Children's Assessment Unit which has been relocated to the "Pink Zone" in ED, establishment of a Project group to review patients who have been in hospital more than 10 days, to identify barriers to patients being discharged and a work group established to identify space to create additional acute assessment beds.

Performance Overview: Activity Context (People Served)

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** has returned to just below normal levels.

4,881

583 Maori, 456 Pacific

People receiving **Surgical Procedures** (in main theatres) has fully recovered.

1,192

133 Maori, 82 Pacific

People **discharged from Kenepuru Community Hospital or Wellington Regional Hospital** (excl Mental Health)

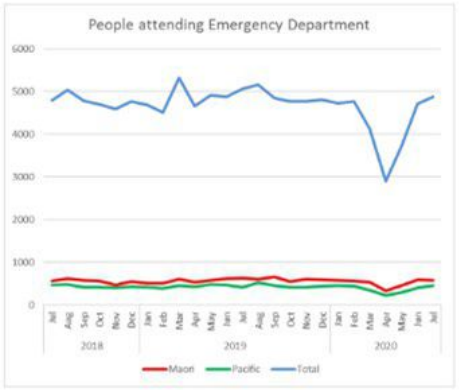
5,311

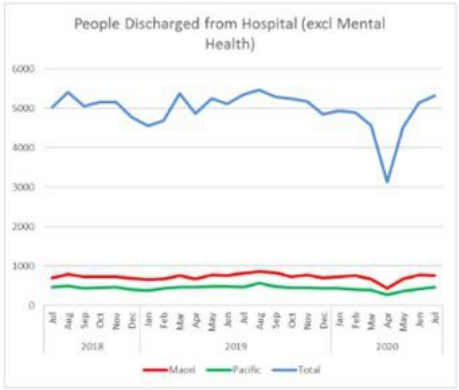
765 Maori, 465 Pacific

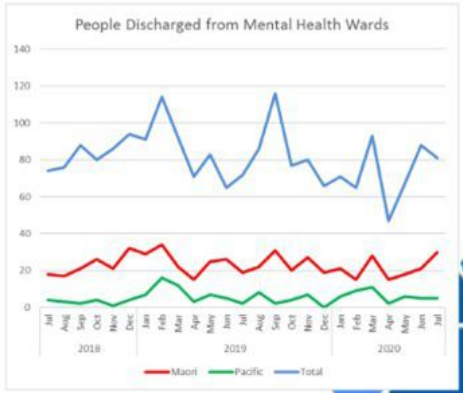
People discharged from **Mental Health Wards**

81

30 Maori, 5 Pacific



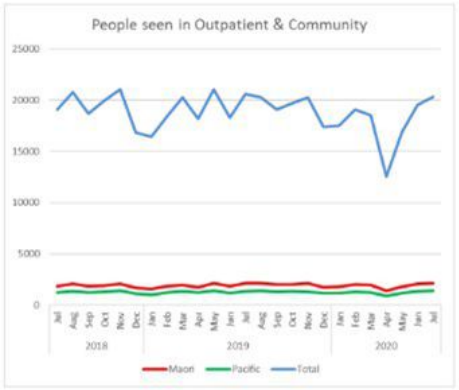


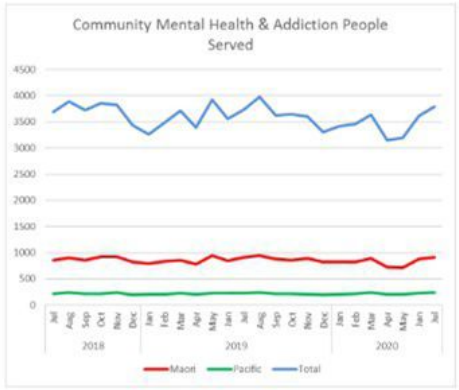


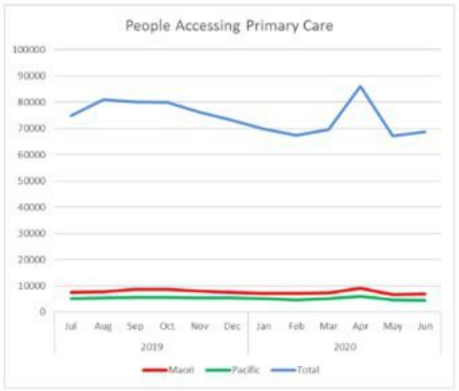
Performance Overview: Activity Context (People Served)

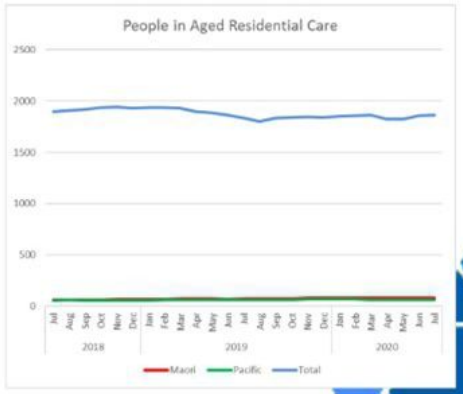
Our services have returned to delivering services to our population without the restrictions due to COVID-19. Services continue to take necessary precautions.

People seen in Outpatient & Community	**20,314**	2,155 Maori, 1,373 Pacific
Community Mental Health & Addiction People Served	**3,785**	910 Maori, 237 Pacific
People accessing primary care	**74,347**	7,950 Maori, 5,282 Pacific
People in Aged Residential Care	**1,866**	76 Maori, 62 Pacific









Financial Overview – July 2020

YTD Operating Position	YTD Provider Position	YTD Funder Position	YTD Capital Exp
$1.8m deficit Incl. $2m COVID-19 costs Incl. $756k Holidays Act	$1.2m surplus	$3.0m deficit	$4.5m spend
Against a budgeted YTD deficit of $2.8m. Month result was $969k favourable, a $3.8m favourable underlying position.	Against a a budgeted surplus of $487k the month result was $1.2m surplus, a $682k favourable result.	Against a budgeted deficit of $3.2m the month result was $3.0m deficit, a $225k favourable result.	Against a KPI of a budgeted spend of $5.4m. This includes funded projects – Children's Hospital

YTD Activity vs Plan (CWDs)	YTD Paid FTE	Annual Leave Taken
3.87% behind[1]	5,312[3]	($9.5m) annualised[4]
239 CWDs below PVS plan (63 IDF CWDs behind, 97 Hutt). Month result -239 CWDs excluding work in progress.	YTD 137 below annual budget of 5,449 FTE excluding outsourced roles. This is 445 FTE vacancies at end July.	Underlying YTD annual leave taken is under by 4.3 days per FTE and Lieu leave taken for public holidays is short by 1 day.

[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 303 cwd outsourced (121 events) ~$1.7m dollars at WEIS price. This is largely Cardiothoracic sent to Wakefield and Orthopaedics sent to Southern Cross.
[3] Paid FTE ignores leave balance movement which is YTD 13 FTE worse than budgeted growth, Outsourced staff are also not counted in this metric which is currently $435k 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 2020

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

ED (SSIED) 6 Hour rule	ESPI 5 Long Waits	Specialist Outpatient Long Waits	Serious Safety Events[2]
72.6%	290	1202	10
22% below the ED target of 95% Monthly -2%	Against a target of zero long waits a monthly movement of -66	Against a target of zero long waits a monthly movement of -249	An expectation is for nil SSEs at any point.

YTD Activity vs Plan (CWDs)	YTD Paid FTE	YTD Cost per WEIS
3.87% behind[1]	3,622[3]	$5,935*
239 CWDs below PVS plan (63 IDF CWDs behind, 97 Hutt). Month result -239 CWDs excluding work in progress.	YTD 42 below annual budget of 3,664 FTE. 179 FTE vacancies at month end.	Against a national case-weight price per WEIS of $5,216 (13.8% above). YTD Dec $5,758 (In Jan pre-COVID-19). *to May20

[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 303 cwd outsourced (121 events) ~$1.7m dollars at WEIS price.
This is largely Cardiothoracic sent to Wakefield and Orthopaedics sent to Southern Cross.
[2] An SSE is classified as SAC1 or SAC2 serious adverse events per HQSC
[3] Paid FTE ignores leave balance movement which is YTD 48 FTE worse than budgeted, Outsourced staff are also not counted in this metric which is currently $17k adverse

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

Section 2.1

Funder Performance

Executive Summary – Funder Performance

- Overall the funder has a positive variance of $225k. Revenue was $542k ahead of budget entirely due to Inter District Flow and COVID 19 revenue.
- Currently payments to our provider services are set at budget as it is too early in the year to record actuals as full phasing plans are implemented.
- Costs for other community services are $200k favourable with age residential care being positive, and primary care demand driven services such as vaccination, urgent dental and other services have residual affect from the first lockdown.
- The ongoing demand for managed isolation facilities, and community surveillance for COVID19 has ongoing demands on CCDHB to invest in health services. The full cost of these services is expected to be covered by MOH revenue.
- In this report we have also highlighted key areas of performance with a focus on our core services and achieving equity:
  - CCDHB did not meet the newborn enrolment targets in Q4 2019/20 for Maori and Pacific but did for the other populations. This drop in performance in Q4 2019/20 is in part due to the impact of COVID where parents have been hesitant to engage with primary care. Recovery plans are in place.
  - The total vaccination coverage in the 2020 year to date exceeds the total rate for 2019 (23% compared to 17%), with 67% of people aged 65+ years already vaccinated, compared to 57% last year. The proportion of eligible people in Māori and Pacific communities who have been vaccinated in the 2020 year to date also exceeds 2019 coverage, and is expected to increase further.
  - Breast screening rates at CCDHB are below the national average for all ethnic groups and cervical screening is below target. All routine cancer screening was stopped during the four-week COVID-19 lockdown. This meant participants were not invited for screening from 27 March 2020. Since the last reporting period screening rates have increased for all groups.
  - We are supporting more older people than ever with long-term health conditions and disabilities to remain in their homes for longer. Developing a wider range of services for older people is a current priority.

Funder Financial Statement of Performance

Month			Variance		Capital & Coast DHB Funder Result - $000 July 2020	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
72,885	72,885	68,138	0	4,747	Base Funding	72,885	72,885	68,138	0	4,747
4,835	4,665	5,353	170	(518)	Other MOH Revenue - Funder	4,835	4,665	5,353	170	(518)
100	45	91	55	9	Other Revenue	100	45	91	55	9
3,253	2,936	2,743	317	510	IDF Inflows PHOs	3,253	2,936	2,743	317	510
18,517	18,517	17,438	0	1,079	IDF Inflows 19/20 Wash-up Prov	18,517	18,517	17,438	0	1,079
99,589	**99,048**	**93,763**	**542**	**5,826**	**Total Revenue**	**99,589**	**99,048**	**93,763**	**542**	**5,826**
					Internal Provider Payments					
824	824	1,029	0	205	DHB Governance & Administration	824	824	1,029	0	205
54,851	54,851	49,100	0	(5,752)	DHB Provider Arm Internal Costs - HHS	54,851	54,851	49,100	0	(5,752)
7,752	7,752	8,831	0	1,079	DHB Provider Arm Internal Costs - MH	7,752	7,752	8,831	0	1,079
3,368	3,368	1,947	0	(1,421)	DHB Provider Arm Internal costs - Corp	3,368	3,368	1,947	0	(1,421)
66,795	**66,795**	**60,906**	**0**	**(5,888)**	**Total Internal Provider**	**66,795**	**66,795**	**60,906**	**0**	**(5,888)**
					External Provider Payments:					
5,703	5,703	5,605	(0)	(98)	- Pharmaceuticals	5,703	5,703	5,605	(0)	(98)
6,726	6,645	6,352	(81)	(374)	- Capitation	6,726	6,645	6,352	(81)	(374)
7,040	7,354	6,884	314	(157)	- Aged Care and Health of Older Persons	7,040	7,354	6,884	314	(157)
2,996	2,862	2,347	(134)	(649)	- Mental Health	2,996	2,862	2,347	(134)	(649)
782	807	347	25	(435)	- Child, Youth, Families	782	807	347	25	(435)
635	805	723	170	88	- Demand driven Primary Services	635	805	723	170	88
2,357	2,356	2,603	(0)	246	- Other services	2,357	2,356	2,603	(0)	246
3,725	3,725	3,645	0	(80)	- IDF Outflows Patients to other DHBs	3,725	3,725	3,645	0	(80)
5,334	5,240	5,091	(94)	(243)	- IDF Outflows Other	5,334	5,240	5,091	(94)	(243)
35,298	**35,498**	**33,597**	**200**	**(1,701)**	**Total External Providers**	**35,298**	**35,498**	**33,597**	**200**	**(1,701)**
516	**0**	**0**	(516)	(516)	- Community COVID PHO, Pharms, ARC	**516**	**0**	**0**	(516)	(516)
102,609	**102,293**	**94,503**	**(316)**	**(7,590)**	**Total Expenditure**	**102,609**	**102,293**	**94,503**	**(316)**	**(8,106)**
(3,020)	**(3,245)**	**(740)**	**225**	**(2,280)**	**Net Result**	**(3,020)**	**(3,245)**	**(740)**	**225**	**(2,280)**

Funder Financials – Revenue

Revenue

- Revenue has a positive variance YTD July of $542k.
- COVID-19 community funding of $225k. This is for Aged Care and Maori COVID-19 response funding. There are cost offsets.
- PHO additional IDF Inflow funding of $317m. This relates to the 2019-20 Quarter 4 PHO wash up processed in July. There are Outflow costs of ($113k) offsetting this revenue.

SIP Funder Revenue Variances	Month $000's	YTD $000's
COVID-19 community funding	225	225
PHO 2019/20 washup funding	317	317
Year to Date Revenue Variances	**542**	**542**

Internal Provider Payments:

- Provider Arm payments have been processed to budget targets for July 2020.

External Provider Payments:

- PHO Capitation expenses are ($81k) unfavourable. Additional costs due to volumes will be offset by additional revenue when the quarter one wash up is processed. Effect is expected to be neutral at year end.
- Aged Residential Care and Health of Older People costs are $314k favourable. Volumes are being maintained.
- Mental Health costs are unfavourable ($134k) due to timing of new contracts and are offset by additional revenue from the Ministry.
- Child and Youth costs are unfavourable ($467k) YTD. This is offset by revenue from MOH for healthy lives contracts.
- Demand driven and other services are favourable $170k. Lower costs due to the effect of COVID-19 lockdown on activity such as vaccination, urgent dental and other services.
- IDF Outflows additional costs ($94k) relates to 2019-20 Quarter 4 PHO wash up processed in July. See offsetting revenue comment.
- COVID-19 funds ($516k) mainly due to ongoing GP assessment and CBAC claims in support of the COVID-19 response as directed by the Ministry. The DHB has received some extra funding for CBACS until September 2020, however this does not fully cover the GP assessments as well. This is under negotiation with MoH.

Inter District Flows (IDF)

DHB of Domicile	YTD July estimated inpatient inflow wash-up (caseweight inpatient IDF)
Hutt Valley	-$536,323
Taranaki	-$220,150
MidCentral	-$136,709
Other under-delivered (9 DHBs)	-$259,075
Other over-delivered (5 DHBs)	$75,891
Hawkes Bay	$121,551
IDF - DHB not yet defined	$167,675
Wairarapa	$440,498
Total undelivered inpatient IDF (negative is CCDHB not delivering services to other DHBs therefore unfavourable from both a patient treatment and P&L perspective)	-$346,643

DHB of Service	YTD July estimated inpatient outflow wash-up (IDF caseweight)
Hutt	-$295,044
Other under-serviced (14 DHBs)	-$153,652
Other over-serviced (4 DHBs)	$32,879
Waikato	$51,047
Total unserviced inpatient IDF (negative is our population not being serviced by other DHBs but favourable from a P&L perspective)	-$364,770

Changed Recognition:

- The DHB is back to standard recognition of IDFs, however due to timeliness of setting all IDFs flows within systems the result has been set to budget for our first month.

