PUBLIC

HUTT VALLEY DHB / Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**AGENDA** Held on Wednesday 5 May 2021 Location: **Hutt Hospital, Level 1, Clock Tower Building, Auditorium Room** Zoom: **876 5068 1844** **NOTE CHANGE Time: 9:30am**
	MEETING

	Item	Action	Presenter	Min	Time	Pg
1	**PROCEDURAL BUSINESS**					
1.1	Karakia/Mihimihi		All members	40	9:30am	2
1.2	Apologies	**ACCEPT**	Chair			
1.3	Public Participation: E tū – Regarding cleaning hours for contracted staff	**VERBAL**	E tū			
1.4	Continuous Disclosure 1.4.1 Combined Board Interest Register 1.4.2 Combined ELT Interest Register	**ACCEPT**	Chair			3
1.5	Minutes of Previous Concurrent Meeting	**ACCEPT**	Chair			9
1.6	Matters Arising from Previous Concurrent Meetings	**NOTE**	Chair			15
1.7	Chair's Report and Correspondence	**NOTE**	Chair			
1.8	Chief Executive's Report	**NOTE**	Acting Chief Executive			16
1.9	Board Work Plan 2021	**DISCUSS**	Chair	10	10.10am	
2	**DHB Performance and Accountability**					
2.1	HVDHB **February** 2021 Financial and Operational Performance Report 2.1.1 Report	**NOTE**	Chief Financial Officer Director Provider Services	10	10.20am	33
2.2	CCDHB **February** 2021 Financial and Operational Performance Report 2.2.1 Report	**NOTE**	Chief Financial Officer Director Provider Services			81
3	**Updates**					
3.1	DSAC Items for Approval	**APPROVE**	Chair of DSAC	10	10.30am	140
3.2	COVID-19 Vaccine Rollout Update	**PRESENT**	Director Strategy, Planning and Performance	15	10.40	
4	**OTHER**					
4.1	General Business	**NOTE**	Chair	5	10.55am	
4.2	Resolution to Exclude the Public	**APPROVE**	Chair			142

Next Board Meeting:
2 June 2021, Time: 9am, **Zoom:** 876 5068 1844
Location: Wellington Regional Hospital, Level 11 Boardroom Grace Neil Block

Karakia

Kia hora te marino

Kia whakapapa pounamu te moana

Hei huarahi mā tātou i te rangi nei

Aroha atu, aroha mai

Tātou i a tātou katoa

Hui e! Tāiki e!

Translation

May peace be wide spread

May the sea be like greenstone

A pathway for us all this day

Let us show respect for each other

For one another

Bind us all together!

CAPITAL & COAST AND HUTT VALLEY DISTRICT HEALTH BOARDS

Interest Register

30/04/2021

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

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

Ria Earp	• Board Member, Wellington Free Ambulance
	• Board Member, Hospice NZ
	• Māori Health Advisor for:
	  ○ Health Quality Safety Commission
	  ○ Hospice NZ
	  ○ Nursing Council NZ
	  ○ School of Nursing, Midwifery & Health Practice
	  ○ Te Hauora Rūnanga o Wairarapa (Community Mental Health & Addiction Services, Wairarapa)
	  ○ Royal Australian New Zealand College of Obstetrics & Gynecology
	• Former Chief Executive, Mary Potter Hospice 2006 -2017

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

	• Husband is a Family Violence Intervention Coordinator at Wairarapa District Health Board • Sister-in-law is a Nurse at Hutt Hospital • Sister-in-law is a Private Physiotherapist in Upper Hutt
Dr Tristram Ingham	• Board Member, Health Quality and Safety Commission • Director, Foundation for Equity & Research New Zealand • Director, Miramar Enterprises Limited (Property Investment Company) • Member, Independent Monitoring Mechanism to the United Nations on the United Nations Convention on the Rights of Persons with Disabilities • Chair, Te Ao Mārama Māori Disability Advisory Group • Co-Chair, Wellington City Council Accessibility Advisory Group • Chairperson, Executive Committee Central Region MDA • National Executive Chair, National Council of the Muscular Dystrophy Association • Trustee, Neuromuscular Research Foundation Trust • Professional Member, Royal Society of New Zealand • Member, Disabled Persons Organisation Coalition • Member, Scientific Advisory Board – Asthma Foundation of NZ • Member, 3DHB Sub-Regional Disability Advisory Group • Member, Institute of Directors • Member, Health Research Council College of Experts • Member, European Respiratory Society • Member, Te Ohu Rata o Aotearoa (Māori medical Practitioners Association) • Senior Research Fellow, University of Otago Wellington • Wife is a Research Fellow at University of Otago Wellington • Co-Chair, My Life My Voice Charitable Trust • Member, Capital & Coast District Health Board • Member, DSAC • Member, FRAC
Dr Chris Kalderimis	• National Clinical Lead Contractor, Advance Care Planning programme for Health Quality & Safety Commission • Locum Contractor, Karori Medical Centre • Contractor, Lychgate Funeral Home
Sue Kedgley	• Member, Capital & Coast District Health Board • Member, Consumer New Zealand Board
Ken Laban	• Chairman, Hutt Valley Sports Awards • Broadcaster, numerous radio stations • Trustee, Hutt Mana Charitable Trust • Trustee, Te Awaikairangi Trust • Member, Hutt Valley District Health Board • Member, Ulalei Wellington • Member, Greater Wellington Regional Council

	• Member, Christmas in the Hutt Committee • Member, Computers in Homes • Commentator, Sky Television
Prue Lamason	• Councillor, Greater Wellington Regional Council • Chair, Greater Wellington Regional Council Holdings Company • Member, Hutt Valley District Health Board • Daughter is a Lead Maternity Carer in the Hutt
John Ryall	• Member, Social Security Appeal Authority • Member, Hutt Union and Community Health Service Board • Member, E tū Union
Naomi Shaw	• Director, Charisma Rentals • Councillor, Hutt City Council • Member, Hutt Valley Sports Awards • Trustee, Hutt City Communities Facility Trust
Vanessa Simpson	• Director, Kanuka Developments Ltd • Executive Director Relationships & Development, Wellington Free Ambulance • Member, Kapiti Health Advisory Group
Dr Richard Stein	• Visiting Consultant at Hawke's Bay DHB • Chairman and Trustee, Crohn's and Colitis NZ Charitable Trust • Member, Executive Committee of the National IBD Care Working Group • Member, Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy • Clinical Senior Lecturer, University of Otago Department of Medicine, Wellington • Assistant Clinical Professor of Medicine, University of Washington, Seattle • Locum Contractor, Northland DHB, HVDHB, CCDHB • Gastroenterologist, Rutherford Clinic, Lower Hutt • Medical Reviewer for the Health and Disability Commissioner

CAPITAL & COAST AND HUTT VALLEY DISTRICT HEALTH BOARDS

Interest Register

EXECUTIVE LEADERSHIP TEAM

30 APRIL 2020

Fionnagh Dougan *Chief Executive Officer 2DHB*	• Board, New Zealand Child & Youth Cancer Network • Trustee, Wellington Hospital Foundation • Adjunct Professor University of Queensland
Rosalie Percival *Chief Financial Officer 2DHB*	• Trustee, Wellington Hospital Foundation
Joy Farley *Director Provider Services 2DHB*	• Nil
Rachel Haggerty *Director, Strategy Planning & Performance 2DHB*	• Director, Haggerty & Associates • Chair, National GM Planner & Funder
Arawhetu Gray *Director, Māori Health 2DHB*	• Co-chair, Health Quality Safety Commission – Maternal Morbidity Working Group • Director, Gray Partners • Chair, Tangata Whenua Advisory Group, Te Hiringa Hauora, Health Promotion Agency
Junior Ulu *Director, Pacific Peoples Health DHB*	• Member of Norman Kirk Memorial Trust Fund • Paid Member of Pasifika Medical Association
Declan Walsh *Director People, Culture and Capabilityn2DHB*	• Nil
Helen Mexted *Director, Communications and Engagement 2DHB*	• Director, Wellington Regional Council Holdings, Greater Wellington Rail • Board member, Walking Access Commission • Partner owns Mexted Motors (supplies/services vehicles for the CCDBH)
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

Thursday, 29 April 2021

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
Christine King *Chief Allied Health Professions Officer 2DHB*	• Brother works for Medical Assurance Society (MAS) • Sister is a Nurse for Southern Cross
Tracy Voice *Chief Digital Officer 3DHB*	• Secretary, New Zealand Lavender Growers Association • Gateway Reviewer
Sarah Jackson *Acting CCDHB Executive Director, Quality Improvement & Patient Safety*	• Nil
Saira Dayal *Acting HVDHB General Manager Quality, Service Improvement and Innovation*	• Fellow of NZ College of Public Health Medicine
Chris Kerr *Chief Nursing Officer 2DHB*	• Member and secretary of Nurse Executives New Zealand (NENZ) • Relative is HVDHB Human resources team leader • Relative is a senior registered nurse in SCBU • Relative is HVDHB Bowel Screening Programme Manager • Adjunct Teaching Fellow, School of Nursing, Midwifery and • Health Practice, Victoria University of Wellington
Karla Bergquist *General Manager MHAIDS 3DHB*	• Former Executive Director, Emerge Aotearoa Ltd • Former Executive Director, Mind and Body Consultants (organisations that CCDHB and HVDHB contract with).
Sally Dossor *Director, Officer Office of the Chief Executive* *Board Secretary*	• Partner is a director of a Magretiek, Biostrategy, and Comrad.

BOARD MEETING **PUBLIC**

	MINUTES Held on Wednesday 7 April 2021 Location: **Wellington Regional Hospital, Level 11 Boardroom Grace Neil Block** Zoom: **876 5068 1844** Time: 9:00am
BOARD MEETING	**PUBLIC**

IN ATTENDANCE

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

Hutt Valley and Capital & Coast DHB

Fionnagh Dougan	Chief Executive
Joy Farley	Director Provider Services
Rosalie Percival	Chief Financial Officer
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 Communication and Engagement
Arawhetu Gray	Director Maori Health
Chris Kerr	Chief Nursing Officer
Sarah Jackson	Director of Clinical Excellence

CCDHB

John Tait	Chief Medical Officer

HVDHB

Sisira Jayathissa	Chief Medical Officer

APOLOGIES

Josh Briggs

BOARD MEETING **PUBLIC**

1 PROCEDURAL BUSINESS

1.1 KARAKIA

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

1.2 APOLOGIES

As noted above.

1.3 PUBLIC PARTICIPATION

NIL.

1.4 CONTINUOUS DISCLOSURE

1.4.1 COMBINED BOARD INTEREST REGISTER

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

1.4.2 COMBINED EXECUTIVE LEADERSHIP TEAM INTEREST REGISTER

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

1.5 MINUTES OF PREVIOUS CONCURRENT MEETING

The Combined Board **approved** the minutes of the previous Combined Public Board Meeting held on 3 March 2021.

	Moved	**Seconded**
HVDHB	John Ryall	Ken Laban
CCDHB	Roger Blakeley	Chris Kalderimis

1.6 MATTERS ARISING FROM PREVIOUS CONCURRENT MEETINGS

Action Number	Due Date	Status	Agenda Item	Action	Notes
20-P0010	7-Apr-21	NEW	Public Participation – CCDHB Staff Petition, Car Parking	Management to bring to the CCDHB Board a paper on what the issues are and the potential options available to a CCDHB Board only session in April at the earliest. Include likely cost, impact and taking into account equity. Hutt Valley Board will remain informed.	In progress
20-P0011	5-May-21	NEW	Public Participation – CCDHB Staff Petition, Car Parking	Management to bring to Board a paper on the long term Climate Emergency Response Plan.	In progress

BOARD MEETING **PUBLIC**

1.7 CHAIR'S REPORT AND CORRESPONDENCE

NOTES:

- Minister has reinstated the regular catch ups with DHB Chairs

1.8 CHIEF EXECUTIVE'S REPORT

The Chief Executive provided an update on the following:

- **COVID-19 Vaccinations**
  - An extra clinic was established in the Hutt Valley and it was well received. Uptake was strong.
  - A question was raised about low numbers in the Hutt Valley. Management noted there are supply chain and storage requirements that have to be managed and the border workers for MIQ are in CCDHB, which were started first.
  - Concern was raised about the storage of the vaccine and management noted it's a nationwide learning process.

- **Annual Plan**
  - It was noted these have been submitted and the DHBs are yet to receive feedback. There is a meeting with the Ministry of Health on 13 April 2021 which will be an opportunity to talk about strategic priorities and outcome delivery.

1.9 BOARD WORK PLAN 2021

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

2 DHB PERFORMANCE AND ACCOUNTABILITY

2.1 HVDHB JANUARY 2021 FINANCIAL AND OPERATIONAL PERFORMANCE REPORTS

This report was taken as **READ.**

The Hutt Valley DHB Board note:

(a) The release of this report to the public.
(b) The DHB had a $309k surplus for the month of January 2021, being $686k favourable to budget;
(c) The DHB year to date had a deficit of ($4.7m), being $1.6m favourable to budget;
(d) The Funder result for January was ($0.5m) unfavourable, Governance $0.1m favourable and Provider $1.1m favourable to budget;
(e) Total Case Weighted Discharge (CWD) Activity was 7% ahead of plan.

	Moved	**Seconded**
HVDHB	John Ryall	Naomi Shaw

2.2 CCDHB JANUARY 2021 FINANCIAL AND OPERATIONAL PERFORMANCE REPORTS

This report was taken as **READ.**

The Capital & Coast DHB Board note:

(a) The release of this report to the public.
(b) The DHB had a ($4m) deficit for the month of January 2021, being ($1.5m) unfavourable to budget before excluding COVID-19 and Holidays Act [2003]
(c) The DHB year to date had a deficit of ($26.7m), being ($8.1m) unfavourable to budget before COVID-19 and Holidays Act [2003]

(d) In the seven months we have incurred $10.7m additional net expenditure for COVID-19 and $4.7m against provision for Holidays Act [2003]
(e) This means that the DHB has an overall YTD deficit of ($11.3m) from normal operations (excluding COVID-19 and Holidays Act) being $7.3m favourable to our underlying budget.

	Moved	**Seconded**
CCDHB	Chris Kalderimis	Sue Kedgley

The following points were discussed when considering these papers in the public excluded section of the meeting on 3 March 2021.

Capital & Coast

- Clinical safety issues in ED were discussed and noted as being an ongoing issue until a more accessible after-hours service can be developed. Many people arrive and don't wait and often are Maori, or in categories 4 and 5. Work is being undertaken on what could be done in the short term in the Hutt in terms of after-hours care. Discussions with ACC are part of the work taking place.
- Colonoscopy and bowel screening times – it is a challenge to meet the volumes as they stand. We are moving away from solely doctor-led services to nurse-led ones.
- The draft Annual Plan, which includes the pathway to sustainability and financial information, can be recirculated.
- In aged-residential care, bed days for subsidised clients have been dropping for many years; however, dementia ones are increasing. This is part of the over-arching work being done which has a focus on frailty and dementia. There are also regular provider network meetings to discuss issues and to seek to address the lack of aged-residential care beds.
- There is a significant change in the acuity of presentation at the CCDHB ED.

Hutt Valley

- It has been a priority to remediate risk in the clinical areas and we expect to come in on budget for Hutt. Discussions continue with the Ministry around COVID cost and what recompense there will be for that.
- The CFO said that the Chair will need to sign off on the letter for the deficit support for the DHB. This had been technically endorsed by the board.
- There was a discussion around the constraints of the ED as a facility. These are to do with the inability of people to move through the continuum into beds and also that the space in which they are being seen is not a high quality environment. A reconfiguration of the footprint is needed to increase the quality environment and ensure a faster flow through.

3 UPDATES

3.1 2DHB HEALTH SYSTEM COMMITTEE UPDATE

Chair of the Health System Committee presented.

The Chair noted in the verbal update that HSC had discussions on Advanced Care Planning. There were questions around the schemes and the funding. It was noted there is funding for NGOs and PHOs and GP practices. The CE provided an update noting that since the meeting, documents from the Ministry of Health have been received clearly articulating funding and it includes both DHBs.

The Chair noted that the Committee had insufficient time for discussion on the Māori Health Strategy reporting and that it was therefore on the agenda for this concurrent Board meeting.

BOARD MEETING **PUBLIC**

3.2 MĀORI HEALTH STRATEGY REPORTING

Director of Māori Health presented.

Both Boards noted:

(a) The release of this report to the public.

(b) This report was submitted for discussion to the Health System Committee.

(c) The appended updates in relation to Taurite Ora and Te Pae Amorangi.

(d) This paper also provides a response to requests for information from Board members at the 3 March Board meetings.

NOTES:

- Management noted there are services already working to create better outcomes for Māori and those services would flourish with more funding. It's about balancing new investment with building on current investments in programmes.
- There was a question about commissioning with iwi and what was the timeline. Management noted iwi are not being commissioned for services, the DHB maintains its commissioning role and continues to decide, based on population assessment and need, where the best places for services are.
- There was a question regarding Wainuiomata and what is the plan. Management advised it is one of the localities within the region that will be focused on. The locality focus will look at the needs of the population and ensuring a pro-equity approach. This work is in early stages and it was noted it can be brought as an item for a future Board meeting. This work is primarily led by the Director Strategy Planning and Performance, working with Director Māori.
- A brief update was provided on the current status of the Māori/Iwi partnership Boards and their governance relationship at this time. The HVDHB and CCDHB Māori Partnership/Relationship boards wanted to look at a two DHB model and this is still in progress. A name has been agreed and part of the leadership however they are still deciding how they want to engage with the Boards. The CE acknowledged the work of the Director Māori Health in supporting and navigating this process.
- There was a question about the performance metrics and what performance data will be operationally useful. It was noted there is prescribed Ministry of Health reporting that must be completed and that capturing ethnicity data can be difficult e.g. there are forms that don't ask. It was noted tracking ethnicity data is a health system struggle and there are new positions coming on board that will seek to address some of the ethnicity data work. There is work being completed on how we capture data as the systems are dated and many require manual extraction.

ACTION: Māori data sovereignty paper to be shared with Board when it is appropriate.

3.3 PACIFIC HEALTH AND WELLBEING STRATEGIC PLAN 2020-2025 UPDATE

Director of Pacific People's Health presented.

The HVDHB and CCDHB Boards note:

(a) This paper was submitted to the Health System Committee for discussion and has come to the Boards for any further questions.

(b) In December 2020, the Pacific Health & Wellbeing Strategic Plan for the Greater Wellington Region 2020-2025 (Pacific Health Strategy) was launched.

(c) In January 2021, a 2DHB Director, Pacific Peoples Health was appointed to lead the Pacific Health Directorates across both Hutt Valley and Capital & Coast DHBs;

(d) This is the first update in relation to the Pacific Health & Wellbeing Strategic Plan for 2021.

NOTES:

- Question regarding the Pacific work in the Disability space. Management noted the Disability team is already being engaged with, however the work is in the early stages.
- The Board commented on the ambitious work contained in the plan and asked how the plan will be resourced to be achieved. Management noted there is work underway to define where resourcing is already addressing the goals of the plan and identifying them clearly to show this.
- Management noted key events for potential workforce engagement have been planned e.g. the Ministry of Education Expo Day.

ACTION: The Board asked for a Pacific patient story or experience to be arranged at a later date.

ACTION: The Board asked for reporting that showed internal work being achieved or completed, e.g. the number of HR policies reviewed.

ACTION: The Board asked for a baseline to be set and show reporting against the baseline to enable a view of progress.

4 OTHER

4.1 GENERAL BUSINESS

Nil.

4.2 RESOLUTION TO EXCLUDE THE PUBLIC

	Moved	**Seconded**
HVDHB	Prue Lamason	Yvette Grace
CCDHB	Sue Kedgley	Roger Blakeley

5 NEXT MEETING

5 May 2021, Zoom: 876 5068 1844, **Location:** Hutt Hospital, Level 1, Clock Tower Building, Auditorium Room **NOTE TIME CHANGE TO 9:30AM**
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 AS AT 30 APRIL 2021

Action Number	Date of meeting	Due Date	Assigned	Status	Date Completed	Meeting	Agenda Item #	Agenda Item title	Description of Action to be taken	How Action to be completed
20-P0011	3-Dec-20	TBC	Chief Financial Officer	In progress		Board - Public	1.3	PUBLIC PARTICIPATION – CCDHB STAFF PETITION, CAR PARKING	Management to bring to Board a paper on the long term Climate Emergency Response Plan.	Progress is being made on developing a 2DHB Sustainability Strategy for presentation to the Board first quarter 2021/22.
21-P03	7-Apr-21	TBC	Chief Digital Officer	NEW - In progress		Board - Public	3.2	Māori Health Strategy Reporting	Māori data sovereignty paper to be shared with Board when it is appropriate.	The issue is still a work in progress with all regional Directors Maori, Iwi, and the Ministry of Health continuing discussions.
21-P04	7-Apr-21	TBC	Director Pacific People's Health Director Clinical Excellence	NEW - In progress		Board - Public	3.3	Pacific Health and Wellbeing Strategic Plan 2020-2025 Update	The Board asked for a Pacific patient story or experience to be arranged at a later date.	Board Secretary to include on forward program for Service Spotlight and Patient Story.
21-P05	7-Apr-21	2-Jun-21	Director Pacific People's Health	NEW - In progress		Board - Public	3.3	Pacific Health and Wellbeing Strategic Plan 2020-2025 Update	The Board asked for reporting that showed internal work being achieved or completed, e.g. the number of HR policies reviewed.	To be included in next Strategic Plan update.
21-P06	7-Apr-21	2-Jun-21	Director Pacific People's Health	NEW - In progress		Board - Public	3.3	Pacific Health and Wellbeing Strategic Plan 2020-2025 Update	The Board asked for a baseline to be set and show reporting against the baseline to enable a view of progress.	To be included in next Strategic Plan update.

Chief Executive's Report

Prepared by: Fionnagh Dougan, Chief Executive

1 Introduction

This report covers the period from 25 March 2020 to 22 Apirl.