IDF Inflow (revenue):

- Overall IDF inflows are favourable by ($317k).
- The majority of the lower IDF inflows (actuals) are caused by inpatient lower volumes in the following specialties:
  - Acute: ($453k); + Cardiothoracic +$475k offset by lower in most others
  - Arranged ($22k); + in NICU, Cardiothoracic offset by lower in Haematology and Oncology
  - Elective: $128k; + in Cardiology, Orthopaedics offset by Gen Surg and Cardiothoracic

IDF Outflow (expense):

- Overall IDF outflows are favourable. This largely relates to lower numbers of CCDHB patients treated at other DHBs as indicated on the table to the left.

Primary Care – Enrolment & Engagement

What is this measure?

- MoH Target: 55% of babies enrolled by 6 weeks of age; 85% of babies enrolled by 3 months of age

Why is this important?

- Primary health organisations (PHOs) provide essential primary health care services to their enrolled population; mostly through general practices. People enrolled with a PHO gain benefits that can include cheaper doctors' visits and reduced costs of prescription medicines.
- Enrolment in primary care close to birth is imperative for ensuring childhood immunisations are given at their milestone age, and to best support the child's health early in life.

How are we performing?

CCDHB met both the newborn enrolment targets in Q4 2019/20:

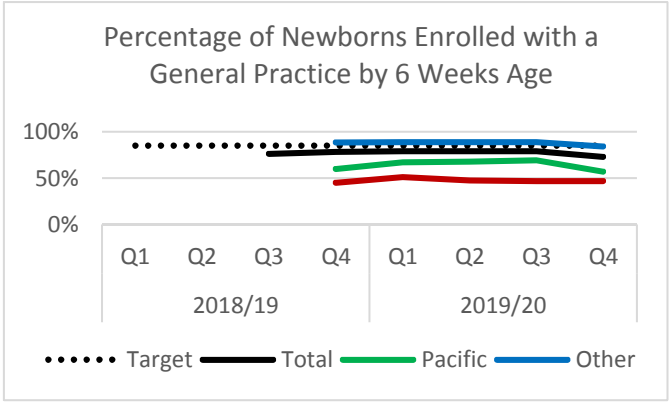
- Target 1: 55% of newborns enrolled by 6 weeks (CCDHB Q4 result = 73%)
- Target 2: 85% of newborns enrolled by 3 months (CCDHB Q4 result = 91%)
- We did not meet enrolment targets for Māori at 6 weeks and 3 month, or Pacific at 3 months.

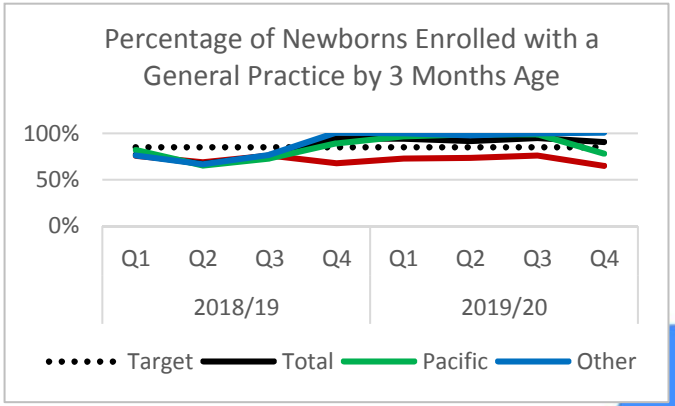
What is driving performance?

- The drop in performance observed in Q4 2019/20 is in part due to the impact of COVID where parents have been hesitant to engage with primary care.

Management comment

- CCDHB has completed a project to improve the timeliness of newborn enrolment. Through this initiative, we have implemented changes to the administrative and IT processes underpinning enrolment. This will make it easier for primary care to connect with families.
- CCDHB has also invested in an integrated maternal and child health service in Porirua, hosted by our largest iwi primary care provider, Ora Toa. Ora Toa will identify Maori women and whanau as soon as pregnancy is confirmed, and provide wrap around intensive support to promote the enduring relationship with primary care.





Influenza - Vaccination Coverage vs 2019

What is this measure?

- MoH Target: 75% of eligible population aged 65 years and over immunised against influenza (annual immunisation) for Māori, Pacific (where relevant), and total populations

Why is this important?

- Increasing influenza immunisation reduces influenza-related morbidity and mortality. The indicator of influenza at age 65 years was selected because this population has a high rate of hospital admissions for influenza-related severe acute respiratory infections. Māori and Pacific people are two to five times more likely to be admitted to hospital for influenza-related severe acute respiratory infections than others.
- COVID-19 presented an added health risk for a number of New Zealanders, with particular vulnerability for people aged 65+ years old, and in Māori and Pacific communities.

How are we performing?

- The total coverage in the 2020 year to date exceeds the total rate for 2019 (23% compared to 17%), with 67% of people aged 65+ years already vaccinated, compared to 57% last year.
- The proportion of eligible people in Māori and Pacific communities who have been vaccinated in the 2020 year to date also exceeds 2019 coverage, and is expected to increase further.

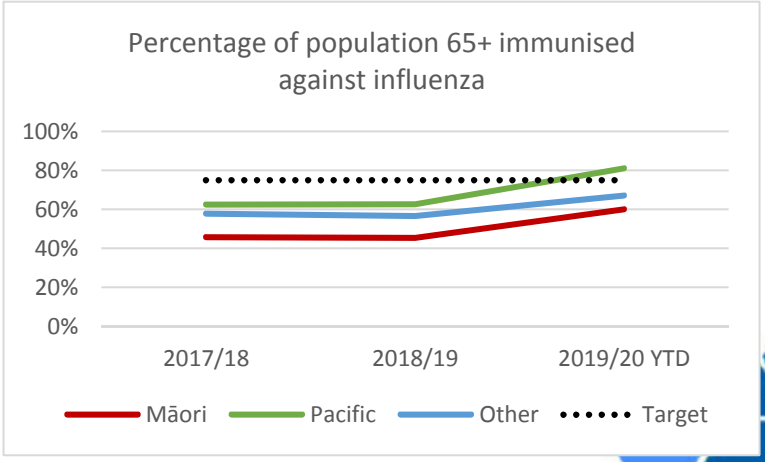
What is driving performance?

- Due to proactive health promotion initiatives in response to the COVID-19 pandemic, rates of uptake for influenza vaccination have increased in our vulnerable communities, including Maori and Pacific people.

Management comment

- Compared to last year, we have vaccinated an additional 20,300 people against influenza; this is a 37% increase compared to last year. We have immunised an additional 1700 Maori and 1400 Pacific immunised. This represents a 57% and 55% increase in people immunised for Maori compared to a 38% increase for non-Maori, non-Pacific
- We have immunised an additional 1,700 people living in our most deprived communities; a 38% increase. We have immunised an additional 4,900 people aged 65 years and older; a 19% increase

CCDHB	# immunised 2020	% immunised 2020	# immunised 2019	% immunised 2019	Difference
Māori	4,750	14%	3,034	8%	1,716
Pacific	3,859	19%	2,489	12%	1,370
Other	66,554	25%	49,311	19%	17,243
Q5	6,272	16%	4,534	12%	1,738
65+	29.891	67%	25,056	57%	4,925
Total	75,163	23%	54,834	17%	20,329



Children – Raising Healthy Kids

What is this measure?

- MoH Target: 90% of children receive their Before School Check (B4SC)
- MoH Target: 95% of obese children identified in the B4SC programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity & lifestyle interventions.

Why is this important?

- The Well Child Tamariki Ora (WCTO) has three aims: focusing on family/whānau experience; population health and best value for the health system; and setting quality indicators to audit health system performance.

How are we performing?

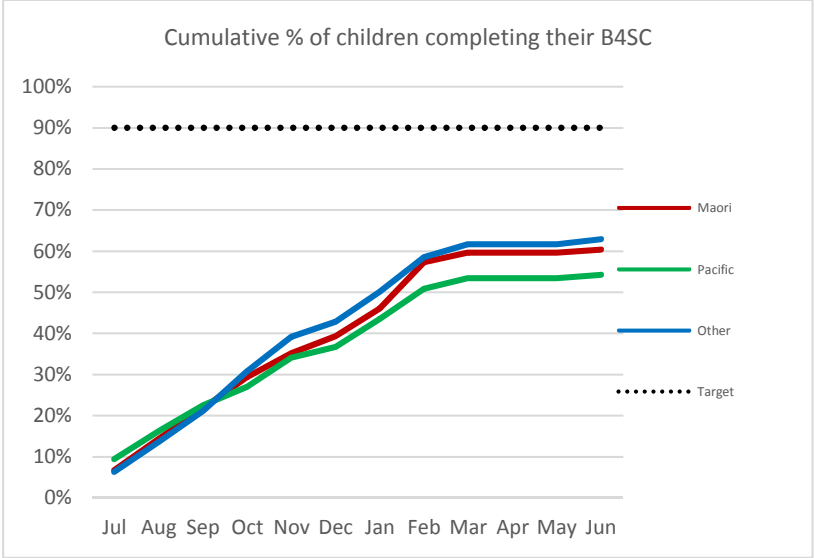
- In 2019/20, 60% of Maori, 54% of Pacific and 75% of non-Māori, non-Pacific children received their B4SC. Prior to lockdown, we were on track to ensure more Māori completed their B4SC compared to 2018/19, and recovering performance for Pacific.

What is driving performance?

- Performance was significantly impacted by COVID-19. The service was not allowed to operate from 23 March 2020 until 8 June 2020. Since restarting, some parents have been reluctant to engage with the service due to their concerns about exposing their children to infections and/or COVID-19; and the requirement for staff and clients to stay home if they have a cold.

Management comment

- Our B4SC providers are collaborating with our Iwi partners on reaching Māori and Pacific family/whānau. We are also looking to support our B4SC providers with additional information to help them reach our Māori and Pacific family/whānau.
- Acknowledgement of referrals reflects effective system processes and sector relationships, we are working with sector partners to improve performance for Pacific.



Prevention – Breast and Cervical Screening

What is this measure?

- MoH Target: 70% of women aged 50 -69 years have had a screening mammogram in the last 2 years.
- MoH Target: 80% of women aged 25 – 69 years have had a cervical sample taken in the last 3 years.

Why is this important?

- The National Breast Screening Programme aims to reduce morbidity and mortality for women due to breast cancer. Breast cancer is New Zealand' third most common cancer and accounts for more than 600 deaths every year.
- The National Cervical Screening Programme aims to reduce the number of women who develop cervical cancer, as it can reduce the risk of developing cervical cancer by around 90%.

How are we performing?

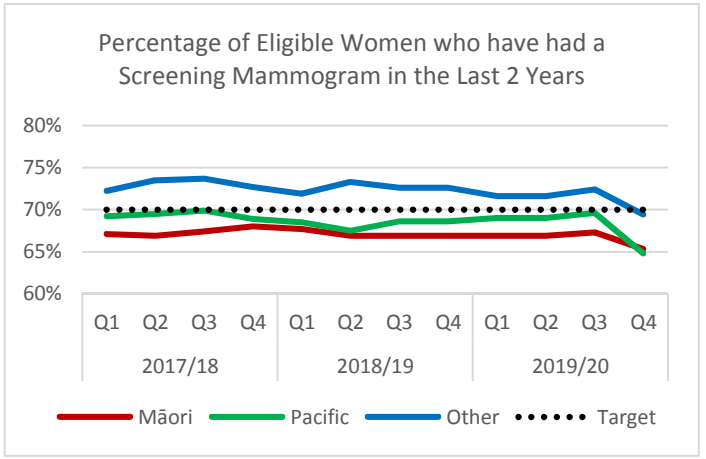
- 67% of non-Māori, non-Pacific women in CCDHB have had a completed breast screen in the last two years, with coverage 3% below the 70% target. Coverage for Maori women is 61% and for Pacific women 60% against the 70% target. Screening rates at CCDHB are below the national average for all ethnic groups.
- 77% of non-Māori, non-Pacific women in CCDHB have had a completed cervical screen in the last three years, with coverage 3% below the 80% target. Coverage for Maori women is 65% and for Pacific women 64% against the 80% target. Screening is lowest amongst Asian women at 62% coverage.

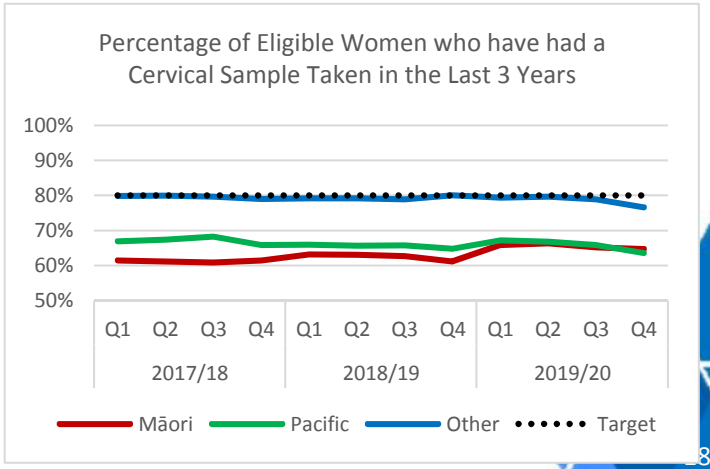
What is driving performance?

- All routine cancer screening was stopped during the four-week COVID-19 lockdown. This meant participants were not invited for screening from 27 March 2020. Since the last reporting period screening rates have increased for all groups. However, Māori and Pacific have remained below the target.

Management comment

- As we recover from COVID-19, we are building on the momentum we had during earlier in the year to support Māori and Pacific women to access screening and rescreening services and support the two-year pathway to achieve the screening targets for Māori and Pacific women.
- We continue to work with stakeholders such as Pacific Navigation service and Māori health providers to improve pathways for referral, booking and rescheduling appointments (especially for those that may have fallen overdue for screening during COVID).
- Regional Screening Services have implemented regular breast screening clinics on evenings during week and plans are in place to continue this longer term.
- We used the COVID lockdown restrictions to streamline processes and as a result same day biopsies and first specialist appointments are now a more regular occurrence in our symptomatic imaging clinic which runs concurrently with the breast clinic.





Localities – Porirua

What is this measure?

- DHB Priority: Keeping our Community Healthy and Well

Why is this important?

- In CCDHB, our growth in unplanned care is concentrated on our populations who are frail or live in areas of higher deprivation, in particular our Māori and Pacific communities in Porirua East.
- In Porirua, the Vaka Atafaga Pacific Nursing Service (VAPNS) operates as an outreach service, and focusses on addressing the needs of the whole fanau. The VAPNS model of care is acknowledges that Pacific people's health and wellbeing can only be adequately addressed with understanding of their lived experiences.

How are we performing?

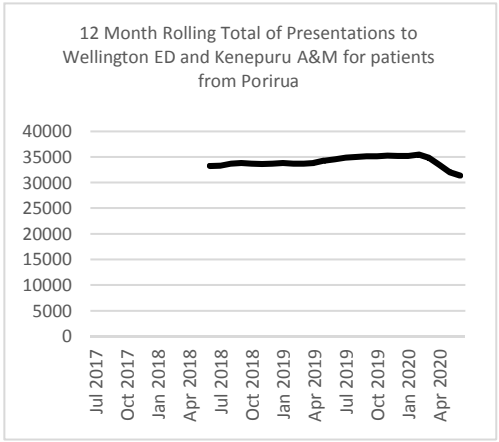
- Prior to the COVID-19 pandemic and lockdown beginning March, the number of presentations to Wellington ED and Kenepuru A&M for Porirua residents had been increasing. In particular, the rate of Pacific people presenting for unplanned care had been increasing faster than for Māori and non-Māori, non-Pacific people.
- VAPNS has worked with 102 referred individuals and 88 additional household members have been engaged with 50 individuals were referred by CCDHB services.

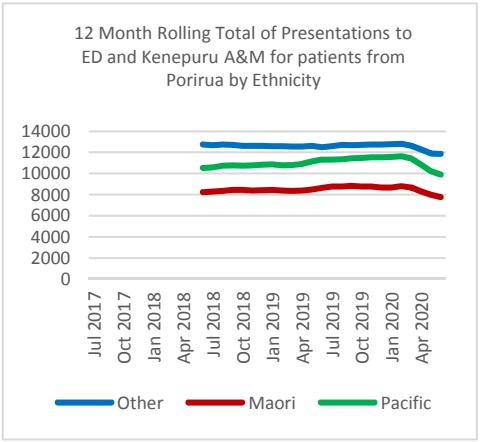
What is driving performance?

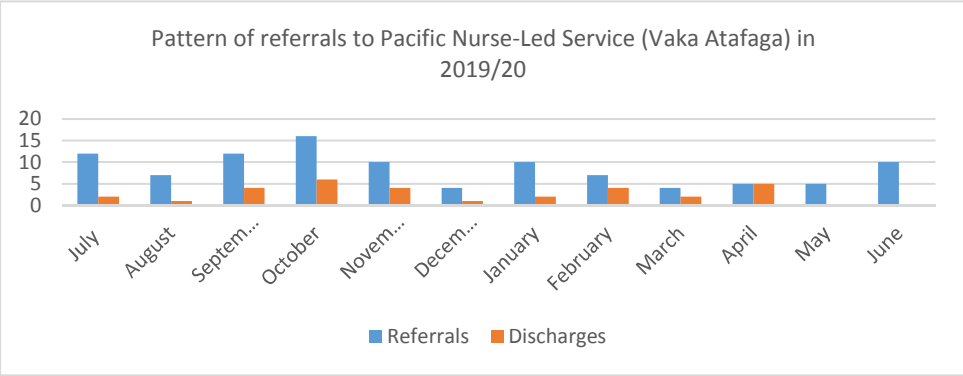
- Pacific households in Porirua are often dealing with complex challenges and may need to be supported for long periods of time to ensure they can develop skills and confidence to make fundamental changes in their lives.

Management comment

- 100% of fanau surveyed said they would recommend VAPNS to other Pacific fanau saying "your Service provides the missing links and you are supportive of the whole whanau."; "They weren't supporting just the patient they supported us as well." and "Because it is a service provided by our people who understand our cultures







Health of Older People – CHOPI, AWHI & AHOP

What is this measure?

- DHB Target: 90% of people 75+ living in own home

Why is this important?

- As outlined in the Healthy Ageing Strategy, we are supporting older people to live well with long-term health conditions and disabilities, and to remain in their homes for longer.
- Investing in healthy ageing has the potential to increase the proportion of healthy, active and independent older people; reduce the incidence of long-term conditions and their impacts on people's lives; and result in long-term savings to the heath system.
- The AWHI, CHOPI and AHOP services exist to respond to the range of health needs for the older person; supporting short hospital stays and reducing deconditioning, and supporting independence in the community.

How are we performing?

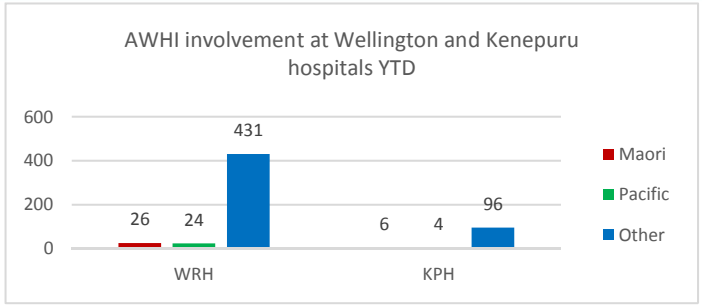
- CHOPI (Community Health of Older People Initative) – since September 2019, this new service has seen 326 people in the Wellington area. AWHI (Advancing Wellness at Home Initiative) – began as a pilot in October 2019, and unscaled to support discharge during COVID-19. In total 587 people have been supported by the AWHI service. AWHI has supported 14% of medical discharges across Wellington Regional and Kenepuru Community hospitals, with an estimated impact of 1704 bed days saved.
- From 25 May to end of July – 73 people were discharged from the new AHOP (Acute Health of Older People) ward under the care of a geriatrician. 69 of these people have been aged 75+ and three were been Maori or Pacific.

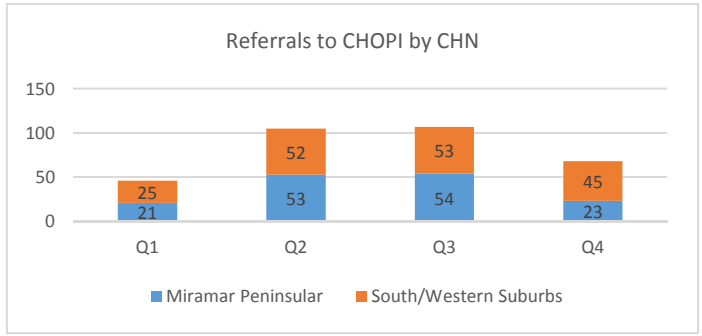
What is driving performance?

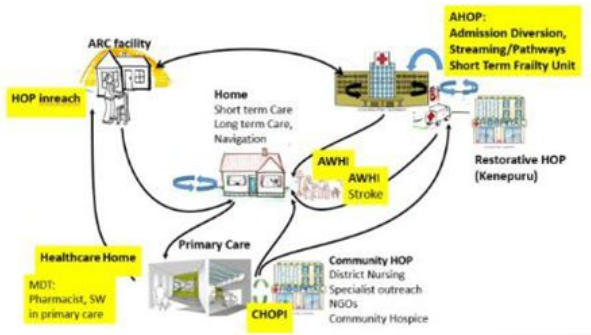
- During quarter 4, AWHI and CHOPI were managing services during all levels of the COVID-19 response. Further, the AHOP unit was initiated at the end of May as we were transitioning into level 1; with patterns of demand and utilisation likely impacted by events over this period.

Management comment

- AWHI, CHOPI and AHOP reflect a whole of system frail persons design informed by community and support reduced presentations to ED, fewer admissions to hospital and faster returns to home.







Section 2.2

Hospital Performance

Executive Summary – Hospital Performance

- Activity delivered by the CCDHB provider arm - ED attendances, surgical procedures, overall discharges, outpatient and community contacts have returned to pre COVID levels and are consistent with previous years for the month of July.
- Improvements in performance are seen across a number of services – faster cancer times, Radiology MRI and CT, Colonoscopy with marginal improvements in planned care targets - elective theatre cases have increased for the month of July 2020 by 3.5% (30 cases) when compared to July 2018. A recovery plan is in development which will need continued support from the private sector however DHBs consider at least a year will be required to address the backlog.
- However, our ED wait times have declined significantly due to a combination of factors – the on-going processes in place related to COVID-19 screening and precautions and our increased the elective and acute surgical work that was delayed during our COVID response. This exacerbates flow given the mismatch between inpatient activity and the existing bed base.
- A number of work streams continue to be rolled out within the Acute Demand and Bed Capacity Programme. Notable highlights are the expansion of the Advancing Wellness at Home Initiative (AWHI) project to a wider catchment and other inpatient wards, increasing the opening hours of the Children's Assessment Unit which has been relocated to the "Pink Zone" in ED, establishment of a Project group to review patients who have been in hospital more than 10 days, to identify barriers to patients being discharged and a working group established to identify space to create additional acute assessment beds.
- Ten serious Safety events were recorded for the month – these are being reviewed in line with our sentinel event processes.
- Outside two extraordinary items (additional costs during COVID-19 and Holidays Act Provisions) not included within the budget the Hospital provider arm has made a cautious start to the new financial year; targeted efficiency measures are in place however the pressure of clinical service demands and FTE management especially around annual leave is going to be a major challenge.

CCDHB Activity Performance

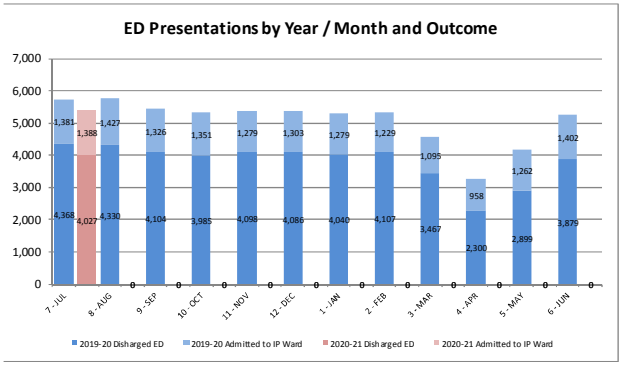
Capital and Coast DHB: July 2021

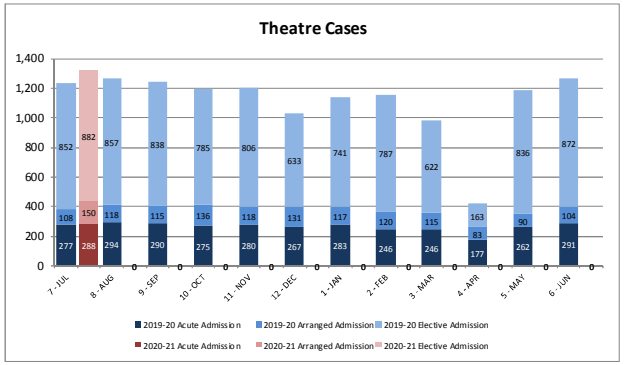
ED Presentations

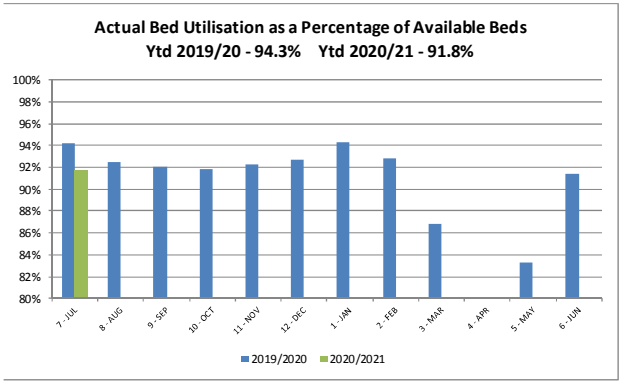
	2019/20	2020/21
YTD Totals	5,749	5,415
Change		-334
% Change		-6%

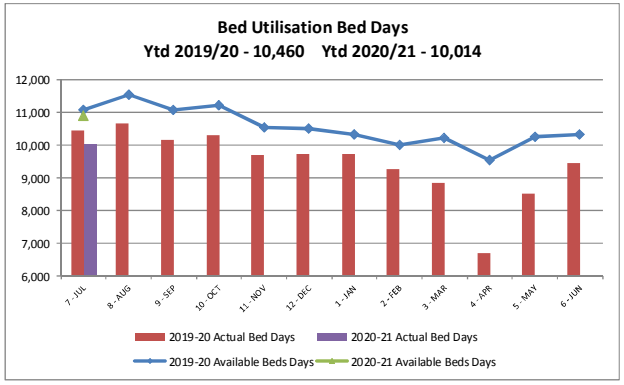
Theatre Cases

	2019/20	2020/21
YTD Totals	1,237	1,320
Change		83
% Change		7%









- The number of ED presentations in July 2020 is lower than the number recorded in the same month in the previous financial year. The emergency department in July 2020 has experienced a 5.8% decrease (334) in the number of presentations compared to July 2019, this equates to an approximate reduction of 10.7 presentations per day.
- The number of presentations for patients aged under 17 in July 2020 was 690 compared to a total of 1,009 in July 2019, a reduction of 319 (31.6% reduction), we are investigating possible reasons for this.
- The utilisation of available of adult beds in core wards in July 2020 is 91.8% which is significantly lower than the 94.3% rate recorded in July 2019. However the number of available beds in July 2020 is lower than in July 2019 due to COVID planning so pressure on beds is actually much higher.
- The Elective theatre cases have increased for the month of July 2020 by 3.5% (30 cases) when compared to July 2018. The increase are spread across a number of specialties in particular General Surgery (54), Cardiothoracic (15) but countered by deceases in Urology (-37) and Ophthalmology (-21).
- A recovery plan is in development which will need continued support from the private sector however DHBs consider at least a year will be required to address the backlog.

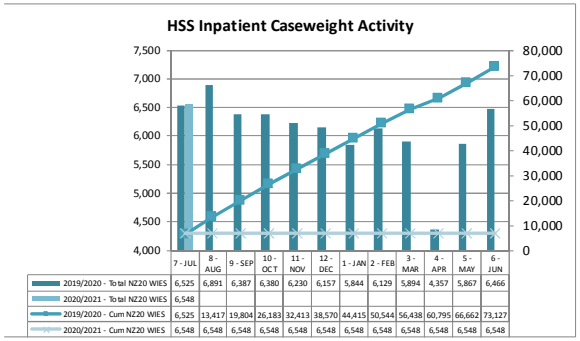
CCDHB Activity Performance

Capital and Coast DHB: July 2021

HSS Inpatient Caseweight Activity

	2019/20	2020/21
YTD Totals	6,525	6,548
Change		22
% Change		0.3%

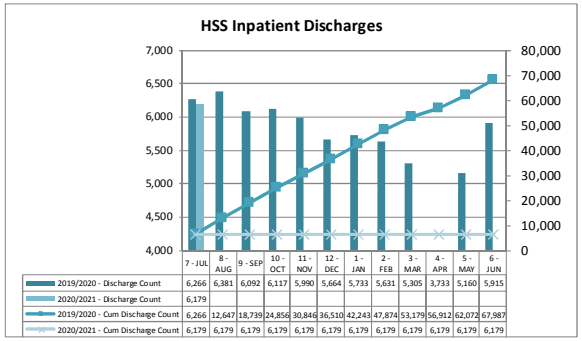
** This includes all Hospital Acitivty including ACC, Non Resident, Non-Casemix but excludes Mental Health*



HSS Inpatient Discharges

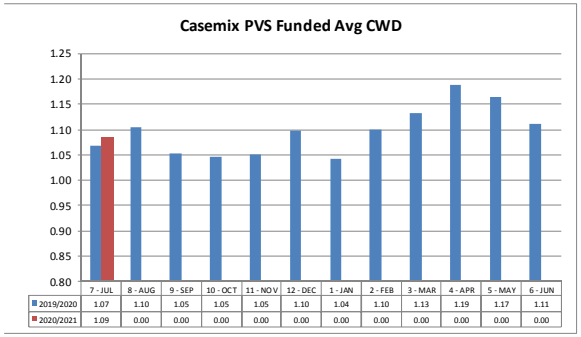
	2019/20	2020/21
YTD Totals	6,266	6,179
Change		-87
% Change		-1.4%

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



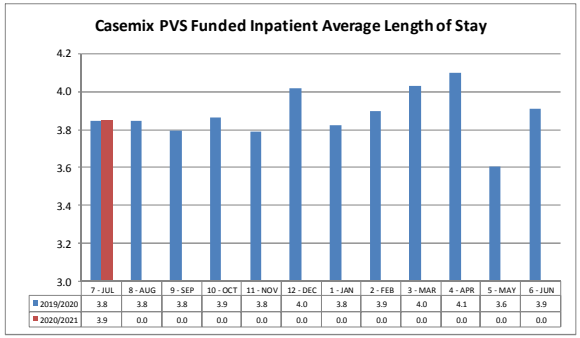
Casemix PVS Funded Avg CWD

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



Casemix PVS Funded Inpatient Average Length of Stay

	2019/20	2020/21
YTD Totals	3.87	3.85
Change		-0.02
% Change		-0.4%



Comparisons with same period last year:

- Local acute CWDs are lower than previous financial year (260 CWDs) with a decrease in discharges; a lower ALOS and a similar average CWD. Both the discharge decrease and CWD decrease is driven primarily by General Medicine, Paediatric Medicine and Cardiology.
- Local Elective CWDs are higher than the previous financial year (10 CWDs) with an increase in discharges; a lower ALOS and similar average CWD. The discharge increase is driven primarily by General Surgery and Vascular Surgery. The CWD increase is driven primarily by Cardiothoracic.
- IDF acute CWDs are higher (18 CWDs) than the previous financial year also with a decrease in discharges a similar ALOS and a higher average CWD. The discharge decrease is driven primarily by Cardiology and Paediatric Surgery. The CWD increase is driven primarily by Neurosurgery and Obstetrics.
- IDF Elective CWDs are higher than the previous financial year (157 CWDs) with more discharges a lower ALOS and a higher average CWD. The discharge increase is driven primarily by Vascular Surgery and Cardiothoracic. The CWD increase is driven primarily by Cardiothoracic, Cardiology and Vascular Surgery.