2 COVID-19 Update

2.1 Current cases

Number of cases: 0
Number of days without cases, HVDHB: 156
Number of days without cases, CCDHB: 163

2.2 Managed Isolation Facilities

Number of COVID-19 cases: 0
Number of guests: 45

2.3 Testing statistics (to 23 April 2021)

	2DHB	HVDHB	CCDHB
Tests performed to date	139,007	30,659	108,350
People tested to date	103,725	25,631	78,094
Testing coverage	22.5%	21.9%	29.6%
Test performed last week (17/04 – 23/04)	1,484	237	1,247

2.4 Testing statistics by ethnicity (to 23 April 2021)

	2DHB		HVDHB		CCDHB	
	Māori	Pacific	Māori	Pacific	Māori	Pacific
Tests performed to date	14,812	10,327	4,615	2,690	10,197	7,637
People tested to date	11,063	7,621	3,782	2,151	7,281	5,470
Testing coverage	22.7%	23.7%	18.8%	19.4%	25.5%	26.0%
Tests performed last week (17/04 – 23/04)	130	126	28	28	102	98

2.5 Vaccinations (to end 23 April 2021)

Please note the vaccine is given in two doses.

All groups	2DHB	HVDHB	CCDHB
Total immunisations	20,867	6,067	14,800
Dose 1 total	16,402	4,606	11,796
Completed total	4,465	1,461	3,004

Group 1	2DHB	HVDHB	CCDHB
Group 1 total	3,188	327	2,861
Group 1 dose 1	2,281	185	2,096
Group 1 completed	907	142	765

Group 2	2DHB	HVDHB	CCDHB
Group 2 total	17,679	5,740	11,939
Group 2 dose 1	14,121	4,421	9,700
Group 2 completed	3,588	1,319	2,239

Definition of groups:

Group 1

- Border Worker
- Household contact of Border Worker

Group 2

- Tier 2 Healthcare Worker
- Emergency Response Services
- Residential Facility Worker
- Person with Elevated Risk
- Other

3 Communications and Engagement

3.1 External engagement with partners and stakeholders

Our proactive engagement focus for April has been focused around the COVID-19 vaccination programme, with one on one engagement with a range of stakeholders including councils, community groups, and NGOs in order to inform our community vaccination engagement activity. We have also hosted a number of Ministers for their vaccinations. More detail is in the Health Promotion Campaigns section below.

At the April Board meeting we signed the Accessibility Charter to show our commitment to accessible information for all. We are the first DHB to sign the Charter which was launched by MSD in 2018. Our Disability Team has been driving the implementation of the Charter across both DHBs. Find out more about what the Charter means https://www.odi.govt.nz/guidance-and-resources/the-accessibility-charter/

General Manager of Disability Strategy Rachel Noble (centre) holds up the signed Accessibility Charter with CE Fionnagh Dougan, Board Chair David Smol, and members of the Executive team.

3.2 External communications and engagement – press releases and pitches

We have continued our focus on proactive external news media and story-telling through highlighting strategies, services and work programmes in our DHBs, along with a continued focus on how we are improving health outcomes for the people of our regions – a sample of these stories is below and featured on following pages.

DHB	Subject	Outlet / Channel
2DHB	COVID-19	Highlighted COVID-19 Minister Hon Chris Hipkins and Associate Health Minister Hon Ayesha Verrall receiving their COVID-19 vaccinations.
2DHB	COVID-19	Highlighted Health Minister Hon Andrew Little receiving his COVID-19 vaccination.
2DHB	COVID-19	Profiled two of our 3DHB Pacific Health Unit staff who received their first COVID-19 vaccinations and are training to vaccinate others.
CCDHB	Cancer	Announced the launch of the free National Bowel Screening programme at CCDHB.

3.3 Health promotion campaigns

COVID-19 vaccination

The COVID-19 vaccination programme continues to ramp up, as does the associated communications and engagement work programme.

Significant internal communications have ensured that more than two thirds of patient-facing DHB staff and contractors have received their first dose at one of four DHB-run vaccination centres through a mix of booked appointments and walk-in clinics. Second doses have now begun to be delivered to this workforce, alongside first doses for remaining people.

In the Community Vaccination Centres (CVCs), we have supported our PHOs with print materials and signage in order to ensure an informed and smoothly run experience for people coming to be vaccinated.

2DHB vaccination centres were visited by several high-profile individuals, who were vaccinated in front of media. This includes four of the five health and COVID-19 Ministers: Hon Chris Hipkins, Hon Peeni Henare, Hon Ayesha Verrall and Hon Andrew Little. Dr Nikki Turner, the Director of the Immunisation Advisory Centre, was also vaccinated at one of our Community Vaccination Centres.

Community engagement

Our referenced above engagement programme is now well-underway, with presentations on the vaccine rollout being given to organisations including Porirua City Council, the Kāpiti Health Action Group, the Wellington Multicultural Council and others. Through building these relationships with key community leaders, we will be able to work alongside them to better reach the communities they represent with information and advice to support everyone to make the confident decision to vaccinate.


COVID-19 vaccination programme update

Vaccinate Greater Wellington website

In this newsletter

We have also commenced production of a weekly newsletter, which tells the stories of our vaccination campaign and provides advice and resources to a broad group of stakeholders. People can subscribe to this newsletter online.

Vaccinate Greater Wellington website

In cooperation with Wairarapa DHB, we have launched the Vaccinate Greater Wellington website. This will serve as the hub for information about our local vaccination rollout, and will work in conjunction with the information on the Unite Against COVID-19 website. It will be regularly updated with videos, news updates, resources, and other information about the vaccination rollout in the region.

Media and social media

We have been involved in a range of media – including television, radio and print – for various stories relating to the campaign. Highlights of stories appearing in the media include:

- Resident, who is 101, gets Covid-19 vaccine as rollout occurs at aged care facilities in Wellington region
- Chris Hipkins, Ayesha Verrall become first ministers to receive Covid-19 jab
- Covid-19 vaccines: Call for the Government to 'ramp up' communication about roll-out
- Minister Peeni Hēnare fronts for Covid-19 vaccine shot, encourages Māori vaccination

We also continue to post regularly across both DHB's social media channels. Popular posts in recent weeks include a post about Junior Ulu, Director Pacific Health, being vaccinated alongside other Pacific Health team members; a post about the DHB COVID-19 Vaccination Lead team meeting with PHO Chief Executives and clinical and COVID-19 leads to plan for the Group 3 and 4 rollout, and a video interview with Otila Tefono, one of our Pacific nurses and vaccinators.

COVID-19 vaccination photo wall

We have developed COVID-19 vaccination 'selfie walls' which will be in recovery rooms from next week. This is part of a campaign we are running to encourage all DHB staff to get loud about their vaccination through their personal social media networks. By sharing our staff photos on social media, we hope it will encourage others to get vaccinated, when it is their turn.

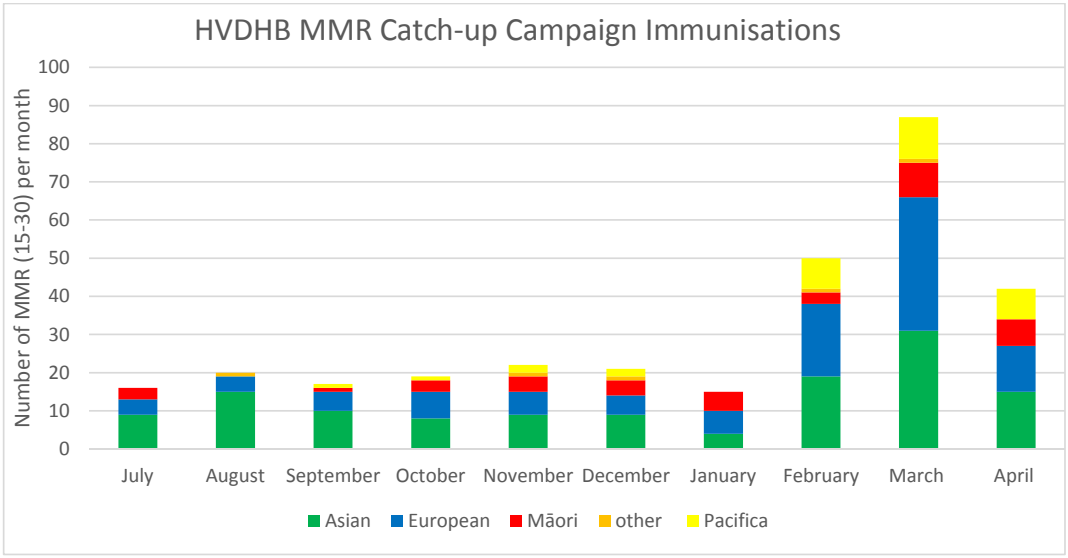
Measles

Since the last Board update we are able to report a significant increase in MMR immunisations for young people, as indicated in the graphs below.

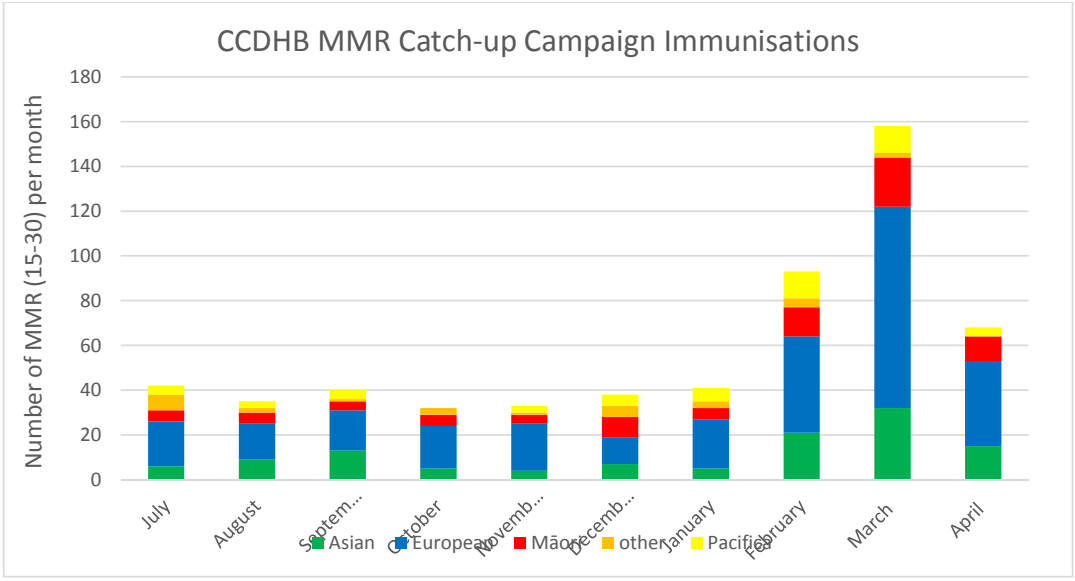
To date, 587 young people in CCDHB and 304 young people in Hutt Valley DHB have been immunised with MMR (Measles, Mumps & Rubella) Vaccine and recorded on the NIR.

Our Youth One Stop Shop targeted outreach service is delivering promotional, pop up, and mobile MMR immunisation services.

Although the Director General of Health has released advice regarding immunisation priorities which states MMR vaccinations can be put on hold until later in the year, we have been able to grow our immunisation capacity through our YOSS' targeted MMR immunisation service so will be able to continue to operate throughout the year while working around COVID-19 vaccination and the Influenza immunisation schedules.



Note: April data is only captured from 1 to 19 April.



Note: April data is only captured from 1 to 19 April.

Bowel Screening

CCDHB has now joined the National Bowel Screening Programme and the first letters are being sent to eligible people aged between 60 and 74 years of age around two weeks before their birthday. This is excellent news for the wider region as it means we can intensify our outreach and messaging to coordinate across our two DHBs.

New Zealand has one of the highest rates of bowel cancer in the world. It is the second-highest cause of cancer death in New Zealand. Around 3200 people are diagnosed every year, and 1200 of those will die from bowel cancer. However, the chance of surviving this cancer is very good when the cancer is found early.

We are committed to achieving equity in screening rates for Māori, Pacific peoples, and people with disabilities and have a robust plan for communicating and engaging with these priority populaitons to ensure equitable participation in the programme.

The number of eligible participants for bowel screening at CCDHB is estimated as 43,240 based on StatsNZ population projections (2018) for the 2020/2021 financial year. This covers people aged between 60 and 74 who are domiciled in the Wellington, Porirua, and Kāpiti regions.

The Ministry of Health has estimated that the CCDHB bowel screening programme is likely to find around 52 colorectal cancers in the first year of bowel screening, with a similar volume expected in the second year. After this time, the DHB is likely to find around 35 cancers through the screening programme per annum.

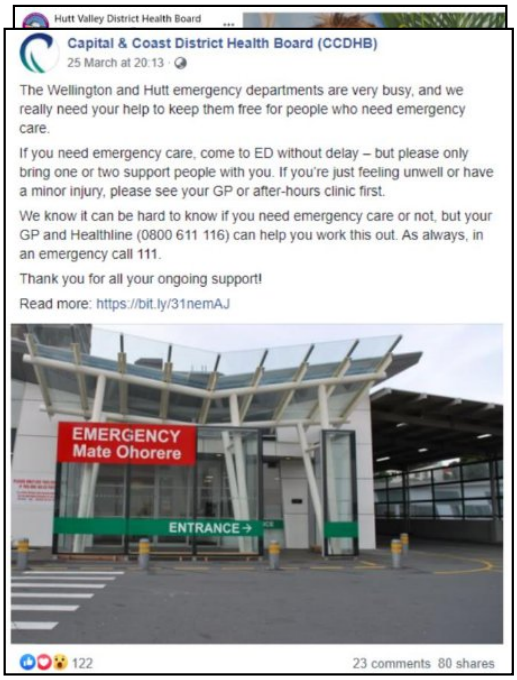
Our display of the giant walk-through 'bowel' at Kenepuru Hospital drew a lot of attention and shows how engaged and ready people are to talk about bowel cancer. The giant bowel shows the variations of polyps from early stage through to cancer and will be in the atrium at Wellington Regional Hospital on 6 and 7 May.

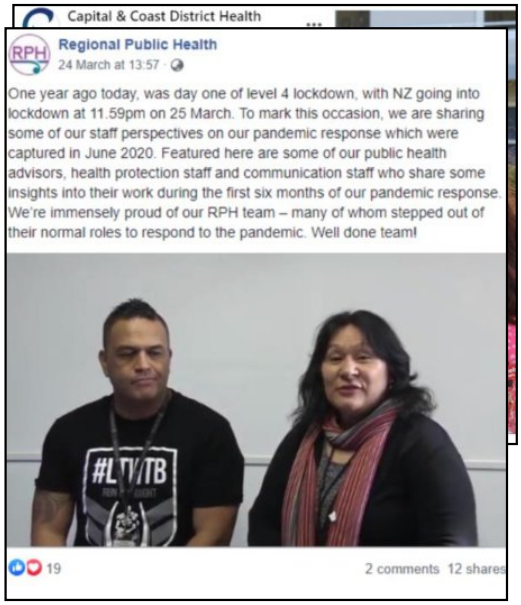
The bowel screening nurses and programme manager inside the giant bowel at Kenepuru Hospital.

3.4 Social media views and stories

CCDHB impressions	HVDHB impressions	RPH impressions
Facebook: 127,365 Twitter: 4,847 LinkedIn: 28,790	Facebook: 239,434 Hutt Maternity Facebook: 9,082 Twitter: 15,879 Instagram: 69,622 LinkedIn: 13,272	Facebook: 10,069

3.4.1 Top social media posts





3.5 Website page views and stories

CCDHB	HVDHB	RPH	MHAIDS
110,110 page views	33,875 page views	9,602 page views	10,586 page views

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

Top five webpages CCDHB

- Staff login
- Careers with CCDHB
- Wellington Regional Hospital
- After hours and emergency care
- Connect Me and Webmail

Top five webpages HVDHB

- Staff login

- Contact Us
- Hutt Hospital campus map
- Careers with HVDHB
- Health Professionals

Top five webpages RPH

- Coronavirus (COVID-19) frequently asked questions
- Measles
- Fruit and Vege Co-ops
- Porirua Children's Ear Van
- Authorised vaccinators

Top five webpages MHAIDS

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

3.5.1 Website stories and releases

Face coverings on public transport

Metlink and Regional Public Health would like to remind our greater Wellington communities to get their COVID-19 and vaccination information from trusted sources.

The Ministry of Health and Unite Against COVID-19 websites contain factual and reliable information on COVID-19 and the vaccination roll-out.

Face coverings are required to be worn on public transport, unless you have a condition that makes wearing one unsuitable or are under 12 years old.

Wearing a face covering on public transport, is a simple and effective way to help keep us all safe. We'd like to thank everyone in our region who continue to wear face coverings on public transport.

Metlink and Regional Public Health are working alongside WREMO and the Ministry of Health, to encourage passengers to follow Government advice to keep each other safe in a COVID-19 world.

Minister marks World Health Day with COVID-19 vaccination

Minister of Health Hon Andrew Little today marked World Health Day by receiving his COVID-19 vaccination at Wellington Regional Hospital.
"The theme for World Health Day 2021 is 'building a fairer, healthier world for everyone' – a theme that certainly resonates in the wake of how COVID-19 has affected so many whānau around Aotearoa," Minister Little said.

"Vaccination is the safest and most effective way to protect people against COVID-19. The vaccination programme will help put the nation back on track so we can once again put our full focus on improving the equity and outcomes of our health system.

"The work that Capital & Coast DHB is doing across the region is an enormous part of that," Minister Little said.

Working closely with its partner PHOs – Tū Ora Compass Health, Ora Toa, Te Awakairangi Health Network and Cosine – HVDHB and CCDHB have to date vaccinated thousands of people eligible under the Group 1 and 2 rollout, and are actively planning for Groups 3 and 4.

Capital & Coast and Hutt Valley DHBs' chief executive Fionnagh Dougan said, "Our staff and those of our PHOs have been working tirelessly on what is the most important vaccination campaign of recent times."

"I am immensely proud of the work that the two DHBs and our providers are doing, from working through the various alert levels of the pandemic and now rolling out the vaccination campaign. We are now planning for the remaining vaccinations and will continue to keep our communities and people safe from COVID-19."

Around 45,000 people eligible for bowel screening test

People aged 60-74 years living in Kapiti, Porirua, and Wellington and who are enrolled with a GP can expect an invitation to participate in the free National Bowel Screening programme over the next two years.

The screening programme – already in place in the Hutt Valley and Wairarapa – starts in Wellington this week, with the first invitations expected to receive some people this month.

"Bowel cancer, especially in its early stages, may not cause any symptoms," said Capital & Coast DHB programme clinical lead Dr Estella Johns.

"By screening every two years, we aim to detect these cancers and save lives. Being able to offer bowel screening at CCDHB is exciting. We've worked hard to ensure we have all the systems in place to be able to treat any cancers we find and still maintain our other services."

Over the next two years, around 45,000 people across the district will be invited for screening around their birthday. There is no need to enrol – a letter and a screening test will be sent to people's homes. Anyone who has recently moved or changed address is urged to ensure their GP has up-to-date information.

Bowel cancer kills around 1200 Kiwis every year, and screening can save lives by helping find it at an early stage. When identified early, bowel cancer is treatable and it is estimated that screening will identify around 700 people in the region each year who will need further investigation.

The two-year rollout means people with an even birth date are invited during year one, and those with odd birth dates invited in year two. The free test is quick, clean, and simple to do at home. It detects minute traces of blood in a very small poo sample – this can be an early warning sign for bowel cancer, alerting doctors that further investigation is required.

"Evidence shows that early identification and treatment of bowel cancer can save lives. However we need to ensure we work together to achieve equitable reach, access, and outcomes – particularly for Māori, Pacific, and Disability communities. Our team is dedicated to ensuring equity is a priority.

"Being able to offer bowel screening at CCDHB is exciting. We've worked hard to ensure we have all the systems in place to be able to treat any cancers we find and still maintain our other services."

CCDHB is also focused on ensuring access to information about bowel cancer and the testing process for the disability community by working to ensure information is available in New Zealand Sign Language, Easy Read, and other formats.

"Disabled people have the same rights as everyone else to access information about bowel cancer and the screening process, so they are able to make informed decisions and take care of their own health. We are working with the Ministry of Health and our community to ensure everyone is included," said general manager Disability Strategy Rachel Noble.

It is important to note that bowel screening is for people with no symptoms of bowel cancer. Anyone with blood in their bowel motion or an ongoing change – of at least six weeks – in their normal bowel habits should contact their GP immediately and not wait for the bowel screening test.

New Zealand has one of the highest rates of bowel cancer in the world. It is the second-highest cause of cancer death in New Zealand. Around 3200 people are diagnosed every year, 1200 of whom those will die from it. However the chances of surviving this cancer are very good when the cancer is found early – this is the goal of the National Bowel Screening Programme.

Protecting our Pacific people from COVID-19

Meet Rose and Otila. They are leading the way when it comes to protecting our Pacific community by getting their first COVID-19 vaccination doses and training to vaccinate others.

They have more than 40 years of experience working in the health sector between them. Otila has extensive experience working mainly in general and obstetric nursing in hospitals in Samoa and New Zealand while Rose is experienced in dialysis, aged care and supporting GP services.

Both are Speciality Clinical Nurses, working in the 3DHB Pacific Health Unit and helping to protect communities from COVID-19.

"For Otila and myself, that also means just being good Pacific role-models," Rose said.

Based at Hutt Hospital, the pair recently completed an Influenza, MMR and Pandemic Vaccinator Foundation Course then went on to complete a COVID-19 education course. They are now trained vaccinators, able to support our staff and Community Vaccination Centres.They will help other staff to get vaccinated and people in our community. All in all, the online training took about eight hours, which they fitted in part-time around their regular work.

"As a Speciality Clinical Nurse and working frontline, it's important that we get the COVID-19 vaccination because as nurses we have a duty of care to our patients.

"As a Pacific mother, this duty of care extends to my family and the Pacific community," Rose said. "We acknowledge that Pacific people may have some fears and doubt about the vaccination and this is normal.

"We encourage them to talk to a health professional, ring their GP clinic and speak to a nurses, ring HealthLine on 0800 611116 or they can even ring through to the Pacific Health Units at Hutt Valley

or Wellington hospitals. We can help with information so Pacific people can feel safe in making the right choices."

Previous COVID-19 lockdowns had impacted communities by restricting people from coming together for community and family events. Vaccination is an important step in protecting our communities against COVID-19.

"We would advise our families to get the vaccine," Otila said. "It's important we are protected against COVID-19. That we are safe, that our families are safe and that we live in a safe community."

3.5.2 New website banners

3.6 Internal Engagement and Communication

3.6.1 Intranet page views and stories

CCDHB	HVDHB
528,089 page views	162,234 page views

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

3.6.2 Top intranet stories

Patient story leads to change in practice

A CCDHB nurse has carried out quality improvement work that led to a change in practice.

A presentation she developed as a result also saw her win an award at an international conference.

Registered nurse Dyan Fei Lariosa-Di Mattina is a pressure injury prevention and management (PIPM) resource nurse based in the Neuroscience ward at Wellington Regional Hospital.

After discovering that a patient had developed a pressure injury behind his ear, she undertook a case study to learn from the incident, explore the topic of pressure injuries to the head, and make recommendations for changes to avoid similar preventable patient harm.

Dyan's work concluded that pressure injuries are almost always avoidable with early detection. She identified key points to prevent head pressure injuries occurring - through regular head assessments, following PIPM guidelines, and improving documentation.

As the patient's injury had developed as the result of a medical device, Dyan worked with the medical device supplier to find a solution. CCDHB is now trialling new Airvo nasal prongs (Optiflow 3S) for oxygen in post brain-injury complex patients, to prevent pressure injury developing behind the ear.

Education was also carried out as part of 7 South staff study days, using the case study as a tool to share information about the prevention of pressure injuries.

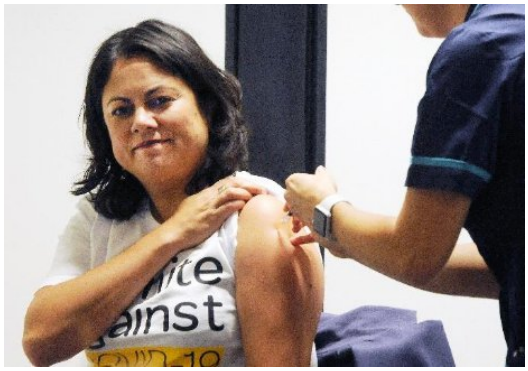
"Greater staff awareness of PIPM can help prevent pressure injuries, as can using the right equipment - such as mattress and prophylactic dressings to offload medical devices," says Dyan.

The ward has not had any cases of pressure injury behind the ears since the changes were introduced.

Dyan's quality improvement work meant a change in practice that helps benefit patients, and also won her the 'best presentation' award at the Australasian Neuroscience Nurses' Association (ANNA) 2020 Virtual Conference "The Heart of Nursing". Dyan was inspired to speak after attending the 2019 ANNA conference, held in Wellington.

COVID-19 Response Minister vaccinated thanks to Hutt staff

COVID-19 Response Minister Chris Hipkins and Associate Health Minister Ayesha Verrall received their first doses of the Pfizer vaccine in Lower Hutt this morning as part of the DHB COVID-19 Vaccination Programme.



The pair became two of the more than 52,000 New Zealanders who had received a dose so far on March 31.

About 16,000 people have already received both their first and second dose, Hipkins said.

After his jab, Hipkins said he "didn't even feel it".

“It is also a show of support for our frontline health workforce, which has recently begun receiving vaccinations.”

The elected officials visited Ropata Health on March 31 for their first of the two required vaccination doses.

Ropata Health is the vaccination site for patient-facing Hutt Valley DHB staff who are getting vaccinated to protect the community from COVID-19.

Dr Verrall said she was excited to be getting the jab. "If we all go through with the vaccine the whole community will be protected."

The Ministry of Health provided extra doses of the vaccine to Ropata Health, which has enabled more people – including the Ministers – to get protected faster.

There were about 5,500 doses administered yesterday around the country and Hipkins said that number would rise to around 7,000 or 8,000 a day as authorities worked through the border workforce, their families, and then frontline medical staff.

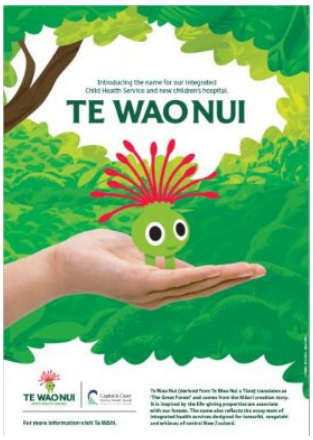
Planning the public rollout for Hutt Valley and Capital & Coast

Running the largest health programme in our history is a big job. Our Hutt Valley and Capital & Coast DHB COVID-19 vaccination team met on Friday 16 April with the leaders of Tū Ora Compass Health, Te Awakairangi Health Network, Ora Toa and Cosine. These Primary Health Organisations (PHOs) are running our Community Vaccination Centres on behalf of the DHBs across the two DHB areas, working together with Māori and Pacific health providers.

On the agenda was planning for how we'll grow our programme to ensure everybody can be vaccinated by the end of 2021. This will involve scaling up to 30,000 vaccinations per week, running in a range of sites so that people can be vaccinated in their community. Over the coming months, you can expect to see vaccination centres open in places like major shopping areas, marae, large GP offices, and other places where people gather.

Vaccination for COVID-19 is free, safe and effective. It is the best thing we can do together to protect ourselves and the people we love

3.6.3 Staff posters



Board Information - Public

5 May 2021

February 2021 Financial and Operational Performance Reports – Hutt Valley DHB

Action Required

The Hutt Valley DHB note:

(a) The release of this report to the public.

(b) The DHB had a $1.1m surplus for the month of February 2021, being ($87k) unfavourable to budget

(c) The DHB year to date had a deficit of ($3.6m), being $1,522k favourable to budget

(d) The Funder result for February was $1.4m favourable, Governance $0.1m favourable and Provider ($1.6m) unfavourable to budget;

(e) Total Case Weighted Discharge (CWD) Activity was 6% ahead of plan.

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

Executive Summary

For February, the Hutt Valley DHB has a surplus of $1.1m which is ($0.1m) unfavourable to budget. Of this unfavourable variance ($1.6m) is in the provider arm services. Activity is 6% ahead of that planned year to date. Total FTE are 189 below budget (143 FTE relate to the MHAIDs and IT move to CCDHB).

Hutt hospital had more ED attendances than budget in February however due to the acuity of presentations, delay in specialty assessment and difficulty in timely disposition, the ability to discharge patients within 6 hours remained a challenge with 84% able to move through the ED within 6 hours. We did note a change to acuity mix with an increase in triage 1, 2 and 3 and decreases in triage 4 and 5 patients. The expectation to improve long waits in ED for patients to see speciality services will be a focus for our hospital wide acute service flow improvement initiative, however the development of sustainable models of care for afterhours services across the district is key to long term improvement in wait times.

Year to date, caseweights for Surgical remain over budget with acute demand the key driver - both Neonatal and Maternity discharges continuing are higher than plan levels. Better managing acute patient flow with a better focus on utilising the tools available (CAPPLAN, Trend Care, Dashboards) will support improved performance.

Planned care – the delivery of Specialist assessments or Treatment within 120 days continues to be a major challenge. While the total February planned care target at 96.6 % was met we are behind target for the additional elective volumes. This is due in part to the impact of acute demand but also limited capacity in the private sector. A revised plan is in development that includes use of Saturday morning lists. We are liaising weekly with the Ministry planned care team seeking support and advice as we lead out our system improvement project aimed at making progress around all aspects of managing elective flow.

Areas of risk - midwifery vacancies - we are continually refining and reviewing processes to manage demand during busy periods and continue to work closely with our staff and union partners on workforce planning across the region noting this issue as requiring national solutions.

Funder key areas of performance with a focus on core services and achieving equity. We are responding to the needs of our children.

- In 2019, 6% of preschool children were overdue annual examination, which show improved performance from the previous year when 16% were overdue. There was also significant improvement in Māori and Pacific children's dental health, with a 14% increase in Māori and Pacific who had caries free teeth at age 5.
- Concern regarding the ongoing decline in performance in diabetes services has been discussed with PHOs. TeAHN has committed to moving practices to pro-active planning, working at an individual patient level.
- We are developing sustainable strength and balance programmes to improve our response to frailty, particularly for Māori and Pacific older peoples.
- We are improving our data to inform the development of initiatives to reduce falls. We are participating in a Regional Equity forum to improve equitable outcomes for dementia.
- We are strengthening primary care with more specialist support, embedding telehealth models of care that started during COVID-19, and continuing the roll out of the Health Care Homes to help keep older people healthy and well in the community.

Strategic Considerations

Service	Financial performance and funding is a key to delivering the services for the Hutt Valley populations.
People	Staff numbers for HVDHB are 189 below plan with additional costs in outsourced personnel for roles employed by CCDHB for MHAIDs and IT.
Financial	Planned deficit for HVDHB $10.6 million with no COVID-19 or Holidays Act provision impacts included.
Governance	The FRAC committee is accountable for scrutinising the financial and operational performance on behalf of the board, and reporting back to the board on issues as identified by the committee.

Engagement/Consultation

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

Identified Risks

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

Attachments

3.1.1 Hutt Valley DHB February 2021 Financial and Operational Performance Report

Monthly Financial and Operational Performance Report

For period ending
28 February 2021

Reported in March 2021

Contents

Section 1

Financial and Performance Overview and Executive Summary

Executive Summary

- Hutt hospital had more ED attendances than budget in February however due to the acuity of presentations, delay in specialty assessment and difficulty in timely disposition, the ability to discharge patients within 6 hours remained a challenge with 84% able to move through the ED within 6 hours. We did note a change to acuity mix with an increase in triage 1, 2 and 3 and decreases in triage 4 and 5 patients. The expectation to improve long waits in ED for patients to see speciality services will be a focus for our hospital wide acute service flow improvement initiative, however the development of sustainable models of care for afterhours services across the district is key to long term improvement in wait times.
- Year to date, caseweights for Surgical remain over budget with acute demand the key driver - both Neonatal and Maternity discharges continuing are higher than plan levels. Better managing acute patient flow with a better focus on utilising the tools available (CAPPLAN, Trend Care, Dashboards) will support improved performance.
- Planned care – the delivery of Specialist assessments or Treatment within 120 days continues to be a major challenge. While the total February planned care target at 96.6 % was met we are behind target for the additional elective volumes. This is due in part to the impact of acute demand but also limited capacity in the private sector. A revised plan is in development that includes use of Saturday morning lists. We are liaising weekly with the Ministry planned care team seeking support and advice as we lead out our system improvement project aimed at making progress around all aspects of managing elective flow.
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- Funder key areas of performance with a focus on core services and achieving equity. We are responding to the needs of our children.
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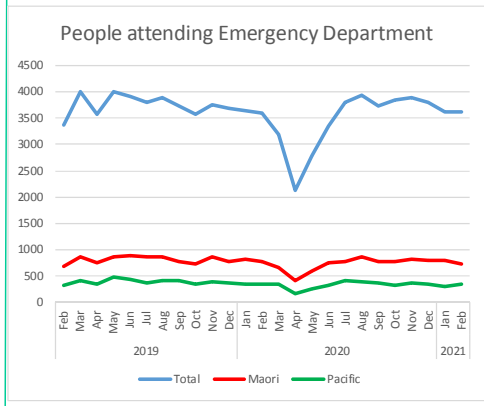
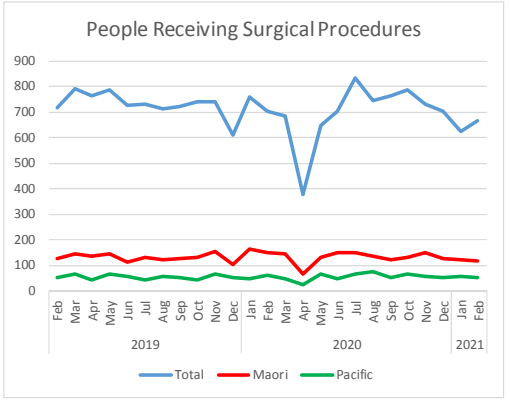
  - We are developing sustainable strength and balance programmes to improve our response to frailty, particularly for Māori and Pacific older peoples.
  - We are improving our data to inform the development of initiatives to reduce falls. We are participating in a Regional Equity forum to improve equitable outcomes for dementia.
  - We are strengthening primary care with more specialist support, embedding telehealth models of care that started during COVID-19, and continuing the roll out of the Health Care Homes to help keep older people healthy and well in the community.
- For February, the Hutt Valley DHB had a surplus of $1.1m which is ($0.1m) unfavourable to budget. A deficit of $1.4m is in the provider arm services. More detail can be found in the Provider Arm summary.

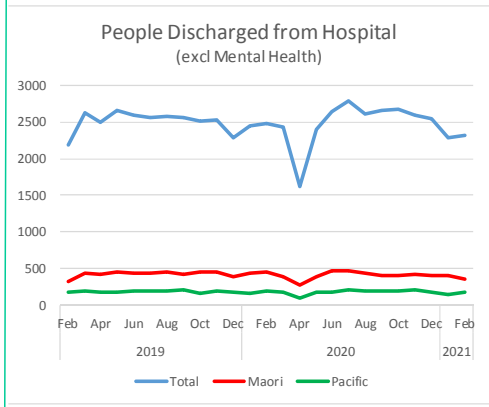
Performance Overview: Activity Context (People Served)

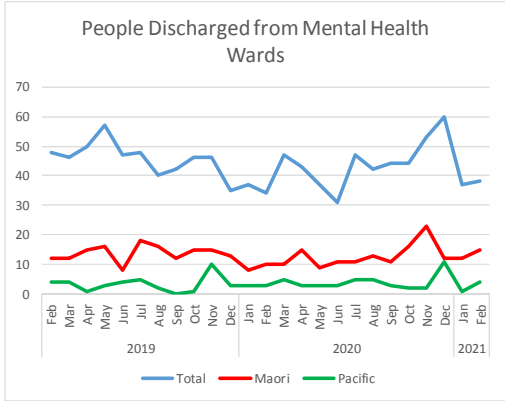
The numbers below count individuals once and are based on Hutt Valley DHB being the DHB of Service. Our services have returned to delivering services to our population without the restrictions due to COVID-19. Services continue to take necessary precautions.

People attending ED	**3,610**	738 Maori, 346 Pacific
People receiving Surgical Procedures	**667**	115 Maori, 53 Pacific
People discharged from Hospital (excl Mental Health)	**2,310**	350 Maori, 180 Pacific
People discharged from Mental Health wards	**38**	15 Maori, 4 Pacific



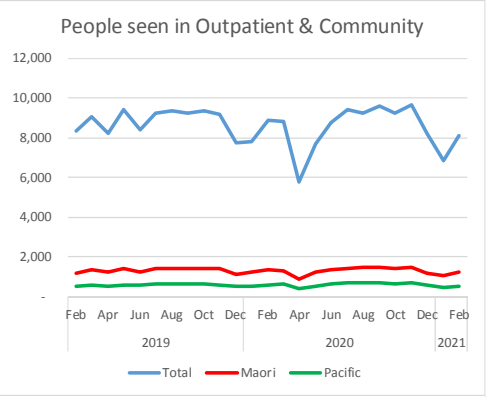


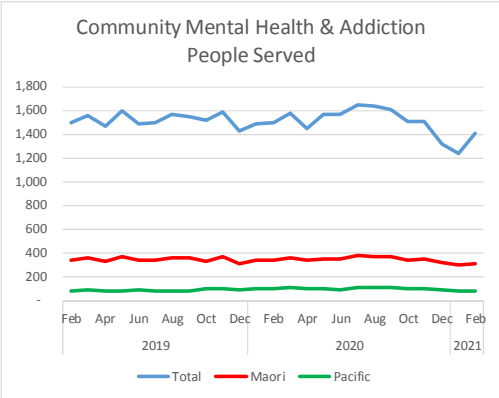


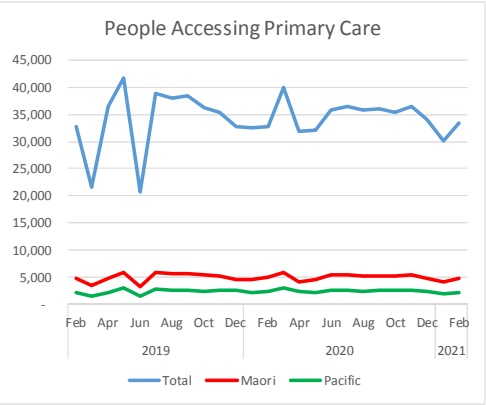


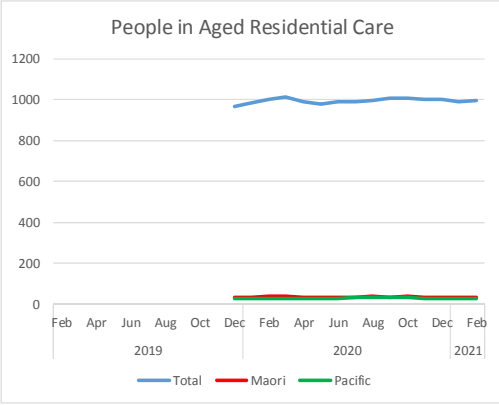
Performance Overview: Activity Context (People Served)

People seen in Outpatient & Community	**8,100**	1,253 Maori, 545 Pacific
Mental Health and Addiction Contacts	**1,408**	310 Maori, 82 Pacific
Primary Care Contacts	**33,462**	4,808 Maori, 2,239 Pacific
People in Aged Residential Care	**998**	35 Maori, 27 Pacific









Financial Overview – February 2021

YTD Operating Position	YTD Provider Position	YTD Funder Position	YTD Capital Exp
$3.6m deficit	$7.4m deficit	$3.1m surplus	$5.5m
Against the budgeted deficit of $5.1m.	Against the budget deficit of $6.1m.	Against the budget surplus of $0.8m.	

YTD Activity vs Plan (CWDs)	YTD Paid FTE	Annual Leave Accrual
6% ahead	1,869	$20.6m
155 CWDs ahead PVS plan for February. IDFs were 38 CWD under budget for the month	YTD 189 FTE below annual budget of 2,058 FTE. Note: The MHAIDS & ITS restructures and change of employer contributed 143 FTE to this variance	This is an increase of $0.7m on prior period.

Hospital Performance Overview – February 2021

YTD Shorter stays in ED	People waiting >120 days for treatment (ESPI5)	People waiting >120 days for 1st Specialist Assmt (ESPI2)	Faster Cancer Treatment
83%	1,270	1,124	75%
12% below the ED target of 95%, Similar to February 2020.	Against a target of zero long waits a monthly movement of 19.	Against a target of zero long waits a monthly increase of 108	Did not achieve the 62 day target. The 31 day target was achieved at 100%

YTD Activity vs Plan (CWD)	YTD Standard FTE	Serious Safety Events
6% ahead	1,863	3
155 CWDs ahead PVS plan for February. IDFs were 38 CWD under budget for the month	185 below YTD budget of 2,037 FTE. Month FTE was 173 under budget an upwards movement from January of 45 FTE.	An expectation is for nil SSEs at any point.

Section 2

FUNDER PERFORMANCE

Executive Summary – Funder

- Overall the funder has a positive variance of $2.380m year to date, with revenue for IDFs being ahead of budget by $0.9m due to wash-ups from last year and increased volumes for the current year. In addition COVID-19 revenue, which is offset by costs also means we are ahead of revenue by a total of $3.5m YTD.
- Aged residential care costs are $224k favourable for the month. Other Health of Older People costs are favourable $247k for the month and $1,207k YTD. The implementation of the frailty model will be supported by this underspend.
- Mental Health costs are favourable $191k for the month, favourable $1,272k YTD, reflecting timing of contracts which will be rectified with the acute care continuum funding.
- In this report we have also highlighted the below key areas of performance with a focus on our core services and achieving equity. We are responding to the needs of our children.
  - In 2019, 6% of preschool children were overdue annual examination, which show improved performance from the previous year when 16% were overdue. There was also significant improvement in Māori and Pacific children's dental health, with a 14% increase in Māori and Pacific who had caries free teeth at age 5.
  - Concern regarding the ongoing decline in performance in diabetes services has been discussed with PHOs. TeAHN has committed to moving practices to pro-active planning, working at an individual patient level.
  - We are developing sustainable strength and balance programmes to improve our response to frailty, particularly for Māori and Pacific older peoples.
  - We are improving our data to inform the development of initiatives to reduce falls. We are participating in a Regional Equity forum to improve equitable outcomes for dementia.
  - We are strengthening primary care with more specialist support, embedding telehealth models of care that started during COVID-19, and continuing the roll out of the Health Care Homes to help keep older people healthy and well in the community.

Funder Financial Statement – February 2021

DHB Funder (Hutt Valley DHB)
Financial Summary for the month of February 2021

Month					$000s	Year to Date					Annual			
Actual	Budget	Variance	Last Year	Variance		Actual	Budget	Variance	Last Year	Variance	Budget	Variance	Last Year	Variance
					Revenue									
37,841	37,970	(129)	34,735	3,106	Base Funding	302,726	303,758	(1,031)	277,877	24,849	455,637	(1,547)	416,816	37,274
2,657	2,341	316	2,068	589	Other MOH Revenue	22,086	18,727	3,359	21,745	341	28,090	3,593	38,006	(6,324)
4	36	(31)	37	(33)	Other Revenue	517	285	232	308	208	427	232	619	40
9,033	9,229	(196)	8,721	312	IDF Inflows	74,714	73,828	886	69,228	5,486	110,742	818	102,280	9,281
49,535	**49,575**	**(40)**	**45,561**	**3,974**	**Total Revenue**	**400,044**	**396,597**	**3,447**	**369,159**	**30,885**	**594,895**	**3,096**	**557,721**	**40,271**
					Expenditure									
328	416	87	383	55	DHB Governance & Administration	3,115	3,325	210	3,064	(50)	4,987	335	4,597	(55)
20,547	21,029	482	20,106	(441)	DHB Provider Arm	167,656	168,238	582	160,893	(6,763)	252,577	1,515	241,131	(9,931)
					External Provider Payments									
2,695	2,726	30	3,720	1,025	Pharmaceuticals	27,626	26,086	(1,539)	25,691	(1,934)	38,866	(2,282)	37,365	(3,783)
4,267	4,369	102	4,239	(28)	Laboratory	35,129	34,949	(180)	33,802	(1,327)	52,424	(112)	50,903	(1,633)
2,587	2,541	(46)	2,421	(166)	Capitation	20,865	20,330	(534)	19,645	(1,220)	30,495	(534)	29,563	(1,467)
984	1,116	132	792	(192)	ARC-Rest Home Level	9,259	9,682	423	7,726	(1,533)	14,543	310	11,877	(2,356)
1,642	1,734	92	1,337	(305)	ARC-Hospital Level	14,386	15,049	663	12,653	(1,733)	22,604	258	19,154	(3,193)
2,465	2,712	247	3,085	620	Other HoP & Pay Equity	20,387	21,594	1,207	22,398	2,011	32,442	967	35,134	3,660
898	1,089	191	579	(319)	Mental Health	7,417	8,688	1,272	5,578	(1,839)	13,045	848	9,580	(2,617)
499	482	(17)	472	(26)	Palliative Care / Fertility / Comm Radiology	3,951	3,854	(97)	3,843	(108)	5,782	(97)	5,788	(90)
1,648	1,324	(324)	1,201	(446)	Other External Provider Payments	13,599	10,845	(2,754)	9,289	(4,310)	17,332	(2,754)	19,220	(866)
8,641	9,151	509	8,118	(523)	IDF Outflows	73,524	73,204	(319)	65,849	(7,674)	109,807	(339)	101,298	(8,847)
0	0	0	0	0	Provision for IDF Wash-ups	0	0	0	43	43	0	0	0	0
47,201	**48,687**	**1,486**	**46,454**	**(747)**	**Total Expenditure**	**396,912**	**395,846**	**(1,067)**	**370,475**	**(26,437)**	**594,905**	**(1,885)**	**565,610**	**(31,179)**
2,334	**887**	**1,446**	**(894)**	**3,227**	**Net Result**	**3,131**	**751**	**2,380**	**(1,316)**	**4,447**	**(9)**	**1,211**	**(7,889)**	**9,091**

There may be rounding differences in this report

Funder Financials – Revenue

Revenue:

- Revenue is made up of base funding, other MOH revenue, other revenue and inter district flows. The table shows the variance for other MOH revenue.
- Base Funding is unfavourable ($129k) to budget for the month and ($1,031k) year to date, reflecting the rate change from 6% to 5% for Capital Charge impacting both Income and expenditure.
- Other MoH revenue is favourable $316k for February and $3,359k year to date, including COVID-19 funding and Planned Care.
- IDF inflows are ($196k) unfavourable for the month driven by current year wash-ups, favourable $886k year to date.