Discharges

- Publicly funded casemix discharges for the month of July 2020 have decreased by 164 (-2.8%) in comparison to the number of discharges recorded in July 2019. The decreases were spread across a number of specialties with the decreases most evident in General Medicine (144 Acute), Paediatric Medicine (101 Acute), Cardiology (46 Acute), Gynaecology (24 Acute, 9 Elective) and Oncology (23 Acute) but were countered by increases in General Surgery (33 Acute, 51 Elective), Neurology (35 Acute), Vascular Surgery (35 Elective) and Cardiothoracic (17 Acute, 14 Elective).
- The number of outsourced discharges in private facilities increased from 117 in July 2019 to 132 in July 2020 an increase of 15 discharge (13% increase).
- The July average CWD is the same as the result in comparison to the previous year.
- The July average Length of Stay for 2020/21 (3.85) is marginally lower (-0.02) than the previous year.

HHS Operational Performance Scorecard – period July 19 to July 20

Domain	Indicator	2020/21 Target	2019-Jul	2019-Aug	2019-Sep	2019-Oct	2019-Nov	2019-Dec	2020-Jan	2020-Feb	2020-Mar	2020-Apr	2020-May	2020-Jun	2020-Jul
Care	Serious Safety Events	Zero SSEs	3	3	2	3	3	9	6	10	9	9	8	6	10
	Total Reportable Events	TBD	1,251	1,180	1,094	1,153	1,058	1,004	879	1,106	1,207	722	903	1,076	1,146
Patient and Family Centred	Complaints Resolved within 35 calendar days	TBD	83.3%	81.7%	97.7%	93.4%	91.9%	87.5%	94.2%	87.7%	92.3%	100.0%	93.6%	94.0%	100.0%
	% Discharges with an Electronic Discharge summary	TBD													
Access	Emergency Presentations		5,749	5,757	5,430	5,336	5,377	5,389	5,319	5,336	4,562	3,258	4,161	5,281	5,415
	Emergency Presentations Per Day		185	186	181	172	179	174	172	184	147	109	134	176	175
	Emergency Length of Stay (ELOS) % within 6hrs	≥95%	78.2%	75.0%	74.4%	77.2%	75.5%	77.4%	80.0%	75.5%	78.7%	84.7%	82.8%	74.6%	72.6%
	ELOS % within 6hrs - non admitted	TBD	85.2%	82.1%	80.3%	83.7%	81.1%	83.2%	85.8%	81.2%	84.6%	90.7%	90.4%	82.6%	79.8%
	ELOS % within 6hrs - admitted	TBD	58.5%	55.9%	58.4%	60.0%	59.6%	61.1%	63.1%	58.6%	61.8%	70.5%	66.3%	54.6%	53.5%
	Total Elective Surgery Long Waits	Zero Long Waits	68	59	64	94	107	135	166	146	178	402	434	356	290
	Additions to Elective Surgery Wait List		1,470	1,420	1,400	1,312	1,399	1,120	1,128	1,411	1,270	554	1,085	1,498	1,375
	% Elective Surgery treated in time	TBD	88.6%	91.2%	92.7%	92.7%	92.1%	92.2%	85.8%	85.9%	89.0%	92.7%	76.4%	71.2%	72.8%
	No. surgeries rescheduled due to specialty bed availability	TBD	13	23	10	5	19	3	1	8	1	1	1	12	5
	Total Elective and Emergency Operations in Main Theatres	TBD	1,195	1,239	1,201	1,179	1,199	997	1,067	1,101	927	378	1,103	1,202	1,237
	Faster Cancer Treatment 31 Day - Decision to Treat to Treat	85%	92.0%	91.0%	93.0%	92.0%	85.0%	97.0%	89.0%	83.0%	88.0%	90.0%	92.0%	89.0%	92.0%
	Faster Cancer Treatment 62 Day - Referral to Treatment	90%	83.0%	92.0%	94.0%	97.0%	86.0%	97.0%	76.0%	88.0%	97.0%	92.0%	67.0%	85.0%	100.0%
	Specialist Outpatient Long Waits	Zero Long Waits	61	0	13	43	91	165	238	324	488	1,079	1,287	1,451	1,202
	% Specialist Outpatients seen in time	Zero Long Waits	91.5%	91.5%	91.0%	92.8%	91.9%	94.4%	80.4%	83.9%	81.9%	87.1%	81.1%	74.2%	74.5%
	Outpatient Failure to Attend %	TBD	6.9%	7.0%	7.3%	7.1%	7.0%	7.6%	6.9%	7.4%	7.7%	4.4%	7.1%	6.6%	7.0%
	Maori Outpatient Failure to Attend %	TBD	13.8%	14.4%	14.1%	14.7%	14.4%	15.8%	14.3%	14.3%	15.2%	8.3%	14.0%	13.6%	14.4%
	Pacific Outpatient Failure to Attend %	TBD	16.8%	15.9%	17.2%	16.7%	14.6%	16.3%	15.9%	15.7%	16.4%	7.8%	16.8%	16.1%	17.0%
Financial Efficiency	Forecast full year surplus (deficit) ($million)		($15.9m)	($15.9m)	($20.9m)	($20.9m)	($26m)	($29.5m)	($29.5m)	($29.5m)	($29.5m)	($47.5m)	($47.5m)	($44.2m)	($39.8m)
	Contracted FTE (Internal labour)		4,812	4,824	4,851	4,864	4,856	4,835	4,837	4,839	4,849	4,895	4,933	4,977	4,980
	Paid FTE (Internal labour)		5,154	5,155	5,187	5,163	5,209	5,263	5,192	5,195	5,197	5,188	5,198	5,307	5,297
	% Main Theatre utilisation (Elective Sessions only)	85.0%	80.4%	78.2%	79.2%	78.1%	79.0%	83.0%	82.0%	81.0%	80.0%	78.1%	82.0%	81.0%	83.0%
Discharge and Occupancy	% Patients Discharged Before 11AM	TBD	23.8%	24.4%	25.8%	25.6%	22.4%	24.0%	23.9%	24.3%	22.7%	19.3%	20.4%	21.9%	24.4%
	Adult Long Stay Patients Not Yet Discharged (>14 days) WLG	TBD	37	31	22	27	32	29	26	39	29	19	24	29	30
	Adult Overnight Beds - Average Occupied WLG	TBD	315	306	314	308	305	289	294	295	275	225	264	294	298
	Adult Long Stay Patients Not Yet Discharged (>14 days) KEN	TBD	24	29	27	19	27	23	23	18	10	17	16	17	20
	Adult Overnight Beds - Average Occupied KEN	TBD	77	84	83	76	71	66	72	69	62	46	55	63	71
	Child Overnight Beds - Average Occupied	TBD	29	32	29	24	24	21	19	21	18	15	18	23	24
	NICU Beds - ave. beds occupied	36	38	31	36	37	36	33	32	28	34	38	30	29	28
ALOS	Overnight Patients - Average Length of Stay (days)	TBD	3.85	3.85	3.79	3.86	3.79	4.02	3.82	3.90	4.03	4.10	3.61	3.91	3.85
Care	Rate of Presentations to ED within 48 hours of discharge	TBD	4.0%	3.8%	3.7%	3.7%	4.2%	3.6%	3.7%	4.2%	3.7%	4.1%	3.3%	3.8%	3.7%
	Presentations to ED within 48 hours of discharge	TBD	231	218	200	196	226	193	196	225	168	133	139	203	199
Staff Experience	Staff Reportable Events	TBD	123	121	125	138	127	102	111	138	137	89	108	161	134
	% sick Leave v standard	TBD	3.7%	3.4%	3.5%	3.2%	2.9%	2.4%	2.1%	2.6%	2.9%	2.2%	2.5%	3.6%	4.0%
	Nursing vacancy	TBD	221.0	221.4	212.2	208.9	213.9	227.3	217.6	210.3	204.8	190.3	168.1	155.6	262.0
	% overtime v standard (medical)	TBD	1.9%	1.8%	1.7%	1.7%	1.7%	1.6%	1.6%	1.7%	1.9%	1.4%	1.4%	1.6%	1.7%

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

Shorter Stays in ED (SSIED)

What is this measure?

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

Why is this important?

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

How are we performing?

- CCDHB SSIED performance for July 2020 was 73%. This result is a decrease on the 75% recorded last month (June 2020) and the 78.3% recorded in July 2019. The performance of patients who were seen, treated and discharged by ED for July 2020 was 82%. The performance of patients who were seen, and admitted to hospital for July 2020 was 57%.
- A factor that impacts on our SSiED performance is the occupancy / bed utilisation in our wards. The average occupancy for July 2020 was 90%. The occupancy rate is based on core Adult Wards (Wellington and Kenepuru) excluding 4 North and ICU. The number of available adult beds in July 2020 was 358.

What is driving performance?

- Our performance being less than target was due to the increase of elective and acute surgical work that was delayed during our COVID response. We also have in place on-going processes related to COVID-19 screening and precautions.
- As we move through winter we are also operating parallel processes in our in-patient wards to manage COVID case definition vs. non-COVID patients. Our acute flow programme of work is focusing on medical teams identifying and discharging patients earlier in the day. This then frees beds for those being admitted from ED to move to the ward in a timelier manner and thus improves our SSiED performance.

Performance	MAY	JUN	JUL
2018-19	83%	76%	78%
2019-20	83%	75%	73%

Breaches	MAY	JUN	JUL
2018-19	886	1188	1149
2019-20	680	1259	1358

ED Volumes	MAY	JUN	JUL
2018-19	5,204	5,031	5,285
2019-20	4,003	4,952	5,024

Management Comment

- The following work streams continue to be progressed and rolled out including:
  - To free up ED, we continue to use Ward 6 East as our "query COVID" ward for patients who have been swabbed as part of their admission process. Once the results come back negative the patients are transferred to the ward where they will be treated for their presenting concern.
  - The Acute Health of the Older Person (A-HOP) / Frailty Unit pilot in Ward 3 continues with an initial review due in late August.
  - The Advancing Wellness at Home Initiative (AWHI) project has been rolled out to a wider catchment and other inpatient wards. AWHI is an early supported discharge for people whose level of function has declined on admission and has involved making changes to the patient care coordination service to identify potential patients needing intervention earlier in admission with the goal of reduction in the over 10 day stays for complex patients in general medicine.
  - Children's Health with Emergency Services continue to work on a project to increase the opening hours and resourcing of the Children's Assessment Unit which has been relocated to the "Pink Zone" in ED had been a direct result of COVID-19 response planning. It has been agreed that this initiative should continue in ED.
  - Project group to review patients who have been in hospital more than 10 days, to identify barriers to patients being discharged continues to identify barriers to discharge and address these with our teams.
  - Activities continue across the organisation to improve discharge processes.
  - Work group established to identify space to create additional acute assessment beds.

Planned Care – Inpatient Surgical Discharges/Minor Procedures

What is this measure?

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

Why is this important?

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

How are we performing?

- Due to timing delays there is a six week lag in MOH reporting for inpatient volumes.
- CCDHB has achieved 95.4% of the target planned care intervention volume YTD as at June month end. This is comprised of a 1,391 under delivery in inpatient discharges, partially offset by a 748 over delivery in minor procedures. This result was confirmed by the MoH as at 3 August 2020.
- As per MoH reporting, CCDHB was adverse 566.9 CWDs YTD as at the end of June, this equates to $2.90m YTD. The June result was favourable 104.2 CWDs, or $543k which was an improvement from May results (-663.6 YTD).
- The MoH had confirmed that they will pay to target for the March to June period as long as 85% of planned discharges are achieved in June. As forecast we performed well in achieving 95.4%.

What is driving performance?

The improvement in discharges and case weights in June supports our recovery post COVID-19 efforts, resulting in 33 ahead of target for June.

Management Comment

We continue to work on scheduling surgery, both in Wellington and Kenepuru, and utilising private facilities where possible. Currently only able to outsource to one provider while new contracts are being negotiated. SMOs continue to be involved with planning surgery based on those with greatest clinical urgency and long waiting times.

MRI and CT Waiting Times

What is this measure?

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

Why is this important?

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

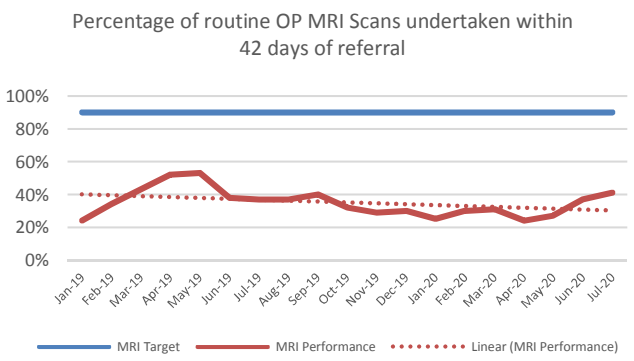
How are we performing?

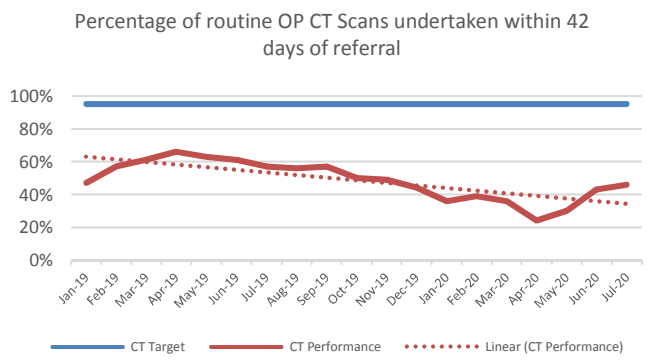
Waiting times for CT and MRI remain high as a result of historical insufficient capacity to meet demand and the pandemic response. Subsequently, the percentage measure is low.

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

What is driving performance?

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





Management Comment

With current waiting times, there is still a critical risk of patient harm including disease progression. The likelihood of significant adverse events remains high and has already occurred on at least two occasions this year. The service continues to prioritise based on clinical urgency and performs Inpatient and ED patients within expected timeframes to maximise inpatient flow.

Actions currently underway to address waiting times:

- Increased outsourcing in line with MOH request and additional unbudgeted spend
- Finalising draft updated agreement with local private Radiology provider lead by SPP with input from both HV and CC DHB Radiology departments
- Ad hoc elective lists booked on weekends staffed with volunteer MIT/SMO where sufficient staffing allows
- Working with the region to increase RMO training positions (long term solution to mitigate national SMO shortages)
- Recruiting to 3 new SMO Radiologist positions

It is difficult to predict with certainty the production and demand in the next 3 – 6 months due to a variety of factors (e.g. recruitment and retention, COVID response, MOH waiting list initiatives) however, we expect further improvement in waiting times through July and August.

Coronary

Coronary Angiography Waiting Times

What is this measure?

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

Why is this important?

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

How are we performing?

- The proportion of patients waiting less than 90 days for angiography has improved (96.6%) a first in 12 months.

What is driving performance?

- With low referral rates in April due to COVID, the service has been able to recover.

Acute Coronary Syndrome

Key clinical quality improvement indicators

What is this measure?

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

Why is this important?

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

How are we performing?