Other MOH Revenue Variance	MTH $000's	YTD $000's
In- Between Travel (prior years)	0	(314)
In- Between Travel (2020/21)	147	28
Capitation Funding	21	359
Planned Care	64	515
COVID-19 Funding	196	3,661
COVID-19 Funding - RPH	(127)	(1,018)
Crown funding agreements		
B4 School Check Funding	14	51
Hospice - Cost Pressure funding	12	94
More Heart and diabetes checks	(5)	(69)
Additional School Based MH Services	(10)	(79)
Maternity Quality and Safety Programme	11	84
Rheumatic Fever Prevention Services	(9)	(46)
Well Child/Tamariki Ora Services	8	49
Other CFA contracts	4	(45)
Year to date Variance $000's	**316**	**3,359**

Expenditure:

Governance and Administration is favourable $87k for January. Provider Arm payments variance includes; IDF Wash-up Payments to the Provider and Capital Charge rate reduction.

External Provider Payments:

Pharmaceutical costs are favourable $30k for February and unfavourable ($1,539k) YTD, reflecting a combination of passing rebates back to the provider arm and seasonal variations.

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

Aged residential care costs are $224k favourable for the month.

Other Health of Older People costs are favourable by $247k for the month and favourable $1,207k YTD.

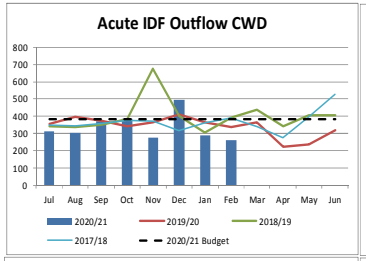
Mental Health costs are favourable $191k for the month, favourable $1,272k YTD, reflecting timing of contracts.

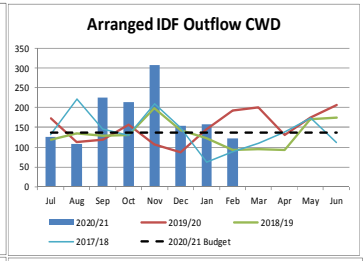
Palliative Care, Fertility and Community Radiology costs are unfavourable by ($17k) for the month.

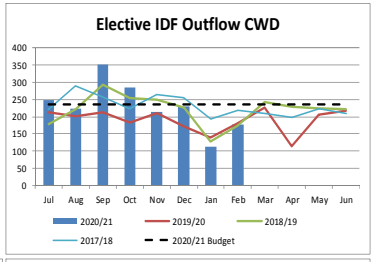
Other external provider costs are unfavourable to budget ($324k) for the month.

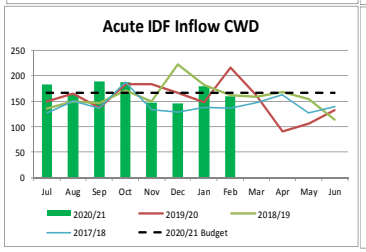
IDF Outflows are favourable $509k, due to Current Year Wash-up payments for lower volumes.

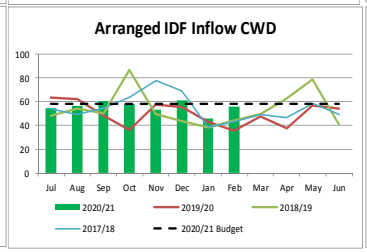
Inter District Flows (IDF)

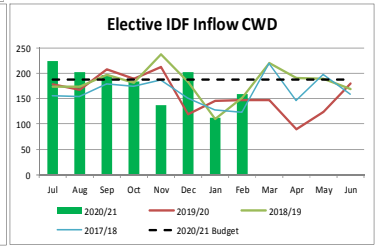












IDF Wash-ups and Service Changes Feb 2021		
IDF Outflows $000s	Variance to budget	
	Month	YTD
Base	(0)	(1)
CCDHB - Advance Care Planning	(5)	(40)
Wash-ups		
2020/21 Outflows	501	(412)
2020/21 PHO	-	(133)
2020/21 FFS	14	14
2019/20 Wash-up	-	254
IDF Outflow variance	**509**	**(319)**

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):

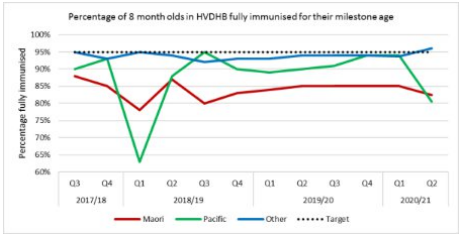
- Based on the data available, overall IDF inflows are over budget YTD by $886k. Inflows for other services $1,005k and inpatient ($439k) under budget. Inpatient inflows are under budget mainly in Plastics, Orthopaedics and General Medicine.

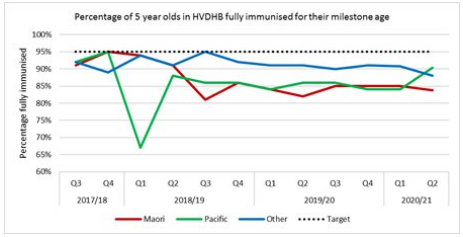
IDF Outflow (expense):

- Based on the data available, overall IDF outflows are over budget by ($319k) year to date mainly due to Inpatient outflows being over budget by ($476k). Inpatient outflows are mainly over budget in Neonates, elective Cardiology and Vascular Surgery at Capital Coast.

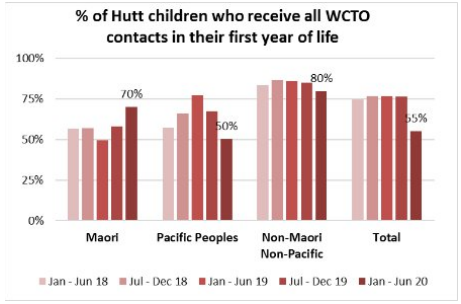
Children 0-4 years – Healthy start

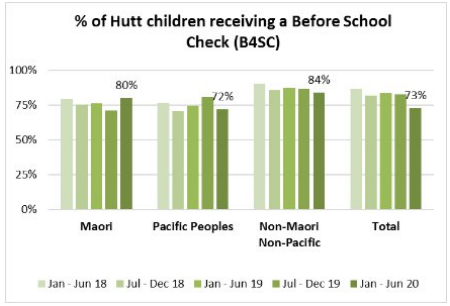
Receive all their scheduled immunisations



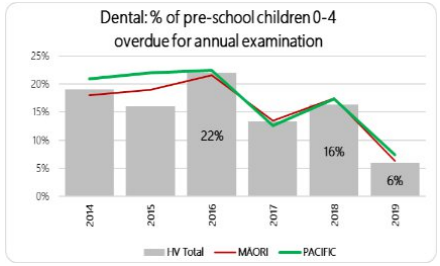


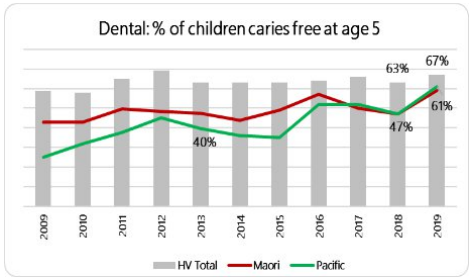
Receive all their Well Child / Tamariki Ora (WCTO) checks





Have healthy teeth





Performance at Quarter One 2020/21

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

Babies immunised at 8 months: Maori at 82%, Pacific 80% & Other over target at 96% at Q2 2020/21; Children at 5 years – little change average Maori 84% Pacific 90% Other 88%

WCTO checks – healthy development, screening for potential problems:

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

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

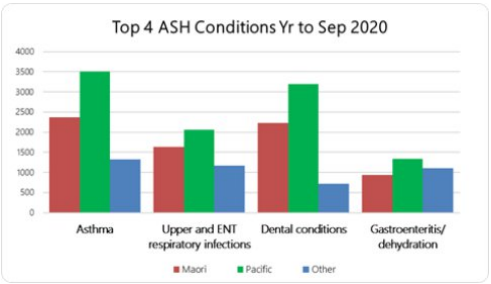
- In 2019, 6% of preschool children were overdue annual examination, which show improved performance from the previous year when 16% were overdue
- In 2019, there was a significant improvement in Māori and Pacific children's dental health, with a 14% increase in Māori and Pacific who had caries free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

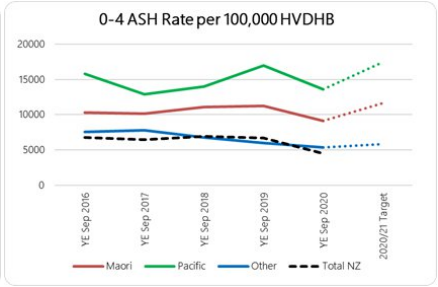
What are we doing?

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

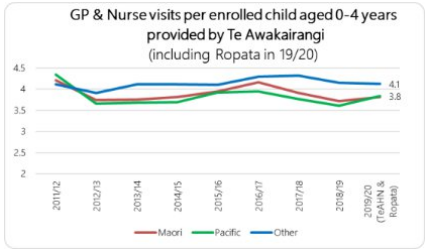
Children 0-4 years – Acute Care

Ambulatory Sensitive Hospitalisations (ASH) – Avoidable Hospitalisations

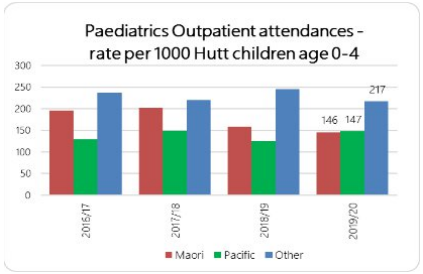


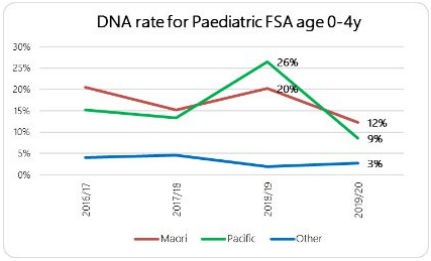


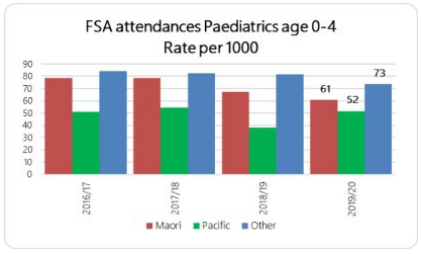
Seen by General Practice



Seen at Paediatric Specialist







Performance at Quarter One 2020/21

Ambulatory Sensitive Hospitalisations (ASH) – Avoidable Hospitalisations

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

Access to GP care

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

Paediatric outpatients

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

What are we doing?

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

Commissioning: Primary & Complex Care

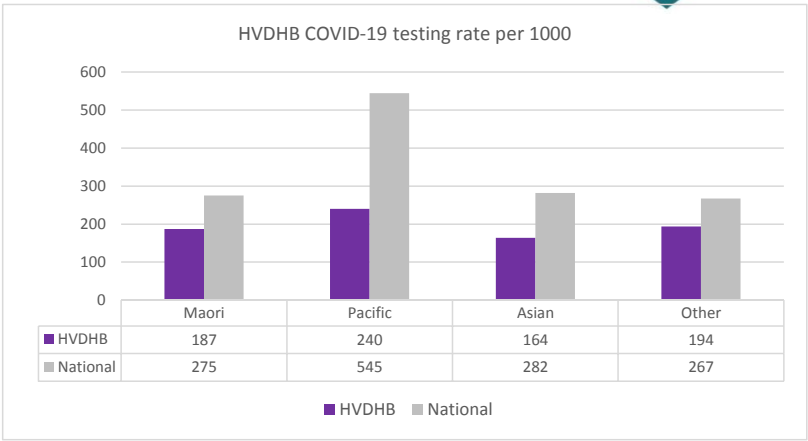
What is this measure?
- COVID-19 testing rate per 1,000 population

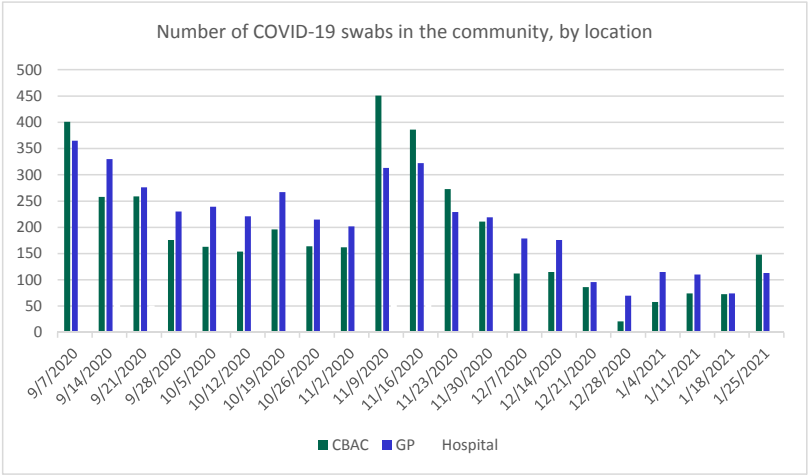
Why is this important?
- The current stage in our COVID-19 response is "maintaining the elimination of disease". This requires strong surveillance to support containment of infection at the border; and robust investigation of any identified cases within the community.
- DHBs are responsible for the organisation and delivery of health services in response to COVID-19. The availability of testing facilities is important for access to testing, and supporting surveillance and contact tracing functions.

How are we performing?
- Our testing rate per 1,000 is 187 for Māori and 240 for Pacific (lower than the national average).
- Nationally, HVDHB ranks 14th highest for testing rate for the total population (193 per 1000). We rank 14th in our testing rate for Māori and 17th for Pacific.
- CBACs have delivered high volumes of swabbing since lockdown, however, the additional swabbing capacity offered through general practices surpassed CBAC volumes until the November cases.
- Our testing volumes partly reflect the communities' responses to the presence of COVID-19 in their communities.

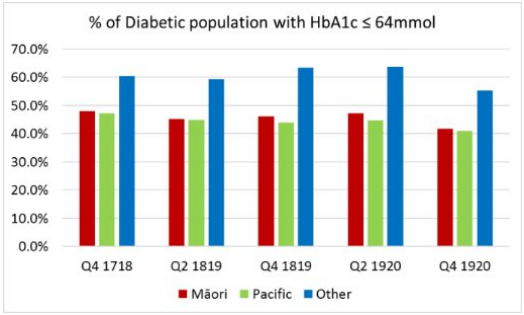
What is driving performance?
- Following the Wellington region community transmission in November, community testing at CBACs increased significantly. However, testing decreased significantly over the Christmas period, and daily swabbing is still below previous volumes.

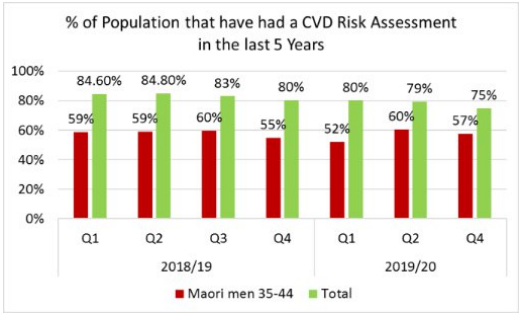
Management Comment
- Our testing regime responds to the Government's testing strategy and our MIF staff and border workers are now being tested at higher rates, and with increased frequency.
- Using our own resources and those allocated by MoH we maintain a state of preparedness in our hospitals and our Regional Public Health Response and community teams are prepared for a comprehensive response.
- Improving testing in our community following the holiday period is a priority, particularly for Māori.
- We have 3 CBACs open; designated practices, and 1 mobile team working across our region.

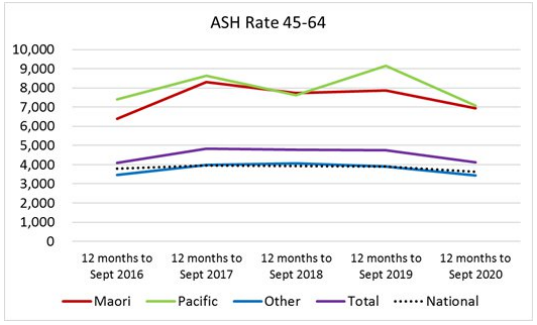


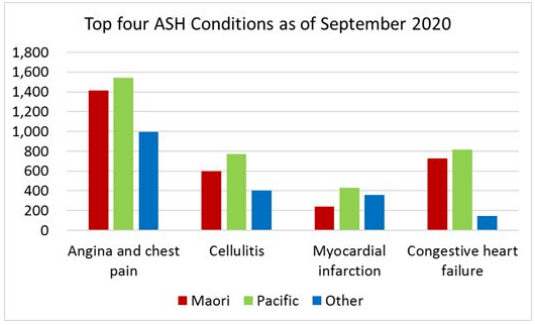


Primary Care: Long Term Conditions









Performance at Quarter Two 2020/21

Diabetes management

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

CVD risk assessment

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

Avoidable hospitalisations (ASH)

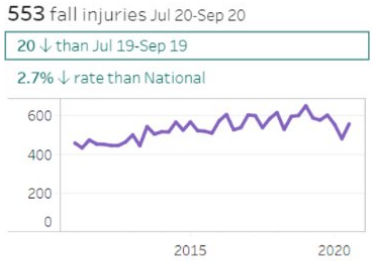
- Angina and Chest Pain highest has decrease for Pacific and Other, constant for Maori, but is still the highest condition.
- Congestive heart failure has returned to a more normal level.

What are we doing?

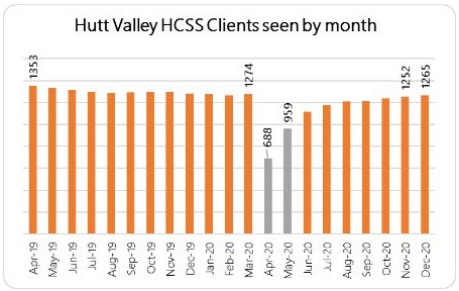
- Concern regarding the ongoing decline in performance in diabetes services has been discussed with PHOs. TeAHN has committed to moving practices to pro-active planning, working at an individual patient level.
- Specialist support to primary care is underway, with areas for expansion being considered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

Health of Older & Frail People – community services

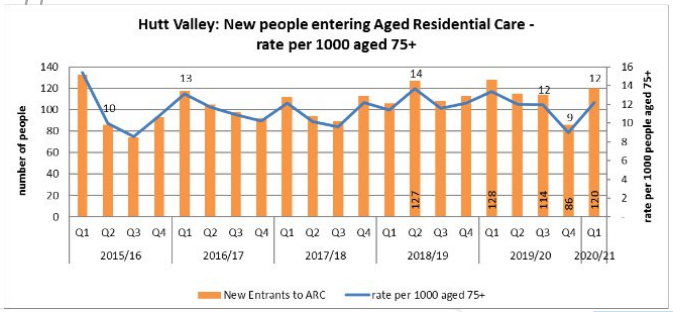
Supported to stay at home safely

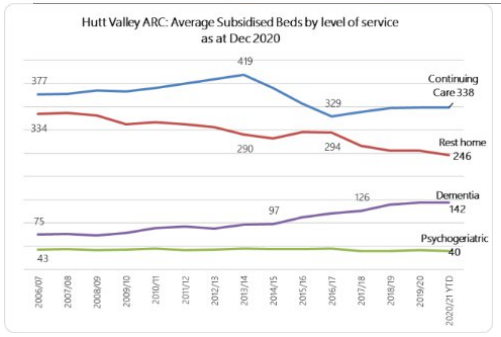


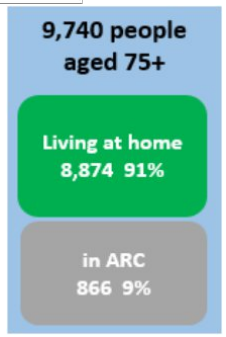
Source: ACC claims for a fall
Rate: Calculated per 1,000 population



Supported in residential care







Performance at Quarter two 2020/21

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

- About 91% (8,875) people aged 75+ years live at home, and 9% (865 clients) in Aged Residential Care facilities as at Dec 2020.
- 1,252 people received Home support during November.

COVID Impact

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

Aged Residential Care:

- Rest home level – bed days for subsidised clients have been dropping over the last few years as people stay at home for longer and enter ARC at higher levels of care
- Dementia level – increasing subsidised beds as more beds have become available
- Continuing care – highest level of care – has been steadily increasing since 2016/17.

What are we doing?

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

Section 3

Hospital Performance

Executive Summary – Hospital Performance

- Hutt hospital had more ED attendances than budget in February however due to the acuity of presentations, delay in specialty assessment and difficulty in timely disposition, the ability to discharge patients within 6 hours remained a challenge with 84% able to move through the ED within 6 hours. We did note a change to acuity mix with an increase in triage 1, 2 and 3 and decreases in triage 4 and 5 patients. The expectation to improve long waits in ED for patients to see speciality services will be a focus for our hospital wide acute service flow improvement initiative, however the development of sustainable models of care for afterhours services across the district is key to long term improvement in wait times.
- Year to date, caseweights for Surgical remain over budget with acute demand the key driver - both Neonatal and Maternity discharges continuing are higher then plan levels. Better managing acute patient flow with a better focus on utilising the tools available (CAPPLAN, Trend Care, Dashboards) will support improved performance across the system.
- Planned care – the delivery of Specialist assessments or Treatment within 120 days continues to be a major challenge. While the total February planned care target at 96.6 % was met we are behind target for the additional elective volumes. This is due in part to the impact of acute demand but also limited capacity in the private sector. A revised plan is in development that includes use of Saturday morning lists. We are liaising weekly with the Ministry planned care team seeking support and advice as we lead out our system improvement project aimed at making progress around all aspects of managing elective flow.
- We continue to work on strategies to 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 address delays in the Care Coordination Pathway. The development of a commissioning led team to bring sector wide coordination of care to patients who have complex discharge needs is going well.
- Our Maternity Units across the region continue struggling with midwifery vacancies - we are continually refining and reviewing processes to manage demand during busy periods and continue to work closely with our staff and union partners on workforce planning across the region noting this issue as requiring national solutions.
- Medical and Surgical service costs remain unfavourable to budget driving the overall provider result. The pressure in Medical and Surgical services is driven by personnel costs in excess of both Nursing, Allied Health and Support staff and treatment related. Previously described trends for patient activity and acuity and the impact of increasingly older, frailer and more complex patients/increasing one to one care, treatment related costs particularly treatment disposables and implants are high again this month taking us well ahead of plan in line with the increased acute demand for surgery. Nursing Mitigations in place include active recruitment for the required FTE to reduce overtime, casual/allocation use, completion of the CCDM roll out and continual review use of minders/cohort watches to keep the level to a reasonable safe level. Leave planning is in place for the holiday period.

Hospital Throughput

Month					Hutt Valley DHB Hospital Throughput YTD Feb-21	Year to Date					Annual	
Actual	Budget	Variance Actual vs Budget	Last year	Variance Actual vs Last year		Actual	Budget	Variance Actual vs Budget	Last year	Variance Actual vs Last year	Annual Budget	Last year
					Discharges							
1,693	974	(719)	1,015	(678)	Surgical	14,982	8,529	(6,453)	8,341	(6,641)	12,950	12,797
1,017	1,471	454	1,756	739	Medical	8,994	13,029	4,035	14,691	5,697	19,737	19,506
467	425	(42)	474	7	Other	3,861	3,650	(211)	3,689	(172)	5,374	5,474
3,177	**2,870**	**(307)**	**3,245**	**68**	**Total**	**27,837**	**25,208**	**(2,629)**	**26,721**	**(1,116)**	**38,061**	**37,777**
					CWD							
879	1,035	156	1,182	304	Surgical	7,813	9,189	1,376	9,300	1,487	13,889	12,852
1,030	790	(240)	932	(98)	Medical	9,419	7,205	(2,214)	7,829	(1,591)	10,719	11,991
502	557	55	530	28	Other	4,463	3,950	(513)	4,307	(156)	5,811	4,698
2,411	**2,382**	**(29)**	**2,644**	**234**	**Total**	**21,695**	**20,344**	**(1,351)**	**21,435**	**(259)**	**30,419**	**29,540**
					Other							
4,026	3,740	(286)	4,028	2	Total ED Attendances	33,261	32,225	(1,036)	33,271	10	48,696	47,491
914	809	(105)	945	31	ED Admissions	8,093	7,556	(537)	7,918	(175)	11,386	11,847
710	745	35	743	33	Theatre Visits	6,182	6,219	37	6,015	(167)	9,370	9,271
116	89	(27)	107	(9)	Non- theatre Proc	1,101	982	(119)	1,013	(88)	1,500	1,891
7,085	6,007	(1,078)	7,073	(11)	Bed Days	58,885	54,104	(4,781)	59,227	342	82,873	85,515
4.28	4.50	0.23	4.32	0.04	ALOS Inpatient	4.49	4.50	0.02	4.43	(0.06)	4.50	4.29
2.00	2.18	0.18	2.14	0.14	ALOS Total	2.05	2.18	0.13	2.17	0.12	2.18	2.20
8.77%	8.02%	-0.75%	7.10%	-1.67%	Acute Readmission	8.18%	8.02%	-0.17%	7.93%	-0.25%	7.31%	7.36%

In February, Surgical discharges were over budget and the same time last year. Medical discharges and CWD for the month were lower than budget and the same time last year. YTD CWD for Surgical services are over budget due to General Surgery, Gynaecology and Plastics. For Medical YTD, discharges are below budget but CWD are higher. Discharges for Paediatrics are lower but Gastroenterology has increased compared to last year. Other services are higher than budget due to more discharges under Maternity.

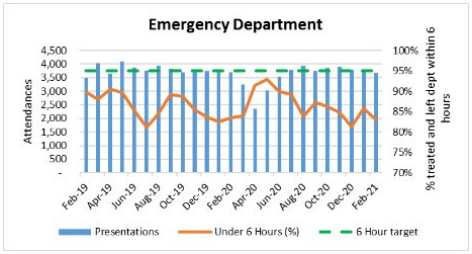
In February, ED visits and admissions were higher than budget but similar to last year. Theatre visits were below budget for the month, but close to budget YTD. Non-theatre procedures were higher than budget for the month and YTD. Bed days were 18% higher than budget for the month but close to the same time last year. Inpatient ALOS in February was shorter than budget. The acute readmission rate was higher than budget for the month and the same time last year.

Operational Performance Scorecard – 13 mths

			13 Months Performance Trend													
Domain	Indicator (MoH KPIs highlighted yellow)	2019/20 Target	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Safe	Serious Safety Events[1]	Zero SSEs	4	1	2	2	2	3	3	1	2	3	0	1	TBC
	SABSI Cases [2]	Zero	2	1	0	0	0	1	0	1	2	1	1	1	0
	C. difficile infected diarrhoea cases	Zero	2	4	0	2	0	3	4	1	1	4	0	1	0
	Hand Hygiene compliance (quarterly)	≥ 80%	83%		87%			82%			79%				
	Seclusion Hours- average per event (MH Inpatient ward TWA)[3]		14.0	31.1	39.1	16.3	13.8	27.7	36.7	11.4	13.3	1.4	43.6	7.6	22.4
Patient and Family Centred	Complaints Resolved within 35 calendar days[4]	≥90%													
	Patient reported experience measure[5] (quarterly)	≥80%	N/a		N/a			N/a			N/a				
Timely	Emergency Presentations	49,056	4,028	3,558	2,405	3,104	3,721	4,039	4,281	3,997	4,273	4,328	4,259	4,059	4,026
	Shorter Stays in ED (SSiED) % within 6hrs	≥95%	83.5%	83.9%	91.4%	93.0%	89.9%	89.2%	84.0%	87.2%	86.3%	84.8%	81.3%	85.8%	83.1%
	SSiED % within 6hrs - non admitted	≥95%	90.1%	90.1%	95.7%	97.0%	94.7%	93.3%	90.7%	91.5%	91.0%	89.8%	86.9%	90.7%	89.9%
	SSiED % within 6hrs - admitted	≥95%	64.4%	66.6%	81.1%	82.4%	76.1%	78.6%	64.5%	75.1%	73.2%	71.8%	66.3%	72.0%	62.8%
	Total Elective Surgery Long Waits -ESPI 5	Zero Long Waits	719	821	1,012	1,077	1,130	1,082	913	915	992	1,002	1,115	1,251	1,328
	No. Theater surgeries cancelled (OP 1-8)		98	194	50	72	98	140	148	154	142	128	138	87	139
	Total Elective & Acute Operations in MainTheatres 1-8[6]		743	704	389	673	733	868	792	805	824	775	744	644	710
	Specialist Outpatient Long Waits- ESPI 2	Zero Long Waits	1,194	1,265	1,396	1,384	1,240	1,096	798	674	723	704	758	1,016	1,124
	Outpatient Failure to Attend %	≤6.3%	7.6%	6.9%	6.1%	7.4%	8.3%	6.8%	6.3%	5.4%	5.6%	6.0%	6.2%	7.7%	5.6%
	Full Year Forecast surplus / (deficit) $m - Provider (1) (2)	($2.03)	($8.19)	($10.37)	($13.04)	($13.59)	($14.20)	($10.61)	($10.61)	($15.38)	($12.54)	($14.33)	($14.64)	($14.29)	TBC
	Full Year Forecast surplus / (deficit) $m - DHB (1) (2)	($8.14)	($10.39)	($13.04)	($14.64)	($15.64)	($21.45)	($10.65)	($10.65)	($13.37)	($12.31)	($12.87)	($14.54)	($14.33)	TBC
	% Theatre utilisation (Elective Sessions only)[7]	≤90%	89.6%	86.4%	74.5%	85.2%	87.6%	85.7%	87.9%	90.4%	86.2%	88.1%	87.2%	86.2%	87.2%
	Overnight Patients - Average Length of Stay (days)	≤4.3	4.35	5.31	4.90	4.26	4.44	4.39	4.76	4.52	4.26	4.72	4.79	4.50	4.36
	Long Stay Patients Not Yet Discharged (>14 days)	≤5	16	7	12	15	14	16	21	17	15	21	24	21	34
	Overnight Beds (General Occupancy) - Average Occupied	≤130	136	129	105	118	136	141	151	144	130	138	144	130	149
	Overnight Beds (General Occupancy) - % Funded Beds Occupied	≤85%	88.2%	79.5%	65.1%	73.1%	84.2%	86.8%	93.1%	88.8%	80.4%	85.1%	93.4%	84.7%	96.5%
	All Beds - ave. beds occupied[8]	≤250	244	223	179	207	241	244	254	249	231	240	240	229	253
	% sick Leave v standard	≤3.5%	2.5%	3.6%	7.5%	6.9%	3.1%	4.3%	4.2%	4.0%	3.4%	3.4%	3.1%	2.0%	2.5%
	% Nursing agency v employee (10)	≤1.49%	3.0%	2.6%	2.3%	3.3%	2.0%	1.6%	1.2%	2.2%	26.2%	12.7%	12.7%	12.8%	TBC
	% overtime v standard (medical) (10)	≤9.22%	9.3%	7.6%	9.2%	9.7%	9.2%	6.7%	7.8%	8.1%	9.2%	10.7%	6.9%	11.9%	TBC
	% overtime v standard (nursing)	≤5.47%	14.1%	10.6%	13.2%	12.6%	12.3%	10.8%	13.6%	12.3%	12.3%	14.4%	11.6%	23.7%	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	31 (197)	100% (100%)
2	692 (5391)	37% (43%)
3	1491 (12088)	24% (26%)
4	1356 (11645)	34% (38%)
5	456 (3942)	73% (73%)
	Mth (YTD)	Mth (YTD)

Arrivals -
Month - 4,026 (4,028)
YTD - 33,263 (33,271)

Self Referred
Month - 2,709 (2,696)
YTD - 22,130 (21,882)

GP Referred
Month - 386 (428)
YTD - 3,197 (3,289)

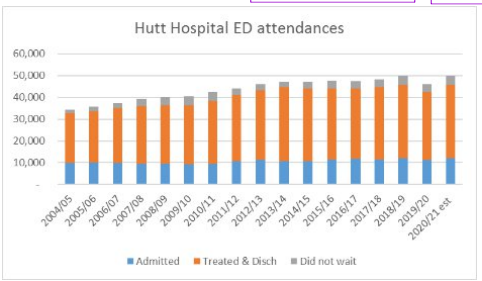
Other
Month - 931 (904)
YTD - 7,936 (8,100)
Current (Last Year)

Seen in Time
Triage
Diagnosis &/or Treatment

Did Not Wait
Month - 360 (337) 9%
YTD - 2870 (3142) 9%

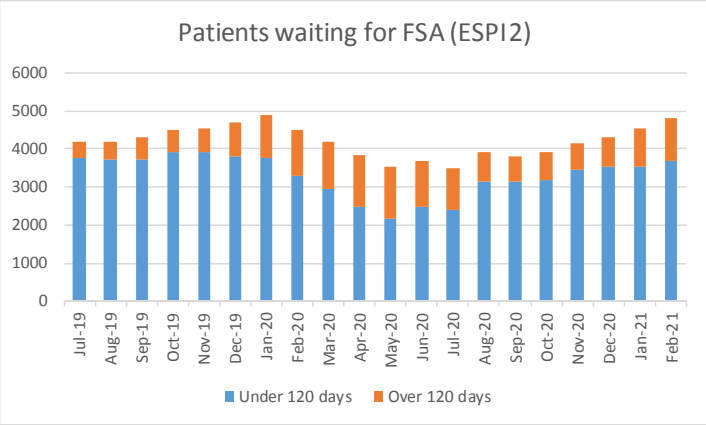
Treated & Disch
Month - 2752 (945) 90% <6hr
YTD - 22300 (22211) 90%

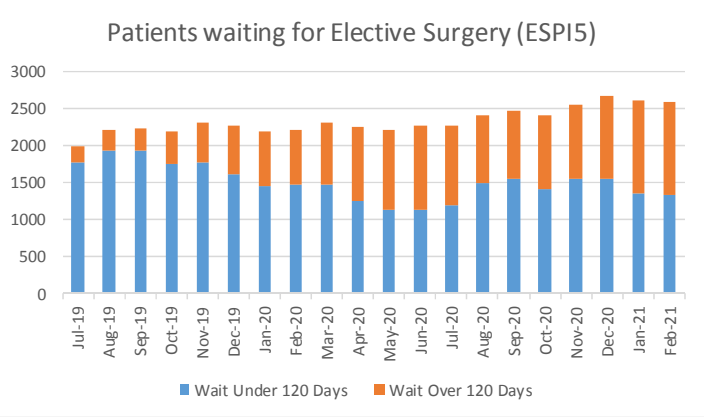
Admitted
Month - 914 (945) 63% <6hr
YTD - 8093 (7918) 71%



- **What is this Measure**
  - The percentage of patients admitted, discharged and transferred from an Emergency Department within 6 hours.
- **Why is it important**
  - This indicator measures flow through the whole system it is impacted by the number planned of people arriving at ED, how fast ED treats them, availability of beds in the hospital and community service availability.
- **How are we performing**
  - Hutt hospital had more attendances than budget in February however due to the acuity of presentations, delay in specialty assessment and difficulty in timely disposition, the ability to discharge patients within 6 hours remained a challenge with 84% able to move through the ED within 6 hours.
  - The total ED attendances in February was similar to Feb 20 however the acuity mix was different with an increase in triage 1, 2 and 3 and decreases in triage 4 and 5 patients.
- **What is driving Performance**
  - Despite an increase in presentations triaged as 1, 2 and 3 there is an overall decrease in admission rate for February compared to Jan 21. Presentations to ED in February have reduced compared with Jan 2021 with a notable decrease in category 4 patients.
  - Our assessment unit continues to efficiently assess, discharge or transfer with an average length of stay of 25 hours for February.
- **Management Comment**
  - TrendCare and CapPlan are proving useful in rostering our staff to best meet the needs of our community presenting to ED for care.
  - The expectation to improve long waits in ED for patients to see speciality services will be a focus for our hospital wide acute service flow improvement initiative. Work is underway to investigate options around surge planning when blocks to patient flow are occurring throughout the hospital.

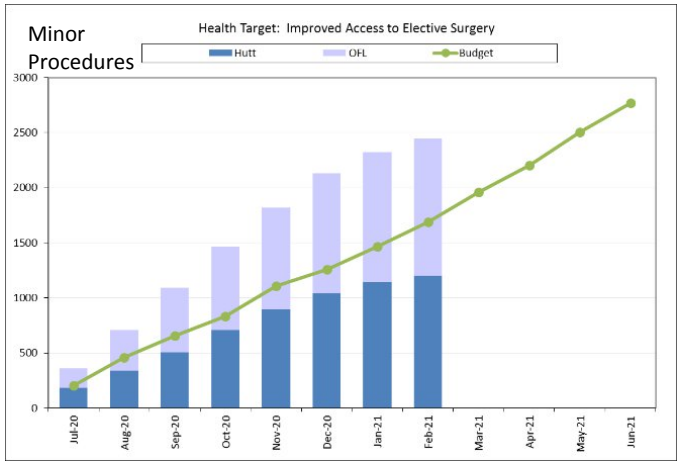
Waiting times - Planned Care

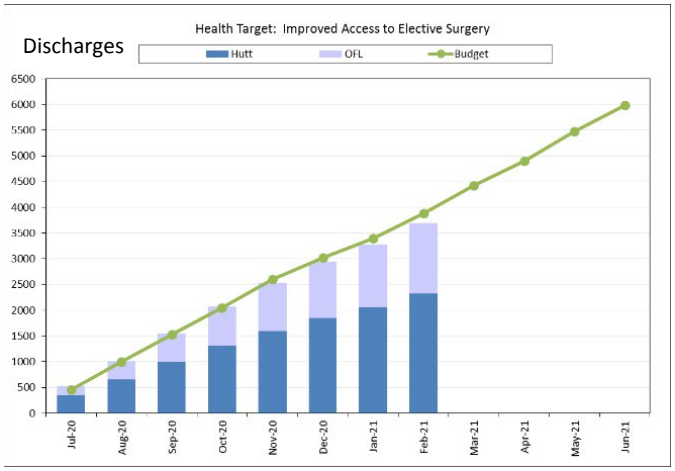




- **What is this measure?**
  - The delivery of Specialist assessments or Treatment within 120 days
- **Why is it important?**
  - It is important to ensure patients receive care at the most appropriate time to support improved health.
- **How are we performing?**
  - The total waiting for an FSA increased by 6% this month and the number waiting over 120 days by 11% (108)
  - The number waiting for elective surgery fell by 10 to 2,598 however the number waiting over 120 days increased by 19 to 1,270
- **What is driving performance?**
  - Principally managing inflows to our waiting list and balancing against outflows is not yet robust,
  - Registered Nursing staffing in Recovery area (PACU) in theatre complex
  - Cancellations (peaking at 25 in one week alone) due to acute demand.
  - Wait list trajectories are behind due to acute demand and historic backlog.
- **Management Comment**
  - Progressing appointment of PACU RN FTE so the establishment fits roster and this will reduce operating theatre delay times.
  - Delivery of our current outsourcing contract of 65 cases to support planned care recovery (40 General Surgery and 25 orthopaedic) is on target for completion by March 2021
  - Progressed ENT locum, backfill surgeons for General Surgery. Alternate Saturday operating lists at HVDHB will commence on 29 March.
  - 2 DHB project commencing to establish short to medium term improvement in OT capacity across 3 Hospitals (Kenepuru, Wellington & HVDHB).
  - Ministry have verbally signalled further PCI recovery funding for 2021-2022 along with an initiative application process.

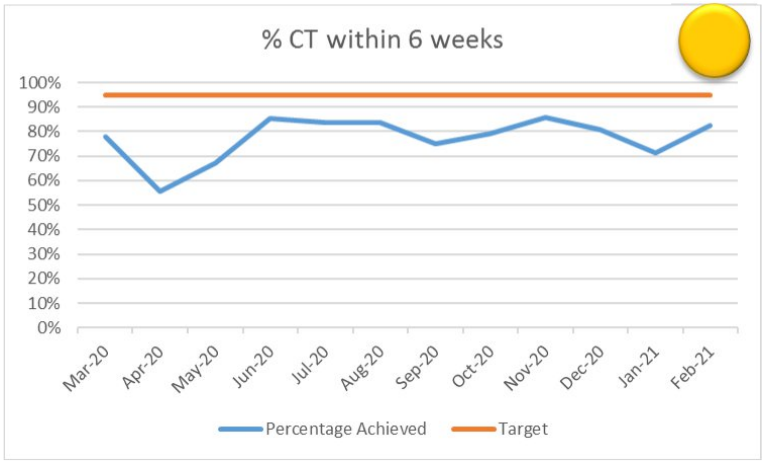
Planned Care – Inpatient discharges and Minor procedures

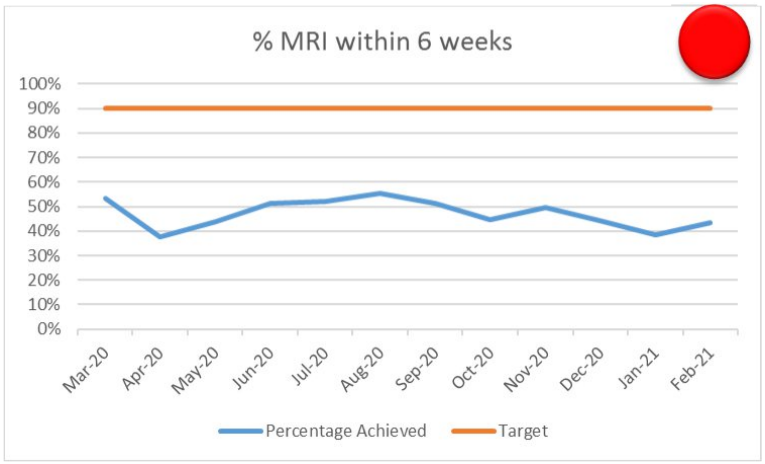




- **What is this measure?**
  - The delivery of an agreed number of inpatient surgical discharges and minor procedures to the Hutt Valley Population
- **Why is it important?**
  - It is important to ensure patients are receiving the planned care procedures required.
- **How are we performing?**
  - Phasing of budgets has been confirmed with the Ministry of Health
  - Discharges are 173 behind budget (123 base and 50 Improvement plan) and Minor procedures are over target
- **What is driving performance?**
  - Two acute theatres are now permanently in place. This supports acute flow but the loss of elective theatre capacity due to acute demand is having an impact on theatre production.
  - The level of minor procedure skin cancer referrals for CCDHB patients is putting significant pressure on the Tertiary Plastic Surgery Service. Plastic Service demand is unable to be met through our current model and staffing. Work has started with CCDHB on the sub-regional skin cancer pathway.
- **Management Comment**
  - The total February planned care target at 96.6 % was met.
  - The CFA for additional MoH planned care recovery funding will assist with additional outsourcing and Hospital initiatives to meet a required reduction in ESPI2 and ESPI 5 waitlists
  - MoH additional funding of $3,922k to increase Planned Care activity:
    - The orthopaedic initiative to reduce ESPI 2 $275k in 2020-2021 is progressing well with positive feedback on the new model.
    - Capital investment of $3,647k to establish a 5 room procedure suite. The Minister of Health has approved funding for the build and concept plans are in the final stages.
    - A Statement of Work for outsourcing of 161 cases is in discussion with SPP and private providers.
  - Recovery wait list trajectories across services are behind due to acute demand and historic backlog dating back to 2019- 2020 . The Ministry have verbally signalled further PCI recovery funding for 2021-2022 along with an initiative application process.
  - An outsourcing 2DHB RFP for a 5 year period from July 2021 has been drafted and private providers have been informed current contracts will cease from 30 June 2021.