1. 70% of high-risk patients will receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0'):
   - CCDHB result for June (most recent data that is available) was 89.7%. As a region we did achieve the target for June, 75% 117/156)
   - Hawkes Bay, did not achieve the target 56.5%, this is an aggregated reflecting access to their local lab as well. Hutt Valley, 66.7%, Wairarapa 54.5% and Whanganui 23.1%, did not achieve the target either.
2. The second measure relates to data quality, integrity – the target is that over 95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS-QI ACS and Cath/PCI registry data collection within 30 days.
   - CCDHB result for June was 97.1%. As a region we achieved target for June – 96.2%.

What is driving performance?

- Not achieving the target differs for each centre. The table below provides a breakdown. The referral to transfer is directly influenced by CCDHB, ultimately this relates access to beds.

	2019 Jul	2019 Aug	2019 Sep	2019 Oct	2019 Nov	2019 Dec	2020 Jan	2020 Feb	2020 Mar	2020 Apr	2020 May	2020 Jun	2020 Jul
Waiting or catheterised in 90 days (3 months) or less	144	139	124	139	140	126	107	99	115	95	85	100	114
Total number waiting or catheterised	197	179	157	171	179	174	169	155	154	118	110	119	118
% of Coronary Angiographies in 90 days (3 months) or less	73.1 %	77.7 %	79.0 %	81.3 %	78.2 %	72.4 %	63.3 %	63.9 %	74.7 %	80.5 %	77.3 %	84.0 %	96.6 %

Faster Cancer Treatment

What is this measure?

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

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

Why is this important?

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

How are we performing?

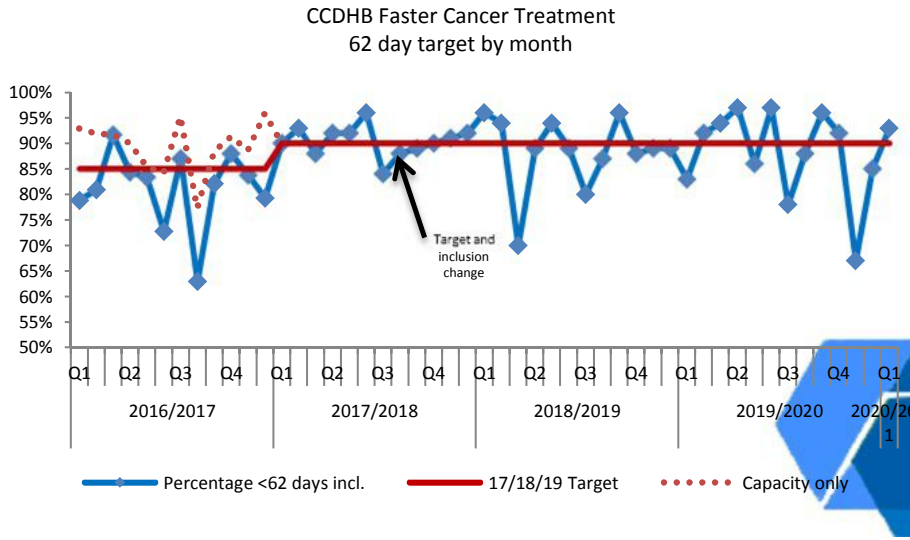
- CCDHB is compliant with the 62 day target for July 93% vs the aim of 90% of patients receiving their first cancer treatment within 62 days of being referred with a high suspicion of cancer.
- CCDHB is compliant with the 31 day indicator for July at 92% vs the aim of 85% of patients commencing treatment within 31 days from decision to treat. CCDHB has been compliant for all quarters in 2019 2020.

What is driving performance?

- Challenges for reaching the 62 day target, such as access to FSA contributed to delays in the front end of the patient pathway.
- In July a low number of patients were referred. Meeting the 31 day indicator was also affected by a reduced number of patients. All 31 day breach patients (4) had surgery as first treatment. Capacity constraints related to urology, breast, lower GI, H&N tumour streams

Management Comment

- Covid 19 planning and beyond proved challenging for services that assess, treat and manage patients with cancer. As a consequence the patients that did present were acute and our numbers remain low. Despite that, previous concerns diagnostic pathway bottlenecks as a consequence of anticipating increasing referrals has not eventuated.



Colonoscopy

What is this measure?

Diagnostic colonoscopy

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

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

Surveillance colonoscopy

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

Why is this important?

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

How are we performing?

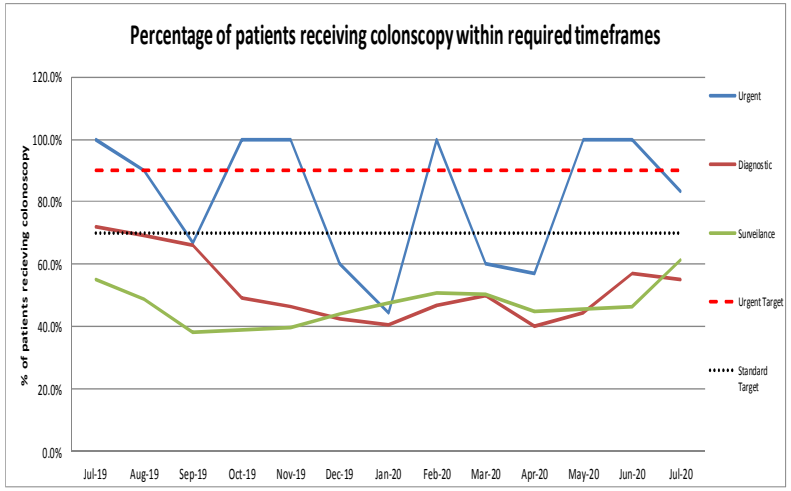
- CCDHB did not meet the Ministry of Health target for non-urgent and surveillance colonoscopies achieving 55.1% and 61.4% respectively against a targets of 70%. We did not meet the Ministry of Health target for Urgent achieving 83%.

What is driving performance?

- At the end of July there were 504 people on the colonoscopy waiting list. Of these, 124 patients had been waiting 'longer than recommended' (a reduction of 60 compared to the previous month).

Management Comment

- We continue to outsource cases to reduce the waiting list which is beginning to have an impact.
- We are well advanced in our bowel screening readiness review



Section 2.3

Mental Health Addiction & Intellectual Disability

Executive Summary – Mental Health Performance

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

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

Indicator	2020/21 Target	2019-Jul	2019-Aug	2019-Sep	2019-Oct	2019-Nov	2019-Dec	2020-Jan	2020-Feb	2020-Mar	2020-Apr	2020-May	2020-Jun	2020-Jul
Access Rate	3%	3.9%			3.6%			3.8%						
Shorter waits for non-urgent Mental Health services <= 3 weeks (Younger Persons Community & Addictions Sector)	80%	34.3%	39.8%	37.8%	47.4%	43.4%	39.0%	52.7%	59.7%	39.1%	34.6%	52.9%		
Shorter waits for non-urgent Mental Health services <= 3 weeks (Adult Community & Addictions Sector)	80%	65.1%	61.9%	59.2%	59.3%	65.3%	55.7%	61.9%	64.5%	59.1%	45.8%	65.8%		
Shorter waits for non-urgent Mental Health services <= 8 weeks (Younger Persons Community & Addictions Sector)	95%	86.4%	85.2%	75.6%	90.2%	83.2%	93.3%	94.6%	82.0%	54.3%	81.5%	96.7%		
Shorter waits for non-urgent Mental Health services <= 8 weeks (Adult Community & Addictions Sector)	95%	91.2%	95.0%	87.2%	89.2%	87.6%	87.9%	91.7%	88.4%	74.1%	78.0%	96.8%		
Community service users seen in person in last 90 days	95%	77.8%	78.2%	79.3%	77.5%	79.1%	76.6%	77.9%	76.4%	68.8%	54.8%	56.1%	62.9%	76.7%
Community DNA rate	<=5%	8.0%	7.5%	7.6%	8.0%	8.6%	7.4%	7.4%	7.8%	7.0%	4.0%	5.1%	6.7%	6.9%
Maori under Section 29 CTO (Rate per 100,000 population) 2019/20 Target: 10% reduction of rate of previous year (405)		425			415			417						
Wellness Plans	95%	42.2%			41.2%			43.1%						
Wellness Plans - Acceptable Quality	95%	71.1%			68.8%			78.9%						
Community Services Transition (Service Exit) Plans	95%	53.3%			48.7%			47.6%						
Community Services Transition (Service Exit) Plans - Acceptable Quality	95%	67.4%			66.1%			61.9%						

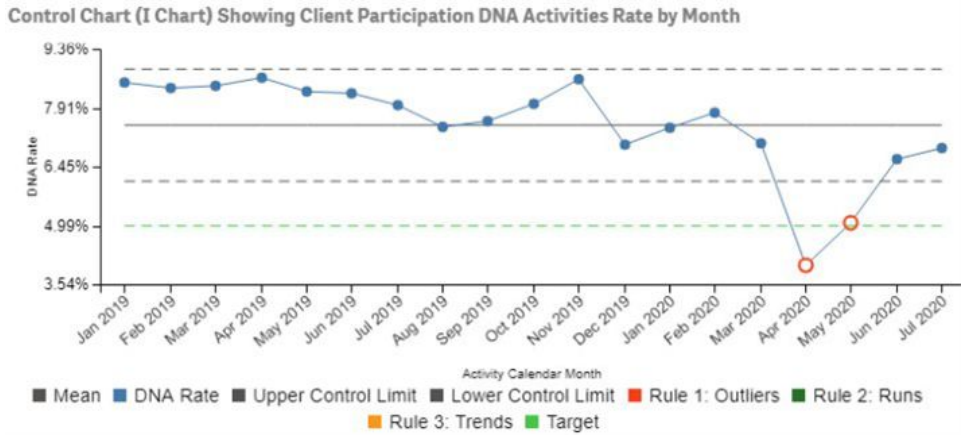
Adverse Performance requiring immediate corrective Action | **Performance is below target, corrective action may be required** | **Performance on or better than Target / Plan**

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

Indicator	2020/21 Target	2019-Jul	2019-Aug	2019-Sep	2019-Oct	2019-Nov	2019-Dec	2020-Jan	2020-Feb	2020-Mar	2020-Apr	2020-May	2020-Jun	2020-Jul
Pre-Admission Community Care	75%	75.7%	66.7%	54.7%	64.7%	58.3%	71.4%	51.2%	71.7%	70.6%	67.6%	63.2%	65.9%	72.5%
Post-Discharge Community Care	90%	75.6%	70.0%	66.4%	72.8%	76.5%	85.7%	73.1%	87.5%	77.5%	75.0%	87.0%	87.8%	78.7%
Acute Inpatient Readmission Rate (28 Day)	<=10%	4.5%	6.7%	3.7%	10.6%	3.3%	2.9%	7.6%	7.9%	3.1%	13.1%	8.5%	5.1%	5.0%
Inpatient Services Transition Plan	95%	65.5%			71.1%			70.5%						
Inpatient Services Transition Plan - Acceptable Quality	95%	73.3%			87.5%			82.7%						
Clinically Safe Acute Inpatient Occupancy Rate Te Whare Ahuru		103.8%	103.0%	101.7%	103.8%	90.6%	100.1%	100.9%	102.4%	98.1%	78.6%	82.0%	103.8%	98.8%
Clinically Safe Acute Inpatient Occupancy Rate Te Whare O Matairangi		98.7%	99.2%		110.0%	104.8%	110.9%	102.9%	105.1%	101.1%	100.0%	93.2%	106.2%	105.6%
Seclusion Hours	Aspirational goal of zero seclusion by 31 December 2020	848	451	711	679	668	404	458	622	995	710	632	984	588
Seclusion Hours - Māori		224	325	190	261	439	113	265	254	682	295	282	639	132
Seclusion Hours - Pacific Peoples		493	6	8	134	162	157	3	289	74	136	116	195	91
Seclusion Events		23	19	18	17	14	11	16	21	32	28	28	28	21
Seclusion Events - Māori		9	11	7	7	8	6	8	13	15	12	14	13	7
Seclusion Events - Pacific Peoples		6	1	1	4	2	2	1	4	4	3	4	9	4

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

KPI Spotlight – MHAIDS Did Not Attend Rate



What is this measure?

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

Why is it important?

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

How are we performing?

There has been an overall reduction in the DNA rate since the first half of 2019. Recent results for April and May are not comparable as there were significantly less face-to-face appointments being offered during the COVID-19 lockdown period.

What is driving performance?

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

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

Section 3

Financial Performance and Sustainability

Executive Summary Financial Performance and Position

- The DHB has budgeted a deficit of $39.8 million. The responsible deficit in the month was $3.7m favourable against budget.
- Two extraordinary items exist which are not included within the budget, which the ministry has advised are regarded as outside the DHBs performance assessment:
  - ($2.0m); COVID-19: additional costs during COVID-19
  - ($0.75m); Holidays Act Provisions
- The DHB had targeted a reasonable number of efficiency measures for the year ahead totalling $38m, which are required to meet our deficit position $3.1 million relates to our first month from both personnel vacancies, efficiency savings across all services and ICT gains through consolidation and rationalisation.
- The DHB also had a number of key safe care initiatives totalling $15.8m which are largely still due to start within the year
- The DHB's cash is under pressure for 2020/21 due to level of deficit support lower than last years deficit and no cash funding provided for provider arm COVID-19 costs. This was mitigated at year end by a delay to payment of capital charge, increase in leave liabilities (as this is non cash) and significant delays to our capex spend (offset by non cash depreciation). The DHB by day 2 of the new financial year was already ($22.8m) in overdraft, offset by $12m in special fund balances.
- The focus of the DHB last year turned to the planning and preparedness for COVID-19. This has resulted in groups being formed and staff dedicated to planning, 122,000 hours of planning recorded up to May 2020 (not direct patient activity) has been focused on COVID-19. We intend to keep a close eye on the latest Auckland outbreak for reintroducing this planning hours tracking.
- COVID-19 from the first outbreak continues to incur some additional costs and also disruption to normal BAU for some components of the hospital operation and management. We have put in place tracking and monitoring systems to enable all the costs to be captured and reported to the Ministry, the key items of which are shown on the next slide, this is in addition to the unfunded ($8m) from the prior financial year.

Non-responsible deficit: COVID-19 & Holidays Act

Last Year			Capital & Coast DHB Operating Results - $000s	This Year to Date			Total Provision/Expense	
COVID-19 change from Trend - Provider	COVID-19 change from Trend - Funder	Holidays Act [2003]	YTD July 2020	COVID-19 change from Trend - Provider	COVID-19 change from Trend - Funder	Holidays Act [2003]	COVID-19	Holidays Act [2003]
	(8,317)		Devolved MoH Revenue		(521)		(8,838)	0
			Non-Devolved MoH Revenue				0	0
2,037			Other Revenue	210			2,247	0
			IDF Inflow				0	0
			Inter DHB Provider Revenue				0	0
2,037	**(8,317)**	**0**	**Total Revenue**	**210**	**(521)**	**0**	**(6,591)**	**0**
			Personnel					
(1,610)		(2,049)	Medical	(411)		(209)	(2,021)	(24,347)
(1,620)		(9,145)	Nursing	(95)		(343)	(1,715)	(39,910)
		(1,370)	Allied Health			(57)	0	(6,643)
		32	Support			(15)	0	(1,783)
		168	Management & Administration			(65)	0	(7,533)
(3,230)	**0**	**(12,365)**	**Total Employee Cost**	**(506)**	**0**	**(690)**	**(3,736)**	**(80,215)**
			Outsourced Personnel					
(51)			Medical	(36)			(87)	0
			Nursing				0	0
			Allied Health				0	0
			Support				0	0
			Management & Administration				0	0
(51)	**0**	**0**	**Total Outsourced Personnel Cost**	**(36)**	**0**	**0**	**(87)**	**0**
2,834			Treatment related costs - Clinical Supp	(78)			2,755	0
(1,952)			Treatment related costs - Outsourced	(582)			(2,534)	0
(1,921)			Non Treatment Related Costs	(630)		(66)	(2,551)	(66)
			IDF Outflow				0	0
	(9,917)		Other External Provider Costs (SIP)		(521)		(10,438)	0
			Interest Depreciation & Capital Charge				0	0
(1,039)	**(9,917)**	**0**	**Total Other Expenditure**	**(1,291)**	**(521)**	**(66)**	**(12,767)**	**(66)**
(4,320)	**(9,917)**	**(12,365)**	**Total Expenditure**	**(1,833)**	**(521)**	**(756)**	**(16,590)**	**(80,281)**
6,357	**1,600**	**12,365**	**Net result**	**2,043**	**0**	**756**	**9,999**	**80,281**

- The year to date financial position includes $2.04m additional costs in relation to COVID-19.
- Revenue of $521k has been received to fund additional costs for community providers which is now exhausted. The DHB may be expected to fund any expenditure involved with assessments through GPs or CBACs.
- IDF revenue and outflow expense were set to an extrapolated rate utilising the non-COVID-19 period (Jul-Feb 20) for Mar-June. This means IDF was not a COVID-19 impact in 19/20. We have yet to have an indication for the new financial year.
- Personnel costs are not split by category in this report, (Direct costs against Medical personnel and Indirect against Nursing personnel to align with our MoH COVID tracker which does not track by personnel group)
- Whilst COVID-19 planning & costs was initially reducing in July, offsetting savings in clinical supplies from getting back to normal has meant the net effect in July was still approx. $2m net impact, which is unfunded but excluded from our responsible deficit.
- Holidays Act is being accrued by month into our provision based on working days in each month, until we revise any provision required / key decisions made on assumptions.