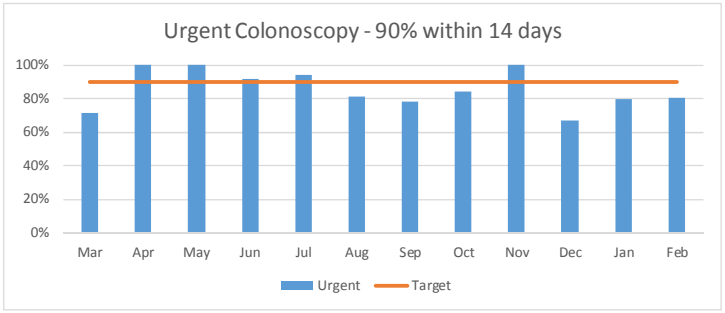
CT & MRI wait times



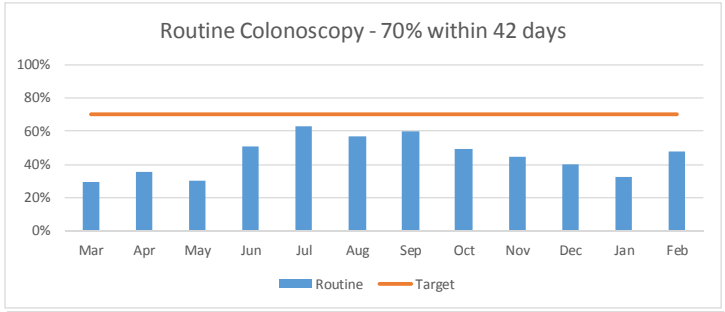


- **What is this measure?**
  - The delivery of computerised tomography (CT) scans and Magnetic Resonance Imaging (MRI) scans in a timely fashion to non-acute patients (within 42 days of referral).
- **Why is it important?**
  - Delayed diagnostic results can negatively affect health outcomes.
- **How are we performing?**
  - The % of patients receiving their MRI within 6 weeks is steady.
  - CT wait times remain close to target but fell over last two months.
- **What is driving performance?**
  - There is insufficient radiologist capacity to meet reporting demand; resulting in outsourcing and delays.
- **Management comment**
  - We are currently scanning all Hutt Valley domicile patients seen by CCDHB, putting further demand on the service.
  - Actions currently underway:
    - Managed daily outsourcing of reporting to Pacific Radiology to support in-house Radiologists.
    - All outpatient CT guided Steroid injections are no longer being provided in house which is creating more capacity for other core business
    - Reviewing what capacity is available to report for Wairarapa reporting
    - Weekend MRI lists have commenced
    - Weekend CT list to manage waitlist
    - MOH Planned Care funding being used to outsource 30 MRIs per month (scan and reports) the reporting of 100 CTs per month .

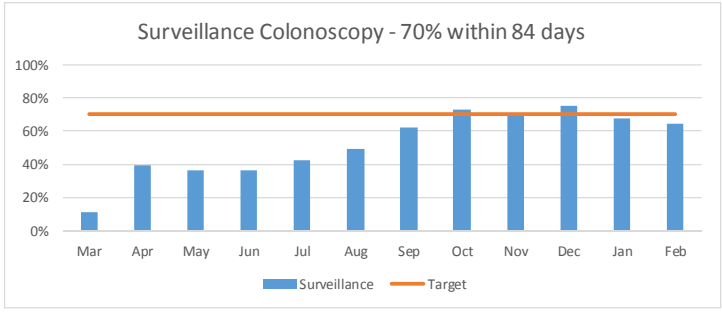
Colonoscopy Wait Times



Urgent
83% YTD



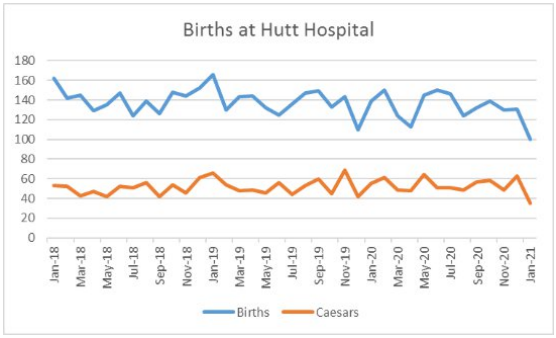
Routine
52% YTD

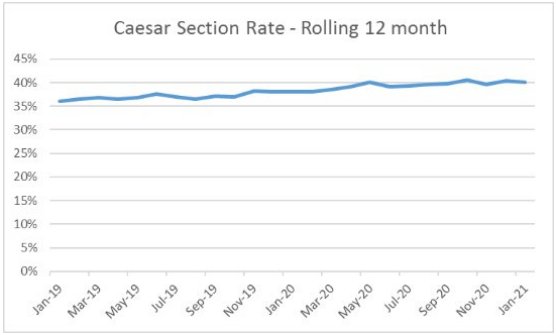


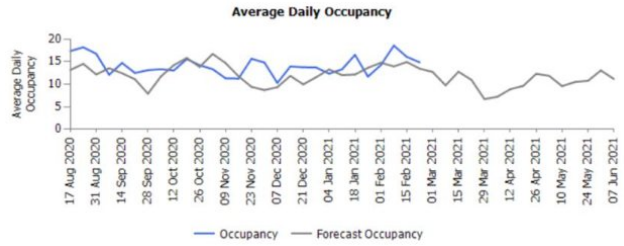
Surveil
63% YTD

- **What is this measure?**
  - The delivery of Colonoscopy, urgent within 14 days, routine 42 days and surveillance within 84 days of being due.
- **Why is it important?**
  - Delayed diagnostic results can negatively affect health outcomes.
- **How are we performing?**
  - We have met the target for Surveillance and are close to target for Urgent colonoscopies. However we continue to struggle with routine
- **What is driving performance?**
  - A growing surveillance waitlist with patients continuing to move onto this from the Bowel Screening Programme.
  - Some gains made in regards to Routine wait times.
- **Management comment**
  - A Nurse Endoscopist has been employed – due to start end March 2021 – this will maintain current list numbers
  - Our Fellow will stay on at reduced FTE to continue providing lists, an SMO will pick up 0.1 FTE for six months from April will help to reduce waiting times.

Maternity

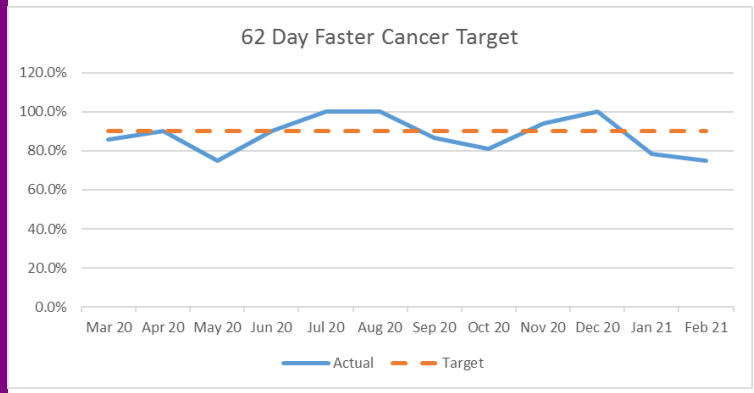


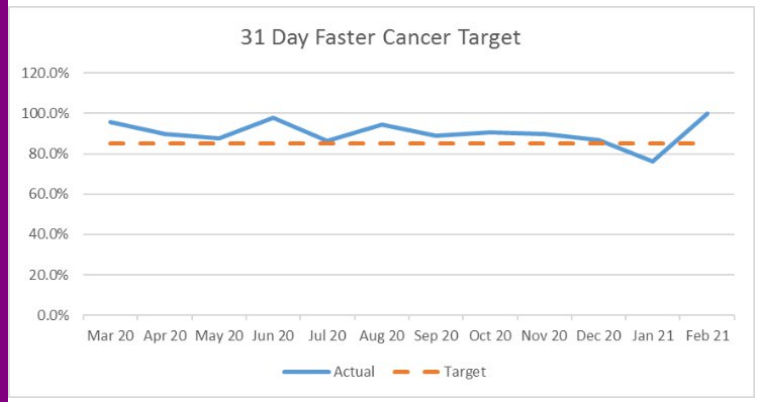




- **What is the issue?**
  - In 2019 a number of clinical and community concerns around Hutt hospital's maternity services were identified.
- **Why is it important?**
  - An external review of the service and HDC investigations showed a number of areas where improvements needed to be made.
- **How are we performing?**
  - A presentation to the CCDHB & HVDHB Boards in March focused on the maternity quality safety programme national clinical indicators – areas HVDHB is performing well in and those where improvement is being directed. We will seek to reduce Caesarean Sections through a birthing optimisation project and prospective case audit over a 3 month period will commence in April 2021
- **Management comment**
  - The Minister of Health confirmed in January 2021 approval to invest $9.47 million capital funding to upgrade the Maternity Assessment Unit, Maternity Ward and Special Care Baby Unit (SCBU).
  - The Governance Group for the facility upgrade has been formed and Phase One of building work (CMT space) is due to commence in March.
  - Midwifery staffing was a key recognised risk in the external review; currently Hutt Valley's inpatient antenatal and post natal ward and Delivery Suite have a combined total workforce of 35.23 FTE. There is a RM vacancy of around 17 FTE at the end of February and an active recruitment campaign is in place.
  - We have processes to manage demand during busy periods. We continue to work closely with our staff and union partners on workforce planning across the region noting this issue as requiring national solutions.
  - We are also developing a more regional approach as both Hutt and WRH units are similarly challenged with workforce shortages.

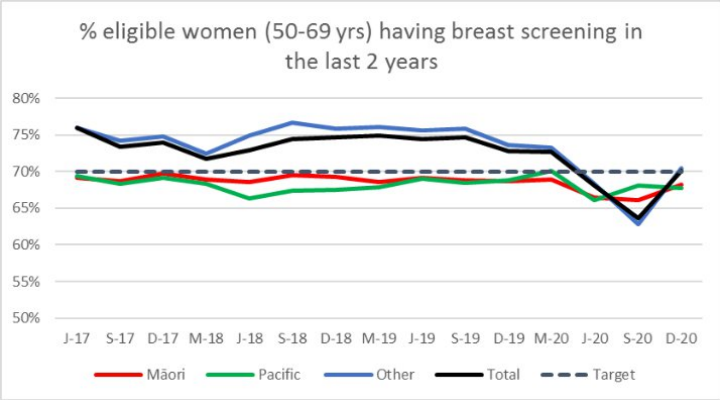
Faster Cancer Treatment

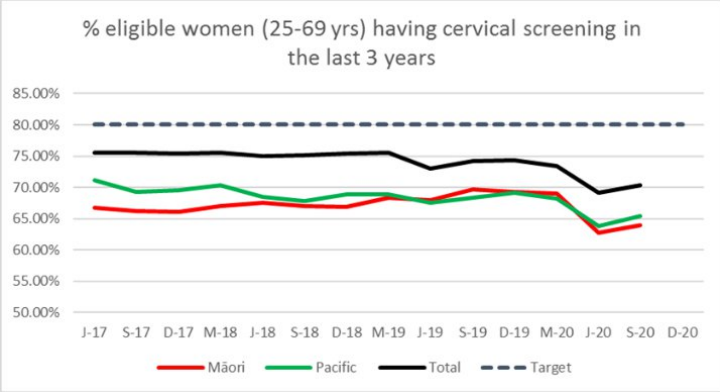




- **What is the issue?**
  - 62 day target: 90% of patients should receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.
  - 31 day indicator: The maximum length of time a patient should have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

Screening





- **What is the issue?**
  - 80% of Women aged 25-69 have completed cervical screening in the previous three years
  - 70% of Women aged 50-69 have completed breast screening in the previous two years
- **Why is it important?**
  - By improving breast and cervical screening coverage DHBs will assist in delivery of the Government's priority to support healthier, safer and more connected communities and our health system outcome that we live longer in good health
- **How are we performing?**
  - COVID lockdowns have resulted in a backlog of 6000 women that are overdue for BreastScreening in the 20/21 year. There has been longstanding recruitment issues for both Medical Imaging Technologists (MIT) and Radiologists.
- **What is driving performance?**
  - With this backlog the service has 36,000 screens due in the 20/21 year.
  - The service is doing Saturday sessions run on a volunteer basis currently as the MIT team has not been fully recruited to.
  - The service is still 2,500 screens behind projections to complete 36,000 scans.
  - Maori, Pacific and Asian (cervical) women continue to be prioritised for screening in both Cervical and Breast Screening.
- **Management Comment**
  - MIT Recruitment has been a focus over the first 2 months of 2021.
  - The Breast Service now has 2 Radiologists training as Breast Specialists.
  - The National Screening Unit Audit of the service was completed in February. We received favourable feedback
  - The National Cervical Screening Programme has signalled that there will be some funding allocated in March/April to assist with COVID catch up activities. been no indication on what the amount of funding will be.

Section 4

Financial Performance & Sustainability

Summary of Financial Performance for February 2021

Month					Hutt Valley DHB Operating Report for the month of February 2021	Year to date					Annual	Annual				
Actual	Budget	Variance	Last Year	Variance	$000s	Actual	Budget	Variance	Last Year	Variance	Forecast	Budget	Variance	Last Year	Variance
					Revenue										
40,498	40,313	185	36,803	3,695	Devolved MoH Revenue	324,812	322,500	2,312	299,622	25,190	485,780	483,750	2,030	454,822	30,958
1,055	1,587	(532)	1,377	(321)	Non Devolved MoH Revenue	14,565	13,165	1,399	12,478	2,087	21,648	20,049	1,598	19,272	2,375
492	632	(140)	438	54	ACC Revenue	4,568	4,985	(417)	4,478	91	6,802	7,219	(417)	6,457	345
451	522	(70)	692	(241)	Other Revenue	5,160	4,218	942	4,309	852	6,851	6,309	542	6,074	778
9,033	9,229	(196)	8,727	306	IDF Inflow	74,714	73,828	886	69,250	5,465	111,560	110,742	818	102,288	9,272
1,245	303	942	265	980	Inter DHB Provider Revenue	8,354	2,424	5,930	2,776	5,578	11,795	3,637	8,158	4,507	7,288
52,775	**52,586**	**189**	**48,302**	**4,473**	**Total Revenue**	**432,174**	**421,121**	**11,053**	**392,912**	**39,262**	**644,436**	**631,707**	**12,729**	**593,420**	**51,016**
					Expenditure										
					Employee Expenses										
4,987	4,865	(122)	4,666	(322)	Medical Employees	41,363	41,858	495	39,516	(1,848)	62,487	63,310	823	60,010	(2,477)
5,808	5,892	84	6,024	216	Nursing Employees	48,291	50,924	2,633	49,248	957	71,858	76,767	4,909	75,339	3,481
2,176	2,681	505	2,698	521	Allied Health Employees	18,799	22,772	3,974	20,664	1,865	28,668	34,575	5,907	32,175	3,507
714	636	(78)	625	(90)	Support Employees	6,222	5,496	(726)	5,654	(568)	9,371	8,394	(977)	8,676	(695)
2,021	2,364	342	2,136	114	Management and Admin Employees	17,400	20,436	3,036	18,608	1,208	26,709	30,842	4,132	28,166	1,457
15,707	**16,438**	**731**	**16,148**	**441**	**Total Employee Expenses**	**132,075**	**141,486**	**9,411**	**133,689**	**1,615**	**199,093**	**213,888**	**14,794**	**204,366**	**5,273**
					Outsourced Personnel Expenses										
656	247	(409)	239	(417)	Medical Personnel	4,764	1,977	(2,787)	2,377	(2,387)	7,359	2,965	(4,394)	3,763	(3,597)
614	91	(523)	182	(432)	Nursing Personnel	4,262	728	(3,533)	1,340	(2,921)	6,772	1,093	(5,679)	2,002	(4,769)
455	87	(367)	40	(414)	Allied Health Personnel	3,052	699	(2,352)	358	(2,694)	5,158	1,049	(4,109)	583	(4,575)
30	20	(9)	27	(2)	Support Personnel	327	163	(164)	316	(11)	408	244	(164)	522	113
443	159	(284)	(36)	(479)	Management and Admin Personnel	3,915	1,123	(2,792)	871	(3,045)	6,120	1,765	(4,355)	1,671	(4,448)
2,198	**605**	**(1,593)**	**453**	**(1,745)**	**Total Outsourced Personnel Expenses**	**16,319**	**4,691**	**(11,629)**	**5,262**	**(11,058)**	**25,817**	**7,116**	**(18,701)**	**8,541**	**(17,276)**
618	696	78	574	(45)	Outsourced Other Expenses	6,448	5,574	(874)	5,947	(502)	9,520	8,363	(1,157)	9,845	325
2,311	2,448	136	2,023	(289)	Treatment Related Costs	20,561	18,973	(1,588)	19,699	(861)	31,255	28,666	(2,590)	27,169	(4,086)
2,223	1,565	(658)	1,323	(900)	Non Treatment Related Costs	17,891	12,241	(5,651)	12,918	(4,973)	27,498	18,465	(9,034)	37,215	9,717
8,641	9,151	509	8,118	(523)	IDF Outflow	73,524	73,204	(319)	65,849	(7,674)	110,146	109,807	(339)	101,298	(8,847)
17,685	18,092	407	17,847	162	Other External Provider Costs	152,618	151,078	(1,540)	140,667	(11,951)	230,930	227,534	(3,396)	218,583	(12,347)
2,263	2,376	114	1,806	(457)	Interest, Depreciation & Capital Charge	16,355	19,013	2,659	16,774	419	24,412	28,517	4,105	25,186	774
51,646	**51,371**	**(276)**	**48,291**	**(3,355)**	**Total Expenditure**	**435,791**	**426,261**	**(9,530)**	**400,806**	**(34,985)**	**658,671**	**642,354**	**(16,317)**	**632,203**	**(26,468)**
1,129	**1,215**	**(87)**	**10**	**1,118**	**Net Result**	**(3,617)**	**(5,140)**	**1,522**	**(7,894)**	**4,276**	**(14,235)**	**(10,647)**	**(3,588)**	**(38,784)**	**24,548**
					Result by Output Class										
2,334	887	1,446	(894)	3,227	Funder	3,131	751	2,380	(1,316)	4,448	1,202	(9)	1,211	(7,889)	9,091
145	49	97	50	96	Governance	658	225	433	318	341	618	310	308	634	(16)
(1,351)	279	(1,630)	854	(2,205)	Provider	(7,407)	(6,116)	(1,290)	(6,895)	(512)	(16,055)	(10,948)	(5,107)	(31,528)	15,473
1,129	**1,215**	**(87)**	**10**	**1,118**	**Net Result**	**(3,617)**	**(5,140)**	**1,522**	**(7,894)**	**4,276**	**(14,235)**	**(10,647)**	**(3,588)**	**(38,784)**	**24,548**

There may be rounding differences in this report

Executive Summary – Financial Position

Financial performance year to date

- Total Revenue favourable $11,053k
- Personnel and outsourced Personnel unfavourable ($2,217k)
  - Medical unfavourable ($2,292k); Nursing unfavourable ($900k); Allied Health favourable $1,621k, Support Staff unfavourable ($891k); Management and Admin favourable $244k; Annual leave Liability cost has increased by $1,784k since January 2020
- Outsourced other expenses unfavourable ($874k), includes Outsourced radiology and inpatient services
- Treatment related Costs unfavourable ($1,588k)
- Non Treatment Related Costs unfavourable ($5,651k), includes Holiday Act provision.
- IDF Outflow unfavourable ($319k)
- Other External Provider Costs unfavourable ($1,540k)
- Interest depreciation and capital charge favourable $2,659k

Analysis of Operating Position – Revenue

- **Revenue:** Total revenue favourable $189k for the month
  - Devolved MOH revenue $185k favourable, driven by a reduction in funding for capital charge offset by PHO and COVID-19 funding.
  - Non Devolved revenue ($532k) unfavourable driven largely by the Regional Breast Screening accounting for revenue in advance year to date.
  - ACC Revenue ($140k) unfavourable.
  - Other revenue ($70k) unfavourable for the month driven by lower than expected Cafeteria and car parking revenue.
  - IDF inflows unfavourable ($196k) for the month driven by current year wash-up payments for lower volumes.
  - Inter DHB Revenue favourable $942k, reflecting the use of shared 2 & 3DHB services, including recoveries from CCDHB for Mental Health. There is a corresponding increase in expenditure.

COVID–19 Revenue and Costs

YTD Result -February 2021	Funder [1] (4)	Provider (excl. Regional Public Health)	Provider - Regional Public Health (RPH) [1][3]	Total
$000s	Actual	Actual	Actual	Actual
Revenue				
MoH Revenue Recognised - COVID19 [2]	3,963	157	891	5,011
Expenditure				
Employee Expenses				
Medical Employees		12	86	99
Nursing Employees		19	197	217
Allied Health Employees		19	229	248
Support Employees		47	0	47
Management and Admin Employees		21	56	76
Total Employee Expenses	**0**	**118**	**569**	**687**
Expenses				
Outsourced - Provider	0	21	0	21
External Providers - Funder	4,944			4,944
Clinical Expenses - Provider	0	2	6	8
Non-clinical Expenses- Provider	0	213	76	289
Total Non Employee Expenses	**4,944**	**236**	**81**	**5,262**
Total Expenditure	**4,944**	**354**	**650**	**5,949**
Net Impact	**(982)**	**(198)**	**241**	**(938)**

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

- The February year to date financial position includes $5.9m additional costs in relation to COVID-19.
- Revenue of $5.0m has been received to fund additional costs for community providers and Regional Public Health.
- The net impact year to date is $0.93m additional costs currently unfunded.

Analysis of Operating Position – Personnel

- **Total Personnel** including outsourced favourable $862k for the month
  - Medical personnel incl. outsourced unfavourable ($531k), Outsourced costs are ($409k) unfavourable, Medical Staff Internal are ($122k) unfavourable, driven by SMO's $403k, and the MHAIDS restructure $230k.
  - Nursing incl. outsourced ($439k) unfavourable. Employee costs are $84k favourable, driven by the 3DHB MHAIDS Restructure $532k. Excluding MHAIDS the unfavourable movements were Registered Nurses ($353k), driven largely by Statutory Leave and Annual Leave costs ($227k). In addition Senior Nurses were favourable $16k and Registered Midwives $140k, offset by Internal Bureau Nurses and Health Care Assistants ($146k), reflecting the impact of ongoing implementation of the Care Capacity Demand Management (CCDM) process and the Maternity Review recommendations.
  - Allied Health incl. outsourced $138k favourable, with outsourced unfavourable ($367k) and internal employees favourable $505k. Employee costs are driven by the 3DHB MHAIDS Restructure $406k, the balance is mostly due to Regional Public Health Vacancies and the impact of Annual Leave taken.
  - Support incl. outsourced unfavourable ($87k), with Outsourced ($9k) unfavourable, and employee costs ($78k) unfavourable, driven by Orderlies ($28k), Cleaners ($23k), Sterile Supply Assistants ($10k) and Tradesmen & Maintenance supervisors ($14k)
  - Management & Admin incl. outsourced favourable $58k; internal staff favourable $342k, Outsourced unfavourable ($284k). This reflects the transition to 2DHB services for ITS and MHAIDS.
  - Sick leave for February was 2.5%, which is the same as this time last year.

FTE Analysis

Month					FTE Report	Year To Date					Annual	
Actual	Budget	Variance	Last Year	Variance	Feb-21	Actual	Budget	Variance	Last Year	Variance	Budget	Last Year
					FTE							
279	288	8	284	5	Medical	280	287	8	289	10	287	294
755	828	73	840	85	Nursing	767	830	63	805	38	829	818
342	418	76	405	63	Allied Health	353	417	63	388	35	417	402
146	137	(8)	143	(3)	Support	146	137	(9)	140	(6)	137	143
318	388	70	352	35	Management & Administration	323	388	65	357	34	388	365
1,839	**2,059**	**219**	**2,025**	**185**	**Total FTE**	**1,869**	**2,058**	**189**	**1,980**	**111**	**2,058**	**2,023**
					$ per FTE							
17,868	16,918	(950)	16,412	(1,456)	Medical	147,926	145,773	(2,153)	136,550	(11,375)	212,993	215,094
7,691	7,117	(574)	7,173	(519)	Nursing	62,965	61,374	(1,590)	61,181	(1,784)	86,111	93,878
6,366	6,413	47	6,659	293	Allied Health	53,184	54,673	1,489	53,245	61	67,802	85,962
4,902	4,636	(266)	4,369	(533)	Support	42,614	40,061	(2,553)	40,248	(2,366)	66,563	58,552
6,362	6,094	(268)	6,061	(301)	Management & Administration	53,816	52,694	(1,122)	52,072	(1,744)	68,709	84,428
8,539	**7,985**	**(554)**	**7,976**	**(563)**	**Average Cost per FTE all Staff**	**70,652**	**68,736**	**(1,916)**	**67,511**	**(3,141)**	**95,523**	**105,731**

Medical under budget for the month by 8 FTE, driven by the MHAIDS restructure 13FTE:
Excluding MHAIDS the contribution to movements were; SMOs under budget by 3FTE, offset by RMO's & House Officers combined.

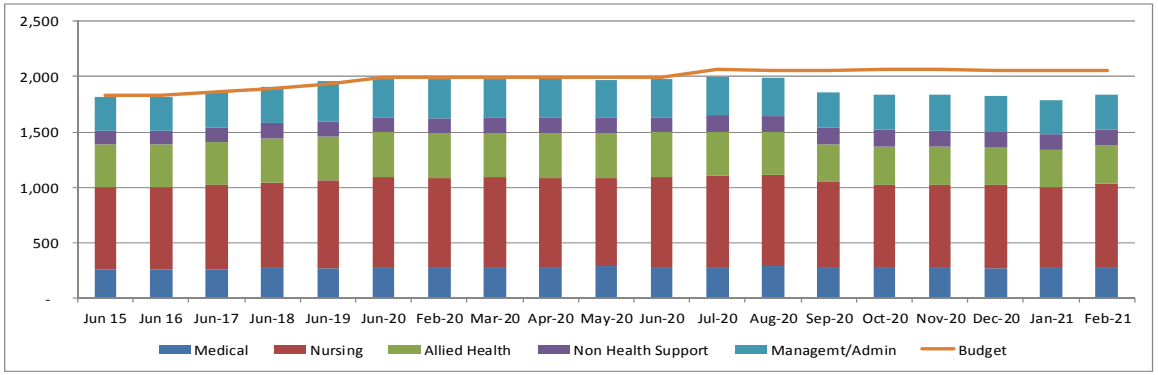
Nursing under by 73 FTE for the month, driven by MHAIDS restructure 75 FTE:
Excluding MHAIDS the contribution to movements were; Internal Bureau Nurses and HCA's are over budget (24) FTE mostly driven by General Medical (3) FTE, Plastics (4FTE), ED (5FTE) and other variances. The recognition of Day's in Lieu earned during January contributed to this variance. This is offset by Midwives 21 FTE. This reflects the transition of changes made under both CCDM recommendations and the Maternity Review.

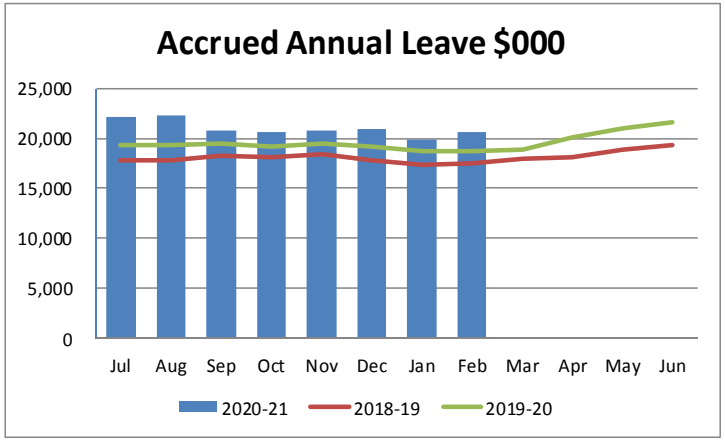
Allied FTEs are under by 76 FTEs for the month, driven by the MAHIDS restructure 62:
Excluding MHAIDS the contribution to movements were; Favourable variances in Health promotion 4 FTE, Other Allied Health 5 FTE, Dental Therapists 2 FTE.

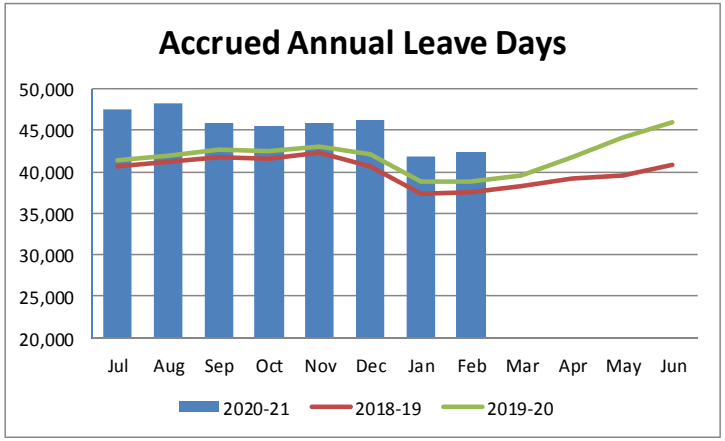
Support FTEs are (8) FTEs over budget driven by Food services (3) FTE, Cleaning (3) FTE and Orderlies (4) FTE, offset by other variances.

Management & Admin are under budget by 70 FTEs driven by the MHAIDS & ITS Restructures 40 FTE.
Excluding MHAIDS and ITS changes favourable variance of 48FTE, other variances include; Executive Office 5 FTE, Project Management 2FTE, SPO 7FTE, Quality 2 FTE, Surgical Women's & Children's 2FTE, Regional Public Health 2 FTE and Breast Screening Programme 5 FTE.

FTE Analysis







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

Analysis of Operating Position – Other Expenses

- **Other Operating Costs**
  - Outsourced other favourable $78k for the month.
  - Treatment related costs $136k favourable in line with the lower volumes.
  - Non Treatment Related costs unfavourable ($658k) including the provision for Holidays Act Settlement ($227k) which is not budgeted as advised by MoH, Security ($13k) related mainly to COVID-19, Consultancy ($30k), Affiliation fees ($21k), recoveries from CCDHB for MHAIDS recoveries other minor variances.
  - IDF Outflows $509k favourable for the month, driven by lower than expected volumes.
  - Other External Provider costs favourable $407k, driven largely by COVID-19 payments to external providers.
  - Interest, Depreciation & Capital Charge favourable $114k, driven by a decrease in Capital Charge with a corresponding reduction in revenue.

Section 5

Additional Financial Information & Updates

Financial Position as at 28 February 2021

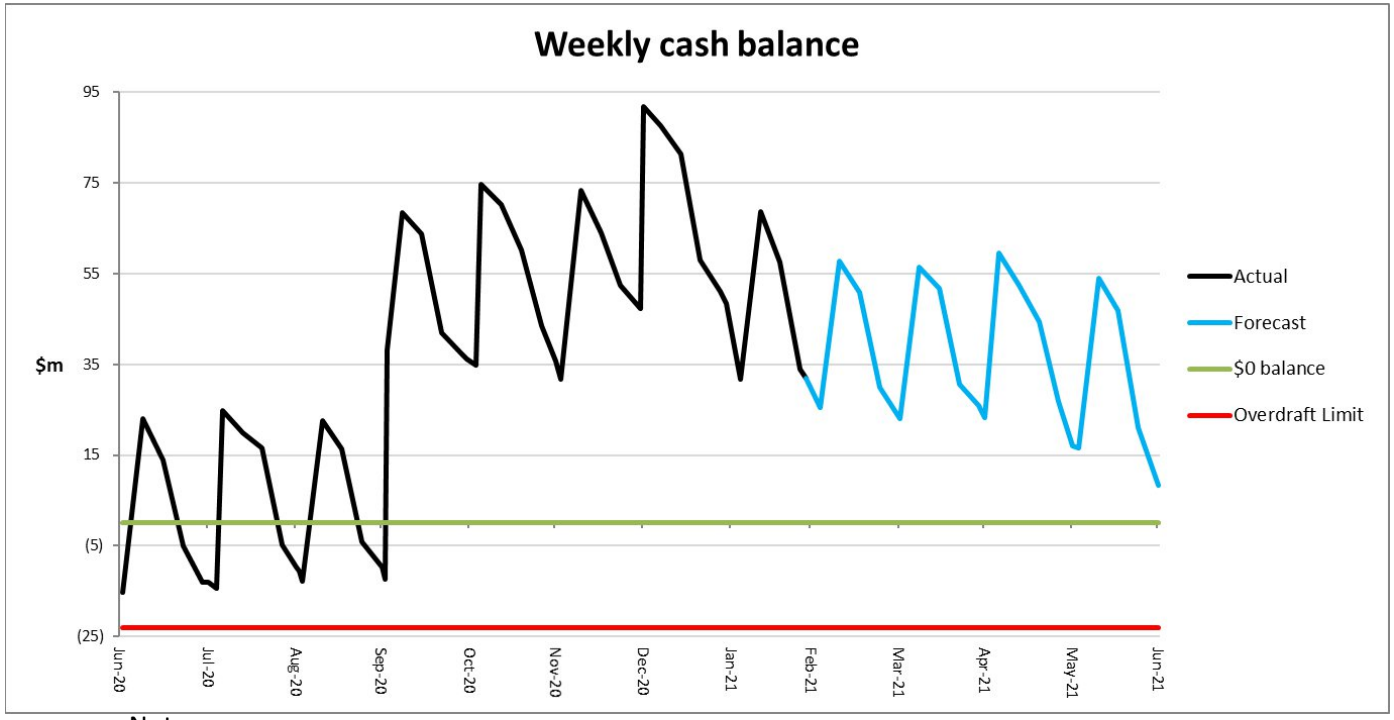
$000s	Actual	Budget	Variance	Jun 20	Variance	Explanation of Variances Between Actual and Budget
Assets						
Current Assets						
Bank	31,979	2,796	29,182	(10,986)	42,965	Average bank balance in Feb-21 was $53.6m ($35m equity injection received Oct-20)
Bank - Non DHB Funds *	5,038	4,927	111	4,927	111	
Accounts Receivable & Accrued Revenue	24,978	27,577	(2,599)	27,577	(2,599)	
Stock	2,241	2,200	42	2,199	43	
Prepayments	1,353	815	538	815	538	
Total Current Assets	**65,590**	**38,315**	**27,275**	**24,532**	**41,058**	
Fixed Assets						
Fixed Assets	224,880	245,285	(20,405)	229,790	(4,910)	
Work in Progress	14,940	11,001	3,939	14,001	939	
Total Fixed Assets	**239,820**	**256,286**	**(16,466)**	**243,791**	**(3,971)**	
Investments						
Investments in Associates	1,150	1,150	0	1,150	0	
Trust Funds Invested	1,290	1,347	(57)	1,347	(57)	
Total Investments	**2,440**	**2,497**	**(57)**	**2,497**	**(57)**	
Total Assets	**307,850**	**297,098**	**10,752**	**270,820**	**37,030**	
Liabilities						
Current Liabilities						
Accounts Payable and Accruals	77,115	65,324	(11,791)	73,615	(3,500)	Includes Holidays Act Provision of $29.3m
Crown Loans and Other Loans	14	42	28	42	28	
Capital Charge Payable	1,289	0	(1,289)	0	(1,289)	
Current Employee Provisions	27,403	26,018	(1,385)	26,518	(885)	
Total Current Liabilities	**105,821**	**91,384**	**(14,437)**	**100,175**	**(5,646)**	
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	5,038	4,927	(111)	4,927	(111)	
Trust Funds	1,237	1,347	110	1,347	110	
Total Non Current Liabilities	**15,425**	**15,426**	**1**	**15,424**	**(1)**	
Total Liabilities	**121,246**	**106,809**	**(14,436)**	**115,598**	**(5,647)**	
Net Assets	**186,605**	**190,289**	**(3,685)**	**155,222**	**31,383**	
Equity						
Crown Equity	158,916	164,123	(5,207)	123,916	35,000	Equity Deficit Support injection received $35m
Revaluation Reserve	146,289	146,289	0	146,289	0	
Opening Retained Earnings	(114,982)	(114,982)	(0)	(76,199)	(38,784)	
Net Surplus / (Deficit)	(3,617)	(5,140)	1,522	(38,784)	35,166	
Total Equity	**186,605**	**190,289**	**(3,685)**	**155,222**	**31,383**	

* NHMG - National Haemophilia Management Group

Statement of Cash Flows to 28 February 2021

$000s	Jul Actual	Aug Actual	Sep Actual	Oct Actual	Nov Actual	Dec Actual	Jan Actual	Feb Actual	Mar Forecast	Apr Forecast	May Forecast	Jun Forecast
Operating Activities												
Government & Crown Agency Revenue	41,434	42,012	44,384	42,820	40,032	89,077	(1,303)	40,009	42,070	41,970	41,977	42,033
Receipts from Other DHBs (Including IDF)	9,112	10,490	8,932	18,597	8,010	13,752	6,345	9,493	10,047	10,080	10,080	10,080
Receipts from Other Government Sources	721	778	753	770	863	669	501	579	638	677	638	750
Other Revenue	1,833	1,581	(2,392)	1,408	(60)	(202)	3,478	63	280	283	280	280
Total Receipts	**53,100**	**54,861**	**51,678**	**63,595**	**48,845**	**103,296**	**9,021**	**50,144**	**53,034**	**53,011**	**52,975**	**53,142**
Payments for Personnel	(21,092)	(16,745)	(18,276)	(19,398)	(17,779)	(20,161)	(18,805)	(18,034)	(19,885)	(19,127)	(18,368)	(19,136)
Payments for Supplies (Excluding Capital Expenditure)	(4,686)	(5,368)	(4,330)	(4,464)	(3,394)	1,140	(6,009)	(12,721)	(5,562)	(5,874)	(5,784)	(5,913)
Capital Charge Paid	0	0	0	0	0	0	0	(3,868)	0	0	0	(3,868)
GST Movement	(710)	75	230	1,030	(1,535)	1,310	2,098	(4,899)	(2,000)	(1,000)	(2,500)	3,350
Payment to Own DHB Provider	0	(0)	(0)	(0)	120	30	30	(180)	0	0	0	(0)
Payment to Own DHB Governance & Funding Admin	0	0	0	0	(120)	(30)	(30)	180	(0)	(0)	(0)	0
Payments to Other DHBs (Including IDF)	(9,106)	(8,637)	(8,548)	(10,119)	(9,151)	(9,151)	(9,222)	(9,137)	(9,156)	(9,156)	(9,156)	(9,156)
Payments to Providers	(18,833)	(19,317)	(19,860)	(19,353)	(16,794)	(19,316)	(19,336)	(17,311)	(20,716)	(19,472)	(19,651)	(19,373)
Total Payments	**(54,427)**	**(49,991)**	**(50,784)**	**(52,305)**	**(48,652)**	**(46,177)**	**(51,274)**	**(65,970)**	**(57,319)**	**(54,628)**	**(55,458)**	**(54,096)**
Net Cashflow from Operating Activities	**(1,327)**	**4,871**	**894**	**11,290**	**193**	**57,119**	**(42,253)**	**(15,826)**	**(4,285)**	**(1,617)**	**(2,483)**	**(954)**
Investing Activities												
Interest Receipts	0	0	0	28	35	39	44	27	21	21	21	21
Dividends	0	0	0	0	0	0	0	0	4	4	4	4
Total Receipts	**0**	**0**	**0**	**28**	**35**	**39**	**44**	**27**	**25**	**25**	**25**	**25**
Capital Expenditure	(913)	(1,399)	(964)	(512)	(595)	(1,028)	(1,226)	(567)	(5,772)	(14,772)	(4,972)	(5,773)
Increase in Investments and Restricted & Trust Funds Assets	99	57	13	(58)	(15)	(48)	17	(8)	0	0	0	0
Total Payments	**(814)**	**(1,343)**	**(951)**	**(571)**	**(610)**	**(1,076)**	**(1,208)**	**(575)**	**(5,772)**	**(14,772)**	**(4,972)**	**(5,773)**
Net Cashflow from Investing Activities	**(814)**	**(1,343)**	**(951)**	**(542)**	**(575)**	**(1,038)**	**(1,164)**	**(548)**	**(5,747)**	**(14,747)**	**(4,947)**	**(5,748)**
Financing Activities												
Equity Injections - Capital	0	0	0	0	0	0	0	0	4,000	13,000	0	0
Equity Injections - Deficit Support	0	0	0	35,000	0	0	0	0	0	0	0	0
Total Receipts	**0**	**0**	**0**	**35,000**	**0**	**0**	**0**	**0**	**4,000**	**13,000**	**0**	**0**
Interest Paid on Finance Leases	(9)	(5)	(3)	(3)	(0)	(3)	(0)	0	(6)	(5)	(5)	(5)
Total Payments	**(9)**	**(5)**	**(3)**	**(3)**	**(0)**	**(3)**	**(0)**	**0**	**(6)**	**(5)**	**(5)**	**(5)**
Net Cashflow from Financing Activities	**(9)**	**(5)**	**(3)**	**34,997**	**(0)**	**(3)**	**(0)**	**0**	**3,994**	**12,995**	**(5)**	**(5)**
Total Cash In	53,100	54,861	51,678	98,624	48,880	103,335	9,065	50,171	57,059	66,036	53,000	53,167
Total Cash Out	(55,250)	(51,338)	(51,738)	(52,878)	(49,262)	(47,256)	(52,482)	(66,544)	(63,097)	(69,405)	(60,435)	(59,874)
Net Cashflow												
Opening Cash	(10,986)	(13,136)	(9,613)	(9,673)	36,073	35,691	91,770	48,352	31,979	25,941	22,572	15,136
Net Cash Movements	(2,150)	3,523	(60)	45,746	(382)	56,079	(43,417)	(16,374)	(6,038)	(3,369)	(7,436)	(6,707)
Closing Cash	**(13,136)**	**(9,613)**	**(9,673)**	**36,073**	**35,691**	**91,770**	**48,352**	**31,979**	**25,941**	**22,572**	**15,136**	**8,429**

Weekly Cash Flow – Actual to 28 February 2021



Note

- the overdraft facility shown in red is set at $23 million as at January 2021
- the lowest bank balance for the month of February was $31.7m

Summary of Leases – as at 28 February 2021

		Original Cost	Monthly Amount	Annual Amount	Total Lease Cost	Start Date	End Date	Lease type
Rental Property Leases	**Occupants**							
Wainuiomata Health Centre	District Nurses (*Lease renewal currently in negotiation)		1,149	13,787		1/11/2017	31/10/2020*	Operating
Public Trust House Lower Hutt	Community Mental Health		23,915	286,976		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, Lagan Building, Upper Hutt	Physiotherapy & Counselling		2,573	30,879		5/01/2021	31/12/2023	Operating
Criterion Lane, Lagan Building, Upper Hutt	Midwives		575	6,897		16/06/2020	16/05/2023	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
			53,498	**641,964**				
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 (121 Vehicles)			33,943	407,312		Ongoing	Ongoing	Operating
Custom Fleet (Nissan Leaf electrical vehicle)			556	6,671		1/10/2020	1/06/2024	Operating
			34,499	**413,983**				
Equipment Leases	**Supplier**							
MRI Ingenia 1.5T	De Lage Landen (paid monthly in arrears)		22,498	269,981	1,349,905	19/09/2019	19/08/2024	Operating
Fluoroscopy Combi Diagnost	De Lage Landen (paid monthly in arrears)		9,753	117,037	585,185	1/08/2019	31/07/2024	Operating
Plastics Micro Power Tools	Stryker New Zealand Ltd	293,188	3,490	41,884	125,652	1/10/2018	30/09/2025	Finance
Orthopaedic Tools	Stryker New Zealand Ltd		9,024	108,292	758,044	1/09/2016	31/08/2023	Operating
3 x Ultrasounds (Equigroup)	GE Healthcare Ltd		7,315	87,782	153,618	28/09/2020	28/06/2022	Operating
1 x Ultrasound Epiq (Equigroup)	Philips NZ Commercial Ltd		1,761	21,129	40,498	28/09/2020	28/08/2022	Operating
CT Scanner 128 Slice (Equigroup)	Toshiba Medical Systems		24,976	299,711	499,518	28/09/2020	28/05/2022	Operating
Philips Digital Diagnost C90	De Lage Landen (paid monthly in arrears)		7,265	87,186	435,930	31/01/2020	31/01/2025	Operating
Philips Digital Diagnost C90	De Lage Landen (paid monthly in arrears)		6,184	74,214	371,070	31/01/2020	31/01/2025	Operating
Philips Diagnost R2	De Lage Landen (paid monthly in arrears)		3,932	47,186	235,930	1/06/2020	1/06/2025	Operating
Philips Digital Diagnost C90 (ED)	De Lage Landen (paid monthly in arrears)		6,177	74,118	370,592	30/09/2020	30/09/2025	Operating
Philips Digital Diagnost C90 (Resus)	De Lage Landen (paid monthly in arrears)		3,877	46,520	232,601	31/08/2020	31/08/2025	Operating
Logiq E10 4D Ultrasound (Equigroup)	GE Healthcare Ltd		3,649	43,794	218,969	28/01/2021	27/02/2021	Operating
		293,188	**109,901**	**1,318,834**	**5,377,512**			
Total Leases			**200,042**	**2,400,522**				

Treasury as at 28 February 2021

1) Short term funds / investment ($000)

NZHP banking activities for the month	Current month ($000)	Last month ($000)
Average balance for the month	$53,567	$71,514
Lowest balance for the month	$31,663	$48,332
Average interest rate	0.64%	0.72%
Net interest earned/(charged) for the month	$27	$44

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		4
Total value of transactions		$63,764 NZD
Largest transaction		$26,029 NZD

	No. of transactions	Equivalent NZD
AUD	4	$45,466
GBP	1	$13,055
SGD		
USD	1	$5,242
Total	**6**	$63,764

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	$4,890	$1,549	$283	$272	$45	$30	$307	$2,404
Accident Compensation Corporation	$864	$497	($63)	$83	$15	$15	$42	$276
Ministry of Health	$817	$264	$495	$27	$18	$34	($22)	$0
Wairarapa District Health Board	$439	$214	$1	$0	$0	($2)	$0	$226
Wellington Southern Community Laboratories	$64	$3	$0	$0	($0)	$0	($0)	$62
ESR Limited	$63	$63	$0	$0	$0	$0	$0	$0
Auckland District Health Board	$61	$74	$0	$7	$0	($20)	$0	$0
Non Resident	$55	$0	$0	$0	$0	$0	$0	$55
Non Resident	$40	$0	$8	$0	$0	$0	$10	$23
Te Awakairangi Health Network Trust	$32	$32	$0	$0	$0	$0	$0	$0
Total Top 10 Debtors	**$7,326**	**$2,696**	**$724**	**$389**	**$78**	**$57**	**$337**	**$3,046**

Board Information – Public

5 May 2021

Capital & Coast DHB February 2021 Financial and Operational Performance Report

Action Required

The Capital & Coast DHB Board note:

(a) The release of this report to the public.