CCDHB Operating Position – July 2020

Month - July 2020				Capital & Coast DHB Operating Results - $000s	Year to Date								Annual		
			Variance					Variance		Adjustments					
Actual	Budget	Last year	Actual vs Budget	YTD July 2020	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	COVID-19 change from Trend	Holidays Act [2003]	Actuals exc COVID-19 / HA	Annual Budget	Last year	Last year exc HA/COVID/ NOS
77,720	77,550	73,491	170	Devolved MoH Revenue	77,720	77,550	73,491	170	4,229	(521)		77,199	930,600	892,143	883,827
3,834	3,625	3,459	209	Non-Devolved MoH Revenue	3,834	3,625	3,459	209	375			3,834	42,688	41,220	41,220
3,694	2,967	3,466	727	Other Revenue	3,694	2,967	3,466	727	229	210		3,904	34,596	36,600	38,636
21,770	21,452	20,181	317	IDF Inflow	21,770	21,452	20,181	317	1,589			21,770	257,429	239,666	239,666
812	782	724	30	Inter DHB Provider Revenue	812	782	724	30	88			812	9,247	8,560	8,560
107,829	**106,376**	**101,320**	**1,454**	**Total Revenue**	**107,829**	**106,376**	**101,320**	**1,454**	**6,509**	**(311)**	**0**	**107,518**	**1,274,560**	**1,218,189**	**1,211,909**
				Personnel											
15,239	15,942	14,405	702	Medical	15,239	15,942	14,405	702	(834)	(411)	(209)	14,619	185,399	175,829	172,170
19,916	18,581	17,541	(1,335)	Nursing	19,916	18,581	17,541	(1,335)	(2,375)	(95)	(343)	19,478	234,861	233,986	223,222
5,750	5,677	5,309	(73)	Allied Health	5,750	5,677	5,309	(73)	(441)		(57)	5,693	69,242	63,729	62,359
892	895	844	3	Support	892	895	844	3	(48)		(15)	877	10,977	9,759	9,790
6,429	6,626	6,420	196	Management & Administration	6,429	6,626	6,420	196	(10)		(65)	6,364	77,509	71,657	71,825
48,226	**47,720**	**44,519**	**(506)**	**Total Employee Cost**	**48,226**	**47,720**	**44,519**	**(506)**	**(3,707)**	**(506)**	**(690)**	**47,030**	**577,988**	**554,960**	**539,365**
				Outsourced Personnel											
504	448	460	(56)	Medical	504	448	460	(56)	(44)	(36)		468	5,280	6,671	6,620
60	25	76	(34)	Nursing	60	25	76	(34)	17			60	298	250	250
134	114	115	(20)	Allied Health	134	114	115	(20)	(19)			134	1,364	1,464	1,464
45	22	42	(23)	Support	45	22	42	(23)	(3)			45	262	287	287
386	84	247	(302)	Management & Administration	386	84	247	(302)	(139)			386	970	2,674	2,674
1,128	**694**	**940**	**(435)**	**Total Outsourced Personnel Cost**	**1,128**	**694**	**940**	**(435)**	**(188)**	**(36)**	**0**	**1,092**	**8,175**	**11,346**	**11,295**
11,134	11,332	10,776	198	Treatment related costs - Clinical Supp	11,134	11,332	10,776	198	(357)	(78)		11,056	133,194	124,009	126,843
1,868	1,882	2,062	14	Treatment related costs - Outsourced	1,868	1,882	2,062	14	194	(582)		1,286	28,959	23,749	21,797
6,287	6,844	6,550	557	Non Treatment Related Costs	6,287	6,844	6,550	557	264	(630)	(66)	5,657	83,461	78,547	76,627
9,059	8,965	8,736	(94)	IDF Outflow	9,059	8,965	8,736	(94)	(323)			9,059	107,584	102,847	102,847
26,755	26,533	24,860	(222)	Other External Provider Costs (SIP)	26,755	26,533	24,860	(222)	(1,895)	(521)		26,234	317,042	307,255	297,339
5,161	5,164	5,112	4	Interest Depreciation & Capital Charge	5,161	5,164	5,112	4	(49)			5,161	57,973	59,648	59,648
60,264	**60,720**	**58,097**	**456**	**Total Other Expenditure**	**60,264**	**60,720**	**58,097**	**456**	**(2,166)**	**(1,811)**	**(66)**	**58,453**	**728,213**	**696,056**	**685,100**
109,618	**109,133**	**103,557**	**(485)**	**Total Expenditure**	**109,618**	**109,133**	**103,557**	**(485)**	**(6,061)**	**(2,353)**	**(756)**	**106,575**	**1,314,375**	**1,262,362**	**1,235,761**
(1,789)	**(2,758)**	**(2,236)**	**969**	**Net result**	**(1,789)**	**(2,758)**	**(2,236)**	**969**	**448**	**2,042**	**756**	**943**	**(39,815)**	**(44,173)**	**(23,852)**
(3,020)	(3,245)	(740)	225	Funder	(3,020)	(3,245)	(740)	225	(2,280)				9,647	10,971	
62	(0)	15	62	Governance	62	(0)	15	62	47				(0)	1,080	
1,169	487	(1,511)	682	Provider	1,169	487	(1,511)	682	2,680				(49,462)	(56,224)	
(1,789)	**(2,758)**	**(2,236)**	**969**	**Net result**	**(1,789)**	**(2,758)**	**(2,236)**	**969**	**448**				**(39,815)**	**(44,173)**	

*HA/FPIM relates to provisions for Holidays Act and impairment of FPIM (National Oracle System)

Note two adjustments are made for COVID-19 and Holidays Act.
These two items form part of the DHB deficit as revenue from MoH/Government has not been received to offset these costs, but is excluded from our responsible deficit.

Executive Summary – Financial Variances

- The DHB deficit year to date is ($1.8m)
- Included within this result is recognition of the adjustment to the holiday act provision ($0.75m) and an estimated impact of COVID-19 of ($2m).
- Excluding the two items above brings the deficit for the year into surplus of $1m being $3.8m favourable to budget.
- Revenue is favourable by $1.5m YTD. The largest variance is due to special fund/ research revenue. Inpatient IDF revenue was recognised to target for July.
- Personnel costs including outsourced is ($1m) YTD however excluding the Holidays Act monthly provision ($.75m) the remainder of the costs are on budget overall for the DHB. This also includes COVID-19 related costs of ($506k) incurred within the year.
- Treatment related clinical supplies $200k, this partially overspend in blood products which were offset by favourable variances across all other categories.
- Outsourced clinical services is on budget YTD.
- Non treatment related costs $557k favourable due to lower spend on asset maintenance, and new investment initiatives not yet commenced.
- The funder arm is slightly favourable for the month across community expenditure whilst programmes commence

Safe Care Initiatives

The DHB budgeted a number of Safe Care initiatives due to commence in the 2020/21 financial year listed below, the planning to commence these activities is occurring.

Care Capacity Demand	Optimisation / Efficiency Impact	Clinical Risk	Final Budget	Achievement to date
CCDM Implementation	CCDM Implementation		$ 4,000,000	Yet to commence, DONM office working on implementation plan
Hospital Flow / Clinical Risk				
Clinical Nurse Specialist Staffing - Emergency Department	Reduced stay in ED and improved management of flow through ED.		$ -	To be absorbed and delivered through internal priortisation
Intensive Care Capacity	Additional beds required to meet demand and reduce short notice cancellations of operating theatres increasing elective procedures.	Safer for patients.	$ -	RBC signed to hire over budget in August
Radiology	Reduced delays in treatment reducing unnecessary bed days and unnecessary outpatient appointments.	Timely access to radiology procedures reducing risk of delayed treatment.	$ 1,400,000	RBCs signed for advertisement
Pharmacy	Reduced avoidable inpatient bed days as a consequence of medicine error.	Reduction in medicine errors - CCDHB has one of the highest medical error rates in NZ due to low pharmacy staffing levels.	$ 320,000	To be progressed as second stage of improvements
Child Acute Assessment - safer emergency care.	Reduced utilisation of Emergency Department improving patient flow.	Safe staffing and patient model of care.	$ 350,000	
Ophthalmology		Safe access to services and compliance with Ministry targets and expectations	$ -	To be absorbed and delivered through internal priortisation
Planning our 2DHB Performance				
Production Planning Technical Support	Improved utilisation of operating theatres, inpatients beds and outsourcing to reduce cost of planned care delivery.		$ -	To be absorbed and delivered through internal priortisation
2DHB Network Planning	Investment in planning and implementation of the 2DHB network.		$ 400,000	Reduced cost through intended use of less consultants
Older People & Frailty				
Early supported discharge from hospital (AWHI)	Allied health teams in the community enabling earlier discharge and fewer bed days.	Better outcomes for people who avoid unnecessary delays in hospital.	$ 400,000	Scaled back to 40% of inital bid in line with timeframes
Frailty Assessment	Reduced admissions and bed days for frail older people reducing demand for inpatient beds.	Improved outcomes for older people as not admitted to hospital.	$ 500,000	
Community Health Older People Initiative	Reduced admissions of older people to hospital and better care in the community.	Geriatrician support for general practise ensuring best clinical practise in the community.	$ 175,000	Scaled back to 50% of inital bid in line with timeframes
Community Pharmacists for older people with multiple medications.	Reducing complications of multiple medications resulting in avoidable use of health services.	Reduced complications from multiple medications.	$ 90,000	Scaled back to 50% of inital bid in line with timeframes
Equity - Community Acute Response - Porirua	To commence the successful Kapiti Acute Response Service to Porirua to reduce unnecessary admission to hospital reducing bed days.	Safer care in community.	$ 225,000	Scaled back to start in Jan 2021
Equity - Mothers, Babies & Families				
Equity - Social Worker support for priority and vulnerable populations	Priority equity focus improving outcomes and making better use of resources.	Safety of our support for mothers, babies and families with children. Especially those who experience risk factors.	$ 200,000	
Equity - Mothers & Babies in Community	Priority equity focus improving outcomes and making better use of resources.	Integrated support in our communities for priority and vulnerable populations to improve outcomes and manage risk.	$ 300,000	
Equity - At Risk/Violence Programmes	Priority equity focus improving outcomes and making better use of resources.	Implement health's response to violence and at risk families as part of the inter-sectoral response.	$ 150,000	
Equity - Youth One Stop Shop in Porirua.	Priority equity focus improving outcomes and making better use of resources.	Provide a service in Porirua equivalent to Kapiti, Wellington Central and Hutt Valley.	$ 500,000	Start date scaled back by 3 months
Mental Health & Wellbeing				
Co-Response Mental Health Team with Police and Ambulance	Reduced avoidable use of Emergency Department through partnering with NZ Police and Welling Free Ambulance	Safer care in the community.	$ 250,000	RBCs hired and in place
Equity - NGO Acute Alternatives	Reduced demand on acute inpatient units.	Safer care in the community and improved mental health.	$ 450,000	
Equity Investment				
Equity investment to support Taurite Ora Implementation - Workforce	Optimising use of health resources.	Improving health outcomes and clinical and cultural safety.	$ 500,000	
Strategic ICT				
ICT investment			$ 5,600,000	
Total Budget Cost			**$ 15,810,000**	

Savings within budget 2020/21

The DHB budgeted a number of savings initiatives within the budget:

Amount	Savings Description
$ 6.8m	0.5% general efficiency saving across DHB expenditure (~$4.6m provider ~$2.2m funder)
$ 1.3m	ICT structure & capitalisation (after investment made)
$ 0.75m	ICT software efficiencies
$ 0.54m	ICT vendor review/delayed roles/other minor items
$ 0.06m	QIPS office savings
$ 0.073m	Nursing office savings
$ 0.16m	Allied office savings
$ 0.8m	Corporate – cleaning, fuel, consultants, capitalisation (11 key initiatives)
$ 0.06m	Maori health office
$ 1.2m	Pharms DPF
$ 2.0m	Pharms rebate
$ 0.086m	RMO bottled water
$ 14.7m	General vacancy rate (reduction in budget for estimated turnover where a role will be left unfilled for a period of time)
$ 7.3m	Additional personnel savings targets (comparison of vacancy rate to timing lag of roles coming on board)
$ 0.3m	Additional vacancy rate (late starting of specific roles)
$ 0.4m	General vacancy rate in GFA arm (SIP team)
$ 1.4m	Joint ELT
$ 37.93m	Total budgeted savings to reach our deficit 2020/21 budget

Analysis of the Operating Position

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

Revenue	• Revenue is favourable by $1.45m YTD. The largest variance is due to revenue for special funds/research of $531k which fluctuates throughout the year depending on funds levels and research funding, followed by MHAIDS revenue of $385k, largely in relation to our national NIDCA contract. • We also note IDF case weight inpatient revenue was set to target for the month whilst all systems are updated for the new financial year; based on preliminary estimates this was $346k behind, almost equivalent to our IDF outflows behind.
Labour (including outsourced)	**Medical Personnel:** Medical Personnel labour month position is favourable within the month by $856k (excluding holidays act). • The favourable position is largely due to vacancies within Surgery, Women's & Children's and the remainder of provider services totalling $1m. This is being offset by an overspend in MHAIDS medical staffing • Internal vacancies total 5.7% across the DHB

Analysis of the Operating Position

Labour (including outsourced)	**Nursing Personnel** Nursing Personnel labour month position is ($1m) unfavourable to budget (excluding Holidays Act) • Across provider services ($511k) and MHAIDS ($556k) • A significant portion ($382k) is annual leave balances increasing of which some will be attributed to COVID-19, and ($302k) of overtime. • Overall Paid FTE for Nursing staff has increased by 60 in June which remained into our July our first month of the new financial year, this equates to an annualised $5.2m compared to last July. This is compounded by price increases equating to an annualised $8m. Whilst these amounts have been budgeted by the DHB it is important to note the scale of the nationally agreed increases which are compounded by any new roles to service our population, the latest May Nursing uplift continuing into the new financial year has not been funded by MoH at this stage and is expected to be part of a pay equity settlement. • Overall vacancies total 7.4% across the DHB, with a lower amount in the main provider services of 5.1%. Within July 2020 374 headcount of bureau and casual staff worked the equivalent of 182 FTE to fill gaps caused by sick leave (not within our hiring level) but also watches of patients and some of these vacant shifts (vacancies are exclusive of 3DHB MHAIDS roles whilst they are brought onto our payroll).

Analysis of the Operating Position

Labour (including outsourced)	**Allied Personnel** Allied Personnel labour month position is ($36k) unfavourable to budget (excluding Holidays Act). • The staffing vacancies of 11.3% is being offset by build-up in annual leave balances (5.3% in provider services). **Support Personnel** Support Personnel labour month position is on budget ($5k) (excluding holidays act). • No significant items to report **Management/Admin Personnel** This personnel category is unfavourable in the month by ($41k) (excluding holidays act). • At a high level it appears due to usage of outsourced contractors, with a usage of $386k within the month • This is offset by staffing vacancies of 9.3% (exclusive of 3DHB ICT whilst they are brought onto our payroll)

Analysis of the Operating Position

Non-Labour	• Generally most other costs are on budget; • Clinical supplies are favourable by $198k; despite ($190k) overspend on blood products – largely intragam and ($161k) in Cardiology cath lab costs. This is being favourably offset by lower dispensed drugs and outreach clinic spend. • Non-treatment related costs are favourable by ($557k) due to lower outsourced facility maintenance, lower rents, but significantly due to safe care initiatives yet to commence
Funder	• The Funder arm has external provider payments which are ($316k) unfavourable to budget, however $516k is within our Funder COVID-19 line which has offsetting revenue from MoH. Therefore is $200k favourable underlying, with no significant items for month one.

Section 4

Financial Position

Cash Management – July 2020

Month : July 2020						Capital & Coast DHB	Year to Date				
			Variance			Statement of Cashflows				Variance	
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	Notes	YTD July 2020	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year
						Operating Activities					
110,833	**111,708**	**106,083**	**(875)**	**4,750**		**Receipts**	**110,833**	**111,708**	**106,083**	**(875)**	**4,750**
						Payments					
62,382	45,974	53,129	(16,408)	(9,253)		Payments to employees	62,382	45,974	53,129	(16,408)	(9,253)
61,464	65,033	57,489	3,570	(3,975)		Payments to suppliers	61,464	65,033	57,489	3,570	(3,975)
12,110	0	0	(12,110)	(12,110)		Capital Charge paid	12,110	0	0	(12,110)	(12,110)
(1,464)	137	(1,294)	1,601	171		GST (net)	(1,464)	137	(1,294)	1,601	171
134,492	**111,144**	**109,324**	**(23,348)**	**(25,168)**		**Payments - total**	**134,492**	**111,144**	**109,324**	**(23,348)**	**(25,168)**
(23,659)	**564**	**(3,241)**	**(24,223)**	**(20,418)**	**6**	**Net cash flow from operating Activities**	**(23,659)**	**564**	**(3,241)**	**(24,223)**	**(20,418)**
						Investing Activities					
96	75	91	(21)	(6)		Receipts - Interest	**96**	**75**	**91**	**(21)**	**(6)**
0	0	0	0	0		Receipts - Other	0	0	0	0	0
96	**75**	**91**	**(21)**	**(6)**		**Receipts - total**	**96**	**75**	**91**	**(21)**	**(6)**
						Payments					
0	0	0	0	0		Investment in associates	0	0	0	0	0
4,610	5,511	1,826	901	(2,784)		Purchase of fixed assets	4,610	5,511	1,826	901	(2,784)
4,610	**5,511**	**1,826**	**901**	**(2,784)**		**Payments - total**	**4,610**	**5,511**	**1,826**	**901**	**(2,784)**
(4,513)	**(5,436)**	**(1,735)**	**880**	**(2,790)**	**7**	**Net cash flow from investing Activities**	**(4,513)**	**(5,436)**	**(1,735)**	**880**	**(2,790)**
						Financing Activities					
0	0	0	0	0		**Equity - Capital**	0	0	0	0	0
0	0	0	0	0		**Other Equity Movement**	0	0	0	0	0
0	0	0	0	0		Other	0	0	0	0	0
0	**0**	**0**	**0**	**0**		**Receipts - total**	**0**	**0**	**0**	**0**	**0**
						Payments					
0	**0**	**0**	**0**	**0**		Interest payments	**0**	**0**	**0**	**0**	**0**
0	**0**	**0**	**0**	**0**		**Payments - total**	**0**	**0**	**0**	**0**	**0**
0	**0**	**0**	**0**	**0**	**8**	**Net cash flow from financing Activities**	**0**	**0**	**0**	**0**	**0**
(28,172)	**(4,872)**	**(4,976)**	**(23,343)**	**(23,207)**		**Net inflow/(outflow) of CCDHB funds**	**(28,172)**	**(4,872)**	**(4,976)**	**(23,343)**	**(23,207)**
18,236	18,236	8,083	0	(10,153)		**Opening cash**	18,236	18,236	8,083	0	(10,153)
110,929	111,783	106,174	(897)	4,744		Net inflow funds	110,929	111,783	106,174	(897)	4,744
139,101	116,655	111,149	(22,446)	(27,952)		Net (outflow) funds	139,101	116,655	111,149	(22,446)	(27,952)
(28,172)	**(4,872)**	**(4,976)**	**(23,343)**	**(23,207)**		**Net inflow/(outflow) of CCDHB funds**	**(28,172)**	**(4,872)**	**(4,976)**	**(23,343)**	**(23,207)**
(9,936)	**13,365**	**3,107**	**(23,301)**	**(13,043)**		**Closing cash**	**(9,936)**	**13,365**	**3,107**	**(23,301)**	**(13,043)**

Capital and Coast DHB
RECONCILIATION OF CASH FLOW TO OPERATING BALANCE

		YTD July 2020		
	Notes	Actual $000	Budget $000	Variance $000
Net Cashflow from Operating		**(23,659)**	**564**	(24,223)
Non operating financial asset items		**(18)**	**-**	(18)
Non operating non financial asset items		**(599)**	**(255)**	(344)
Non cash PPE movements				
Depreciation & Impairment on PPE		(2,668)	(2,118)	(550)
Gain/Loss on sale of PPE		0	-	0
Total Non cash PPE movements		**(2,668)**	**(2,118)**	**(550)**
Interest Expense		**-**	**-**	**0**
Working Capital Movement				
Inventory		439	-	439
Receipts and Prepayments		16,667	-	16,667
Payables and Accruals		8,049	(949)	8,998
Total Working Capital movement		**25,155**	**(949)**	**26,104**
Operating balance		**(1,789)**	**(2,758)**	969

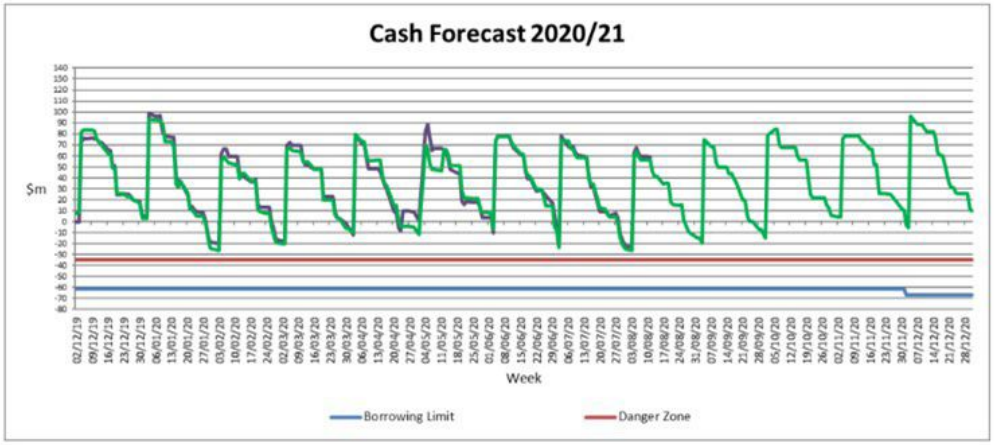
Current Ratio – This ratio determines the DHB's ability to pay back its short term liabilities.
DHB's current ratio is 0.31 (June 20: 0.32);

Debt to Equity Ratio – This ratio determines how the DHB has financed the asset base.
DHB's total liability to equity ratio is 40:60 (June 20: 40:60).

Debt Management / Cash Forecast – July 2020

Accounts Receivable
31-Jul-20

Aged Debtors report ($'000)	Total	Current	1-30	31 - 60	61 - 90	91+	Previous Period
Ministry of Health	10,504	5,390	349	72	-	4,693	10,601
Other DHB's	5,804	1,321	380	278	648	3,177	5,300
Kenepuru A&M	237	36	55	12	134	-	259
ACC	352	190	- 5	3	1	163	(119)
Misc Other	5,692	2,399	424	308	234	2,327	4,265
Total Debtors	22,589	9,336	1,203	673	1,017	10,360	20,306
less : Provision for Doubtful Debts	(2,141)						(2,227)
Net Debtors	20,448						18,079



Cash Management

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

Debt Management

- **Ministry of Health:** invoices on hold due to contracts not yet signed by MOH, reports not yet provided by CCDHB or disputed invoices.
- **Other DHB's:** Single largest debtor outstanding for more than 91 days is Hutt Valley DHB at $3.18m
- **Kenepuru A&M:** Includes significant number of low value patient transactions. Provision of the overdue debts is $116k
- **Misc Other:** Includes non-resident debt of approx. $2.8m. About 60% of the non-resident debt have payment arrangements in place. The balance will be referred to collection agencies if unpaid.

Balance Sheet / Cashflow – as at 31 July 2020

Jun-20	Month : July 2020							Capital & Coast DHB Balance Sheet
					Variance			
Actual	Actual	Budget	At July 2019	At June 2020	Actual vs Budget	Actual vs July 2019	Notes	YTD July 2020
31	31	31	33	31	0	(3)	1	Bank
6,523	0	6,523	0	6,523	(6,523)	0	1	Bank NZHP
11,683	12,369	11,683	11,030	11,683	687	1,340	1	Trust funds
49,375	53,018	49,375	60,266	49,375	3,643	(7,248)	2	Accounts receivable
8,995	9,434	8,995	9,243	8,995	439	191		Inventory/Stock
6,257	6,369	6,257	4,005	6,257	112	2,364		Prepayments
82,864	**81,222**	**82,864**	**84,578**	**82,864**	**(1,642)**	**(3,356)**		**Total current assets**
522,978	522,017	525,556	537,738	522,978	(3,538)	(15,721)		Fixed assets
14,796	14,796	14,796	9,859	11,626	0	4,936		Work in Progress - CRISP
54,148	56,798	54,147	33,731	57,317	2,650	23,067		Work in progress
591,922	**593,611**	**594,499**	**581,328**	**591,921**	**(888)**	**12,282**	3	**Total fixed assets**
0	0	0	0	0	0	0		Investments in New Zealand Health Partnership
1,150	1,150	1,150	1,150	1,150	(1)	(0)		Investment in Allied Laundry
1,150	**1,150**	**1,150**	**1,150**	**1,150**	**(1)**	**(0)**		**Total investments**
675,936	**675,982**	**678,513**	**667,056**	**675,935**	**(2,531)**	**8,926**		**Total Assets**
0	22,336	4,871	7,955	0	(17,465)	(14,381)		Bank overdraft HBL
76,604	66,411	76,604	69,440	76,604	10,193	3,029	4	Accounts payable, Accruals and provisions
0	0	0	55	0	0	55	7	Loans - Current portion
(252)	1,641	772	1,937	(252)	(869)	296	6	Capital Charge payable
593	593	593	593	593	0	0		Insurance liability
36,144	21,302	36,144	88,465	36,144	14,842	67,163	5	Current Employee Provisions
140,857	140,926	140,857	52,468	140,857	(69)	(88,458)	5	Accrued Employee Leave
7,299	8,468	7,299	10,207	7,299	(1,169)	1,739	5	Accrued Employee salary & Wages
261,245	**261,677**	**267,141**	**231,120**	**261,245**	**5,464**	**(30,557)**		**Total current liabilities**
0	0	0	0	0	0	0		Crown loans
95	100	95	80	95	(5)	(20)		Restricted special funds
605	605	605	605	605	0	0		Insurance liability
6,564	6,564	6,564	6,352	6,564	0	(213)		Long-term employee provisions
7,264	**7,269**	**7,264**	**7,037**	**7,264**	**(5)**	**(232)**		**Total non-current liabilities**
268,510	**268,947**	**274,406**	**238,157**	**268,510**	**5,459**	**(30,790)**		**Total Liabilities**
407,426	**407,035**	**404,107**	**428,899**	**407,425**	**2,928**	**(21,864)**		**Net Assets**
816,257	812,773	812,773	785,364	816,257	0	27,409		Crown Equity
(3,484)	0	0	0	(3,484)	0	0		Capital repaid
0	1,400	0	0	0	1,400	1,400		Capital Injection
130,944	130,659	130,660	131,361	130,659	(1)	(702)		Reserves
(536,292)	(537,797)	(539,326)	(494,439)	(536,008)	1,528	(43,358)		Retained earnings
407,425	**407,036**	**404,107**	**428,899**	**407,425**	**2,928**	**(21,864)**		**Total Equity**

Balance Sheet

The DHB has budgeted a total Provision of $80m for the Holidays Act remediation across Employee Provisions and Accrued Employee Leave, with the actual provision recorded to Accrued Employee Leave. Settlement will require a large cash injection.

There was a favourable variance of $14.8m in the Current Employee Provisions account due to timing of a third fortnightly payroll in July of $13.8m.

Cash flow

The DHB's overall cash position at the end of July was $22m in overdraft mainly due to Capital Charge of $12.1m being paid in early July. This was also reflected in the lower than budgeted variance in the creditors balance.

The Payments to Employees variance was largely due to the third payroll payment in July mentioned above.

The DHB's liquidity going forward is of concern as the current assets of $81m is significantly lower than the $262m of current liabilities, this means the DHB is solely reliant on crown funding to meet payments as they fall due.

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

Capital Expenditure and Projects Summary July 2020

Capital Expenditure Spend on Approved Projects

		Actual spend on live projects				Forecast spend on approved projects				
Asset Category	Approved Capex Budget	PY Spend to 30 June 2020	July actual spend	Actual LTD Spend	To spend	Sept 20 Quarter	Dec 20 Quarter	Mar 21 Quarter	Jun 21 Quarter	Total Forecast
Buildings	997,385	-	-	-	997,385	536,704	460,682	-	-	997,385
Clinical Equipment	749,520	-	31,842	31,842	717,678	190,634	320,644	206,400	-	717,678
ICT	48,549	-	-	-	48,549	8,677	39,872	-	-	48,549
2020-21 projects	**1,795,454**	-	**31,842**	**31,842**	**1,763,612**	**736,015**	**821,198**	**206,400**	-	**1,763,612**
Buildings	19,952,050	6,455,360	577,422	7,032,782	12,919,268	1,208,443	3,173,561	3,700,890	3,624,331	11,707,226
Clinical Equipment	43,412,182	20,431,692	3,534,908	23,966,600	19,445,582	5,599,976	8,783,682	2,341,947	1,354,229	18,079,834
ICT	9,941,865	7,439,035	145,143	7,584,178	2,357,687	486,002	729,003	548,873	458,808	2,222,687
Prior Year projects	**73,306,096**	**34,326,087**	**4,257,473**	**38,583,560**	**34,722,536**	**7,294,421**	**12,686,247**	**6,591,711**	**5,437,368**	**32,009,747**
Total	**75,101,551**	**34,326,087**	**4,289,315**	**38,615,402**	**36,486,149**	**8,030,436**	**13,507,445**	**6,798,111**	**5,437,368**	**33,773,359**

Key highlights to July 2020 are:

- $1.8m in projects have been approved and are progressing in July 2020
- Cash spend in July 2020 was $4.3m. A significant portion ($2.75m) were clinical equipment replacement of Cardiac monitors, Electronic Infusion Devices, Cart Washer, Defibrillators & Vital signs monitors
- The development of business cases from the 2020/21 Capital Plan are at various stages. It is anticipated that $3m-$4m be presented for approval each month.
- The forecast cash spend for the year is $48m-$50m funded from depreciation ($37m), Crown Equity ($6.4m) and leases
- An average monthly spend of $3.5m-$4m will see the cash spend $48m. This presumes not further COVID-19 disruption that will negatively impact workforce and the supply chain logistics

BOARD INFORMATION – Public

September 2020

2DHB Major Capital Projects Advisory Committee (MCPAC) Update

Action Required

The Boards note:

(a) The first MCPAC meeting was held on 4 September 2020.

(b) The MCPAC Terms of Reference were approved by the Boards in May 2020.

(c) The five projects within the scope of MCPAC including the New Children's Hospital.

(d) Future updates on the New Children's Hospital will be part of the MCPAC Update.

(e) High level MCPAC public updates will be provided where possible.

Strategic Alignment	Capital projects are aligned with delivery of the DHBs strategic plan
Endorsed by	Fionnagh Dougan, Chief Executive 2DHB Major Capital Projects Advisory Committee
Presented by	David Smol, Chair, 2DHB Major Capital Projects Advisory Committee
Purpose	Provide governance for 2DHB major capital projects and comply and fulfil funding conditions required by the Minister of Health and Minister of Finance
Contributors	As noted in the MCAP papers
Consultation	NA

Executive Summary

The Hutt Valley and Capital & Coast Boards agreed to establish the Major Capital Projects Advisory Committee (MCPAC) for the purpose outlined below:

- Provide governance for 2DHB major capital projects.
- Comply and fulfil funding conditions required by the Minister of Health and Minister of Finance.
- Replace the previous Children's Hospital Portfolio Board.

The MCPAC Terms of Reference was approved by the Boards at the 29 May 2020 Board meeting.

Currently committee membership consists of David Smol (Chair of both Boards), Wayne Guppy (Deputy Chair of Hutt Valley DHB) and Hamiora Bowkett (Ministerial appointment to the Capital & Coast Board). Tony Lloyd is the Ministry of Health (MOH) expert member and Bruce McLean is an independent expert member.

The Terms of Reference allows for up to four independent members to be appointed to provide expert advice as required. The Boards requested the Terms of Reference include a requirement for a member of the Māori/Iwi Partnership Board as one of the external experts that could be co-opted on to the Committee.

At the first meeting the 2DHB Major Capital Projects Advisory Committee (MCPAC) discussed each of the five projects within the scope of MCPAC:

1. Children's Hospital Project
2. Copper Pipes Remediation Project
3. Individual Service Units (ISU) Project
4. Te Whare Ahuru Rebuild Project
5. Maternity and Neonatal Facilities Upgrade Project

Due to the nature of managing capital projects, most information will be public excluded however overarching public updates will be provided where possible.

Strategic Considerations

Service	All services
People	Capital projects contribute to improving the wellbeing of our staff and health outcomes of our population.
Financial	Funding from MOH, CCDHB and HVDHB
Governance	Critical to the successful delivery of major projects

Engagement/Consultation

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

Identified Risks

N/A

Attachment/s

1. MCPAC Terms of Reference

Board Information – Public

September 2020

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

Action Required

The Boards note:

(a) There were no items requiring Board approval in this meeting.

(b) A presentation was given on the two health strategies, CCDHB Health System Plan and HVDHB Vision for change.

(c) Comprehensive updates were provided on the 2DHB Maternal, Child and Youth Commissioning and 2DHB Health of Older People work programmes.

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

Executive Summary

There are no decisions seeking Board approval from the previous meeting of the Health System Committee on 23 September 2020. A presentation was given on the CCDHB Health System Plan and the HVDHB Vision for Change. Report updates on the 2DHB Maternal, Child and Youth Commissioning and 2DHB Health of Older People work programmes were discussed.

The reports can be found in the full Health System Committee papers on the DHB websites or in the Diligent Boardbook for 23 September 2020. The presentation has been included below.

Presentation

Strategic Considerations

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

Engagement/Consultation

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

Identified Risks

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

Attachment/s

1. NIL

Board Decision – Public

September 2020

Disability Support Advisory Committee (DSAC) Update and Items for Board Approval

Action Required

The Board approve, the following decisions endorsed by DSAC:

(a) The signing of the Accessibility Charter as presented in the paper following.

The Boards note:

(a) Three comprehensive presentations were made on the following:

- The Living Life Well Strategy
- Acute Care Continuum
- MHAIDS High Demand

(b) DSAC endorsed the approach of the Sub-Regional Disability Advisory Group (SRDAG) to provide feedback on the Health System Review.

Strategic Alignment	Annual Plans, Te Pae Amorangi, Taurite Ora and Sub Regional Disability Strategy 2017-2022
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 decisions seeking Board approval have been endorsed by the Disability Support Advisory Committee (DSAC) in their meeting on 23 September 2020. There were no amendments requested by the Committee. The full papers can be located on the DHB websites or in the DSAC Diligent Book for 23 September 2020. The presentations have been linked below.

Items worth noting for the Boards in this meeting include an update on the Living Life Well Strategy, the Acute Care Continuum and MHAIDS high demand. DSAC discussed the feedback from Sub-Regional Disability Advisory Group (SRDAG) on the Health System Review and endorsed the approach being taken.

Living Life Well

Acute Care Continuum

MHAIDS High Demand

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

1. Signing the Accessibility Charter Cover page
2. Accessibility Charter

Board DECISION – Public

September 2020

Signing the Accessibility Charter

Action Required

The Board approve:

(a) The signing of the Accessibility Charter.

The Board note:

(b) The Accessibility Charter and the approach to implementation being a targeted approach tackling specific areas that have a wider scope of impact and will be affordable.

Strategic Alignment	3DHB Disability Strategy
Author	Rachel Noble, General Manager disability, Strategy and Innovation
Endorsed by	Rachel Haggerty, Director - Strategy, Innovation and Performance Sandra Williams, Executive Leader – Planning and Performance
Presented by	Rachel Haggerty, Director, Strategy Innovation and Performance
Purpose	An update on the status of the introduction of the Accessibility Charter to health services operated by the DHBs and their subsidiaries. Seeking Board approval to adopt and sign the Accessibility Charter.
Contributors	3DHB Disability Team
Consultation	2DHB Executive Leadership Team, CCDHB and HVDHB

Executive Summary

1. The Accessibility Charter was launched in 2018. It is endorsed by public service Chief Executives' who are committed to the provision of accessible information and online tools to progress the development of equitable public services for disabled people by removing barriers.
2. The Accessibility Charter outlines best practice to support people to be independently engaged with the health and disability sector by having greater control over what occurs for them.
3. The Accessibility Charter has a direct correlation with the intent and purpose of the Sub-Regional Disability Strategy 2017-2022.
4. The signing of the Accessibility Charter endorses the authentic commitment to the objectives of the accessibility Charter by the DHBs. It is a requirement that the Chief Executive, and Communications and IT managers sign the Accessibility Charter, giving employees the mandate to work towards an accessible environment for both people using health services, and employees.
5. Having endorsement of DSAC, will signal to all stakeholders that the DHBs are committed to addressing inequities across the service framework. The DHBs will be seen as a leader in the sector.
6. Central agencies are expected to report on progress with the Ministry of Social Development every six months. Within the DHBs we recommend six monthly reports are presented to the Sub Regional Disability Advisory Group (SRDAG) and the Disability Support Services Committee (DSAC) against an agreed annual plan.

Strategic Considerations

Service	Services become more accessible to people with disabilities over the next five years. This includes communications, technology and physical environments/
People	The Disability education programme for workforce is critical to the success of the Accessibility Charter.
Financial	The financial implications will be managed by an annual investment plan and be integrated in to the facilities, technology and service development plans across the organisation.
Governance	The signing of the Accessibility Charter will strengthen the Disability Strategy implementation.

Engagement/Consultation

Patient/Family	Not applicable
Clinician/Staff	Not applicable
Community	Developed and discussed with the Subregional Disability Advisory Group including the Kaunihera Whaikaha and the Fono.

Attachment/s

1. The Accessibility Charter

1. BACKGROUND

The Accessibility Charter was launched in 2018. It is endorsed by public service Chief Executives' who are committed to the provision of accessible information and online tools to progress the development of equitable public services for disabled people by removing barriers.

The purpose of the accessibility Charter is to:

- improve access to information provided by government agencies to people who experience barriers in accessing information
- provide affected people with a consistent experience when accessing information
- meet NZ's international obligation under the United Nations Convention on the Rights of Persons with Disabilities

The Accessibility Charter outlines best practice to support people to be independently engage with the health and disability sector by having greater control over what occurs for them. The charter embodies the principles of self-determination which include, being person-centred, easy to use, equitable access to services, relational and strengths focused. These principles are key in developing and governing behaviour of health services now and into the future.

The Accessibility Charter has a direct correlation with the intent and purpose of the Sub-Regional Disability Strategy 2017-2022. Both the Accessibility Charter and the Sub-Regional Disability Strategy are aligned to the principles of the United Nations Convention on the Rights of Persons with Disabilities, which is endorsed by Government.

2. INTENT

Accessibility can be defined as the "ability to access" the functionality, and possible benefit, of health services, and in relation to the Accessibility Charter it is applied to describe the degree to which DHBs services, workforce and environment is accessible by as many people as possible.

The concept of accessible design ensures both "direct access" (i.e. unassisted) and "indirect access" meaning compatibility with a person's assistive technology (e.g. computer screen readers). Accessibility is strongly related to universal design which is the process of creating services that are usable by people with disabilities who have access and functional needs, across all services and areas of health, this also means creating environments that encourage and engage people with disabilities as employees. This is about making all aspects of the DHB health service accessible to all people, whether they have a disability or not.

Accessibility is often used to focus on people with disabilities and their right of access to health services, often through use of assistive technology. Another dimension of accessibility is the ability to access information and services by minimising the barriers of distance and cost, as well as the usability of the health service. This is where our initiatives are aiming toward, providing universal access to health services which ensures equitable engagement at every point of the system by all, including not only physical access but access to the same tools, services, and facilities which are in place and developing into the future.

Additionally the Accessibility Charter emphasises the need for employers to better integrate and retain the workforce who identify as having a disability. The DHB's need to have in place policies to provide "reasonable accommodation" for employees with disabilities and apply a non-prejudicial employment framework, however, many do not.

3. PROGRESS TO DATE

In February 2019, the Accessibility Charter was first raised with the Board and the, then, Chief Executive for consideration and approval. This was to progress the development of a strategy allowing for endorsement of the Charter and its intent to ensure health services were equitable and accessible for

all. This process was previously agreed by the Sub Regional Disability Advisory group when they met in January.

The Board were advised that endorsement of the Accessibility Charter required authentic commitment from the DHB (primarily the CEO, and the executive directors of both the Information Communication and Technology (ICT) and Communication teams) to the principles of best-practice "accessibility" when establishing policy and practice expectations across the DHB.

All areas of the DHB will be affected, as accessibility of information requires improvement at all points of our work across the whole region. This includes signage, guides, literature, all web content, strategies, policies and information publically or internally available.

To date the following initiatives demonstrate some of the ways the 3DHB Disability Team are already advancing the work of the Accessibility Charter:

- Advising the Children's Hospital
- Website Audit by Intopia to take place late September/early October
- Accessibility Advice given to the design of the relocated Hutt DHB Community and Rehabilitation Services which are now being built with accessible toilets and an accessible kitchen
- Three members of the Disability Team completed the Introduction to Digital Accessibility course at Victoria University
- Development of a guide for hiring managers around the recruitment of people with disabilities
- Established a NZSL filming studio
- Currently being trained and advised on doing Easy Read, Audio and Large Print format translations correctly
- New Disability page on the website will have information presented in all formats as a model for other pages
- Developing a business case for an Accessible Documents Unit
- Promoting accessibility of CBACs and hospitals during the COVID
- Inclusion of accessibility questions in the Telehealth survey
- Reviewed the My Health Passport, developed additional versions
- Input into inclusive development principles for the National Bowel Screening program

3.1 Where we are now

Signing the Accessibility Charter indicates that the DHB has made a commitment to working progressively over the next 5 years to ensure all information intended for the public is accessible to everyone and that everyone can interact with services in a way that meets the individual need to promote their independence and dignity.

This includes meeting the government's web accessibility and usability standards, ensuring information is available in a range of accessible formats, compliance with accessibility standards, responding positively when people make staff aware of instances of inaccessibility and adopting a flexible approach to interacting with the public and actively championing accessibility within the leadership team.

3.2 Planning into the future

There are multiple ways the DHBs could approach the implementation of the Accessibility Charter keeping in mind the need to:

- include but not be limited to the built environments and Information Communications Technology (ICT),
- ensure an accessibility lens is attached to all DHB activities both internally and externally,

- developmental activities include an genuine co-design process involving representatives from relevant stakeholder circles,
- development of practice principles to be applied in activities intended to entrench the Accessibility Charter in BAU.

In our environment of financial constraint, we need to implement financial rigour in all activities, ensuring value for the community and the health system. The resourcing of the Accessibility Charter will be based on a pragmatic plan to ensure that available resourcing is used effectively and the opportunities for gain are maximised.

There are two options identified for implementing the Accessibility Charter. This paper recommends Option Two: a targeted programme.

Option 1: Mapping Project/Gap Analysis

Audit the current environment to identify the health information being produced, the physical environment and the all communications interactions to identify the information that is required by people using all CCDHB services.

This would include referrals, treatment plans, medication, therapy regimes and any other information that is intended for public consumption; and all of our facilities and service environments. It is worth noting that the physical environment of each hospital was audited a few years ago by an external agency. This led to single initiatives to address a small number of issues however most remain unaddressed.

This approach can create a very large work programme. This can result in affordability challenges and slow progress.

Option 2: Targeted Programme

A targeted programme would focus on priority area, ensuring accessibility in key areas. It is proposed that we approach developmental activities by “area”, not health service, this would see a plan put in place over an agreed period (e.g. 5 years) for addressing key barriers DHB wide for example to ensure:

- all reception desks are accessible and enable effective engagement
- bathrooms are accessible and useable
- entrances are accessible and useable
- all direct patient communications are available in appropriate formats.

In addition, when new services, facilities, or technology are being developed the Accessibility Charter is taken in to account. A plan would be created each year to ensure progress on an annual basis.

Accessibility Charter

Our organisation is committed to working progressively over the next five years towards ensuring that all information intended for the public is accessible to everyone and that everyone can interact with our services in a way that meets their individual needs and promotes their independence and dignity.

Accessibility is a high priority for all our work.

This means:

- meeting the New Zealand Government Web Accessibility Standard and the Web Usability Standard, as already agreed, by 1 July 2017
- ensuring that our forms, correspondence, pamphlets, brochures and other means of interacting with the public are available in a range of accessible formats including electronic, New Zealand Sign Language, Easy Read, braille, large print, audio, captioned and audio described videos, transcripts, and tools such as the Telephone Information Service
- having compliance with accessibility standards and requirements as a high priority deliverable from vendors we deal with
- responding positively when our customers draw our attention to instances of inaccessibility in our information and processes and working to resolve the situation
- adopting a flexible approach to interacting with the public where an individual may not otherwise be able to carry out their business with full independence and dignity.

Our organisation will continue to actively champion accessibility within our leadership teams so that providing accessible information to the public is considered business as usual.

Chief Executive	Manager Communications	Manager IT

Date _____

New Zealand Government

Capital and Coast DHB and Hutt Valley DHB

CONCURRENT Board Meeting

Meeting to be held on 30 September 2020

Resolution to exclude the Public

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

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

TABLE

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

Reports Drafts		
Collective Insurance Risk Share Agreement 2020/21	As above	As above
Radiology X-Ray and Ultrasound Equipment Upgrades and Room Refurbishments	As above	As above
CCDHB Copper Pipes Mediation	As above	As above
HVDHB August 2020 Financial and Operational Performance Report	As above	As above
CCDHB August 2020 Financial and Operational Performance Report	As above	As above
Staff Health and Safety Reports 4.3.1 HVDHB Dashboard 4.3.2 CCDHB Dashboard	As above	As above
Major Capital Projects Advisory Committee Update	As above	As above
People, Culture and Capability Update	As above	As above
Sustainability Update	As above	As above
Facilities and Infrastructure Reports	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.