(b) The DHB had a ($311k) deficit for the month of January 2021, being ($644k) unfavourable to budget before excluding COVID-19 and Holidays Act [2003]

(c) The DHB year to date had a deficit of ($27m), being ($8.8m) unfavourable to budget before COVID-19 and Holidays Act [2003]

(d) In the eight months we have incurred $11.5m additional net expenditure for COVID-19 and $5.3m against provision for Holidays Act [2003]

(e) This means that the DHB has an overall YTD deficit of ($10.2m) from normal operations (excluding COVID-19 and Holidays Act) being $8m favourable to our underlying budget.

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

Executive Summary

There is ongoing significant cost due to the COVID response into the 20/21 fiscal year. Uncertainty remains around how much of the DHB COVID response costs will be funded in 20/21. The Ministry have asked DHBs is to separately report unfunded net COVID impacts for 20/21, these being considered outside our responsible deficit and budgets. They have also advised that ongoing provisions for the liability due to Holidays Act remediation are to be reported separately to the base budget.

Excluding the COVID-19 net expenses and Holidays Act [2003] provision the DHB's result for the eight months to 28 February 2021 is $10.2m deficit, versus a budget deficit of $18.2m.

Additional net COVID related expenditure above funding, year to date is $11.5m.

The monthly provision for increasing Holidays Act liability is $645k and year to date the impact on the result is $5.3m

For the eight months to 28 February 2021 the overall DHB year to date result, including COVID and Holidays Act costs is $27m deficit.

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

Capital Expenditure was $40 million year to date.

We had a negative cash Balance at month-end of $9.7 million offset by positive "Special Funds" of $13 million, net $3.3 million. It should be noted that there is a significant amount of the COVID response that has not been funded by the crown at this time and this has a negative cash impact on the DHB.

Fundamentally the underlying causes for our continued delays in waiting times in ED are well canvassed - our acute front door (ED and acute assessment units) is undersized for the population served and not configured for contemporary models of care; there are recognised bed and theatre deficit on the Wellington Regional Hospital campus. All this is exacerbated by operating parallel processes in our in-patient wards to manage COVID case definition vs. non-COVID patients.

We continue our across a number of streams to improve flow alongside approaches to redesign the Front of Whāre (ED and acute assessment units) to facilitate delivery of contemporary models of care and ensure facilities are appropriately sized to meet demand. This latter work has commenced within a project structure. Winter planning is running parallel to this preparing for the upcoming winter months and surge of acute demand.

Planned care – the delivery of Specialist assessments or Treatment within 120 days continues to be a major challenge. Our outsourcing volume is still being affected by contractual constraints however our in-house elective surgical discharges were just 13 adverse to our planned 484 despite high volumes of cancellations due to increased acute demand in February. Our focus remains on scheduling our longest waiting patients in all specialities, and ensuring our theatre sessions are fully utilised. The installation of new operating lights in Kenepuru theatres has commenced. It is planned that one theatre will be closed for a four month period until the work is completed. Staff from Kenepuru theatres are being relocated to theatre 13 in Wellington so work can continue. Recruitment of anaesthetists to our current vacancies is making progress.

Our Maternity Units across the region continue to struggle with midwifery vacancies and high occupancies - we are continually refining and reviewing processes to manage demand during busy periods and continue to work closely with our staff and union partners on workforce planning within the national frameworks.

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

Strategic Considerations

Service	Financial performance and funding is a key to delivering the services for the Wellington population and Tertiary services for the region.
People	Staff numbers are 141 FTE above our annual budget (however note lead DHB roles).
Financial	The YTD result for the DHB was ($10.2m) deficit from normal operations, against our DHB budget of ($18.2m). An additional ($11.5m) was spend on unfunded COVID-19 costs split between the provider and funder arm, and ($5.3m) was recognised for Holidays Act provisions.
Governance	The Board has a responsibility to scrutinise the financial reports alongside FRAC, and report back issues as identified.

Engagement/Consultation

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

Identified Risks

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

Attachment/s

3.1.1 Capital & Coast DHB January 2021 Financial and Operational Performance Report

Capital & Coast District Health Board

Monthly Financial and Operational Performance Report

For the period ending 28 February 2021

Presented in April 2021

Capital & Coast District Health Board
ŌPOKO KI TE URU HAUORA

Contents

Section 1

Financial and Performance Overview
and Executive Summary

Executive Summary

- There is ongoing significant cost due to the COVID response into the 20/21 fiscal year. Uncertainty remains around how much of the DHB COVID response costs will be funded in 20/21. The Ministry have asked DHBs is to separately report unfunded net COVID impacts for 20/21, these being considered outside our responsible deficit and budgets. They have also advised that ongoing provisions for the liability due to Holidays Act remediation are to be reported separately to the base budget.
- Excluding the COVID-19 net expenses and Holidays Act [2003] provision the DHB's result for the eight months to 28 February 2021 is $10.2m deficit, versus a budget deficit of $18.2m.
- Additional net COVID related expenditure above funding, year to date is $11.5m.
- The monthly provision for increasing Holidays Act liability is $645k and year to date the impact on the result is $5.3m
- For the eight months to 28 February 2021 the overall DHB year to date result, including COVID and Holidays Act costs is $27m deficit.
- The DHB has submitted an Annual baseline budget of $39.8 million deficit, with a two year path to breakeven and the Annual Plan for 2020/21 has now been signed.
- Capital Expenditure including equity funded capital projects was $40m year to date.
- We had a negative cash Balance at month-end of $9.7 million offset by positive "Special Funds" of $13 million (net $3.3 million). It should be noted that there is a significant amount of the COVID response that remains unfunded by the crown at this time and this has a cash impact on the DHB. Overall the DHB cash balance is better than was budgeted for this point in time however the equity injection of $39.8m signalled in the 2021/22 Annual Plan will be requested for the last quarter of the year.

Executive Summary continued

- Fundamentally the underlying causes for our continued delays in waiting times in ED are well canvassed - our acute front door (ED and acute assessment units) is undersized for the population served and not configured for contemporary models of care; there are recognised bed and theatre deficit on the Wellington Regional Hospital campus. All this is exacerbated by operating parallel processes in our in-patient wards to manage COVID case definition vs. non-COVID patients .

- We continue our across a number of streams to improve flow alongside approaches to redesign the Front of Whāre (ED and acute assessment units) to facilitate delivery of contemporary models of care and ensure facilities are appropriately sized to meet demand. This latter work has commenced within a project structure . Winter planning is running parallel to this preparing for the upcoming winter months and surge of acute demand.

- Planned care – the delivery of Specialist assessments or Treatment within 120 days continues to be a major challenge. Our outsourcing volume is still being affected by contractual constraints however our in-house elective surgical discharges were just 13 adverse to our planned 484 despite high volumes of cancellations due to increased acute demand in February. Our focus remains on scheduling our longest waiting patients in all specialities, and ensuring our theatre sessions are fully utilised. The installation of new operating lights in Kenepuru theatres has commenced. It is planned that one theatre will be closed for a four month period until the work is completed. Staff from Kenepuru theatres are being relocated to theatre 13 in Wellington so work can continue. Recruitment of anaesthetists to our current vacancies is making progress.

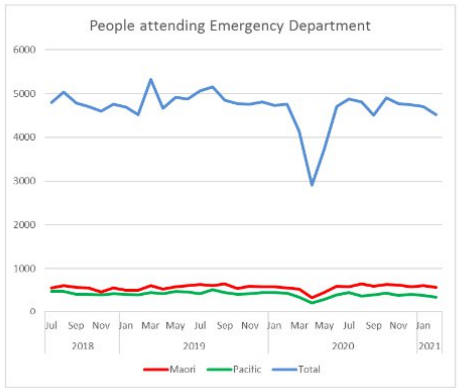
- Our Maternity Units across the region continue to struggle with midwifery vacancies and high occupancies - we are continually refining and reviewing processes to manage demand during busy periods and continue to work closely with our staff and union partners on workforce planning within the national frameworks.

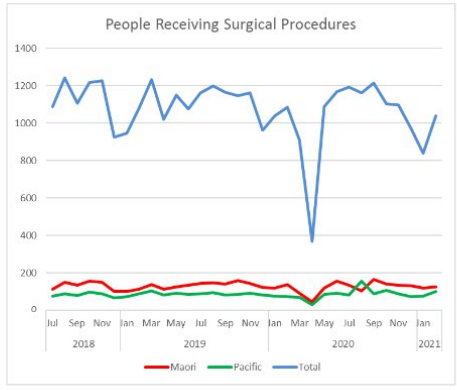
- The provider arm remains within budget outside two extraordinary items (additional costs during COVID-19 and Holidays Act Provisions) not included within the budget. Targeted efficiency measures are in place however the pressure of clinical service demands and FTE management especially around annual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

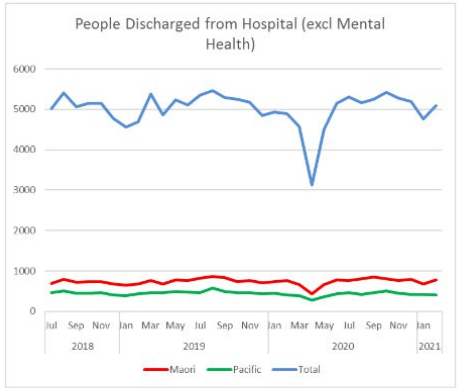
Performance Overview: Activity Context (People Served)

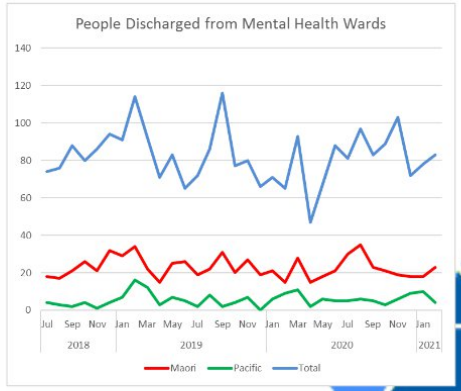
CCDHB funds services that touch thousands of people in our community every month. Unless otherwise indicated, the numbers below count individuals once and are based on CCDHB being the DHB of Service. Our services have returned to delivering services to our population without the restrictions due to COVID-19.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

People attending ED	**4,517**	576 Māori, 355 Pacific
People receiving Surgical Procedures (in main theatres)	**1,040**	126 Māori, 100 Pacific
People discharged from Kenepuru Community Hospital or Wellington Regional Hospital (excl. Mental Health)	**5,093**	785 Māori, 409 Pacific
People discharged from Mental Health Wards	**83**	23 Māori, 4 Pacific



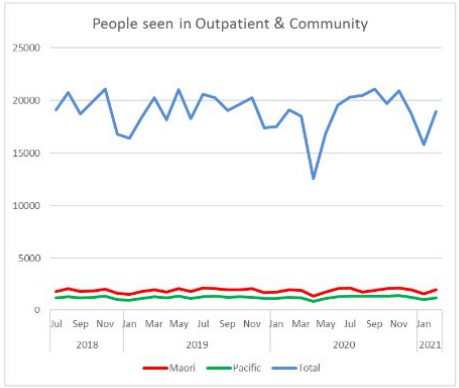


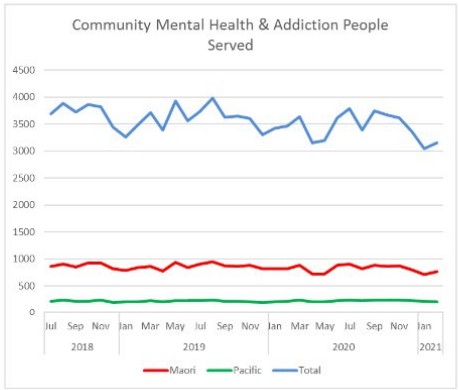


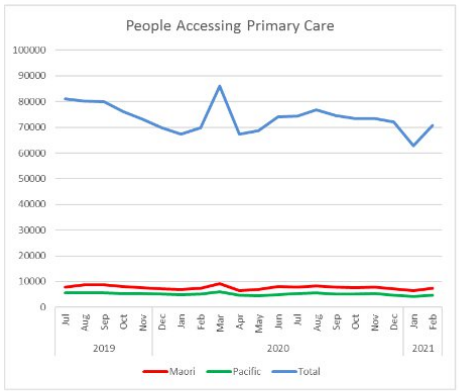


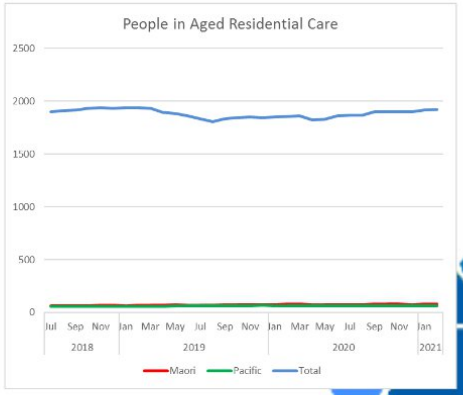
Performance Overview: Activity Context (People Served)

People seen in Outpatient & Community	**18,944** 2,010 Māori, 1,240 Pacific
Community Mental Health & Addiction People Served	**3,152** 770 Māori, 208 Pacific
People accessing primary care	**70,621** 7,362 Māori, 4,659 Pacific
People in Aged Residential Care	**1,921** 79 Māori, 61 Pacific









Financial Overview – February 2021

YTD Operating Position	YTD Provider Position	YTD Funder Position	YTD Capital Exp
$27m deficit Incl. $11.5m COVID-19 costs Incl. $5.3m Holidays Act	$32.4m deficit Incl. $11.5m COVID-19 costs Incl. $5.3m Holidays Act	$4.8m Surplus Incl. $.6m COVID-19 costs	$40m spend Incl. $20.4m strategic capex
Against a budgeted YTD deficit of $18.2m. BAU Month result was 771k Favourable. YTD $8m favourable BAU variance.	Against a budgeted deficit of $25.9m. BAU Month result was $200k unfavourable. BAU YTD $10.3m favourable variance.	Against a budgeted surplus of $7.7m. BAU Month result was $.8m favourable result. YTD $2.3m unfavourable BAU variance.	Against a KPI of a budgeted baseline (non-strategic) spend of $44.1m. Strategic incorporates funded project such as Children's Hospital

YTD Activity vs Plan (CWDs)	YTD Paid FTE	Annual Leave Taken
0.45% ahead[1]	5,590[3]	($7.22m) annualised[4]
214 CWDs ahead PVS plan (52 IDF CWDs ahead, but 169 Hutt ahead). Month result -72 CWDs excluding work in progress.	YTD 141 above annual budget of 5,449 FTE (budget excludes lead DHB). There is 616 FTE vacancies at end February inclusive of lead DHB transfers.	Underlying YTD annual leave taken is under by 2.87 days per FTE and Lieu leave taken for public holidays is short by 3.42 days.

[1] Note that the PVS (Price volume schedule for HHS/MHAIDS) is not total Surgical/Medical case-weight throughput largely due to Non-Residents & ACC. Also Outsourced PVS cases within this result cannot yet be compared to target, however a total of 1572 cwd outsourced (895 events) ~$8.7m 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 10FTE worse than budgeted growth, Outsourced staff are also not counted in this metric which is currently $5.1m 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 – February 2021

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

ED (SSIED) 6 Hour rule	ESPI 5 Long Waits	Specialist Outpatient Long Waits	Serious Safety Events[2]
62.5%	578	353**	4
32.5% below the ED target of 95% Monthly -8.9%	Against a target of zero long waits a monthly movement of +86	Against a target of zero long waits, a monthly movement of -39** **February not yet available	An expectation is for nil SSEs at any point.

YTD Activity vs Plan (CWDs)	YTD Paid FTE	YTD Cost per WEIS
0.45% ahead[1]	3,663[3]	$5,821*
214 CWDs ahead PVS plan (52 IDF CWDs ahead, but 169 Hutt ahead). Month result -72 CWDs excluding work in progress.	YTD 12 below annual budget of 3,675 FTE. 274 FTE vacancies at month end.	Against a national case-weight price per WEIS of $5,545 (5% above).*to Dec 2020

[1] Note that the PVS (Price volume schedule for HHS/MHAIDS) is not total Surgical/Medical case-weight throughput largely due to Non-Residents & ACC. Also Outsourced PVS cases within this result cannot yet be compared to target, however a total of 1572 cwd outsourced (895 events) ~$8.7m 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 12 FTE worse than budgeted, Outsourced staff are also not counted in this metric which is currently $860k 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 unfavourable variance of ($2.9m). Revenue is $12.6m ahead of budget most of which is mainly due to CCDHB having additional COVID accrued revenue of $14.2m. This includes additional revenue for Pharmaceuticals to offset the effect of COVID in the unstable international market. Offsetting COVID costs are ($15m). Recovery of all costs remains the subject of negotiations with MoH seeking a full cost recovery. The ongoing demand for managed isolation facilities, and community surveillance will continue.
- An amount of ($2.3m), was not paid to the Provider Arm due to under achievement of the IDF targets at YTD Feb 2021. Reduced revenue of ($2.6m) from the Ministry for capital charge costs offsets a reduced cost in the Provider Arm. This is offset by increased costs associated with the supply of pharmaceuticals
- Funding for community services are ($7.6m) unfavourable with Pharmaceuticals being ($7.5m) over budget. There have been increased Pharmaceutical market costs driven by COVID as well as some model changes that have attracted more costs. Note comment above. Age residential care reflects the impact of stronger homecare support services and models of care for older people. Primary care demand driven services such as vaccination, urgent dental and other services are also underspent reflecting the impact of COVID.
- There remains risk in the loss of inter-district flow revenue, planned care for the provider arm and pharmaceutical costs in a post-covid environment. All of these elements are being closely managed.
- In this report we have also highlighted key areas of performance with a focus on our core services and achieving equity. It is recognised that these highlight significant need for improved service delivery and a pro-equity commissioning approach:
  - CCDHB has invested in a new Māori and Pacific midwifery collective in Porirua which will improve access to antenatal care in Porirua and across the DHB catchment.
  - We have seen increased in Māori and Pacific enrolments, particularly for Ora Toa PHO. We continue to work with maternity services and PHOs to improve performance for new-born enrolments.
  - The Diabetes Clinical Network have identified opportunities to reconfigure Network membership and apply and equity lens to work going forward to implement Quality Standards of Diabetes Care 2020
  - There are a range of Pacific providers working collaboratively to address inequities and the level of high unmet needs in Pacific communities; focused on supporting Pacific families with complex health and social needs to access primary health care services.
  - We are working on ED waiting times through community responses to population drivers alongside approaches to redesign the Front of Whāre (ED and acute assessment units) to facilitate delivery of contemporary models of care and ensure facilities are appropriately sized to meet demand.
  - We actively look at flow through our CAMHS services, and have been provided with some specific training from Werry Workforce on this to assist us in managing flow within our teams as effectively as possible.

Funder Financial Statement of Performance

Month					Capital & Coast DHB Funder Result - $000 Feb 2021	Year to Date				
			Variance						Variance	
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year		Actual	Budget	Last year	Actual vs Budget	Actual vs Last year
72,885	72,885	68,138	0	4,747	Base Funding	583,080	583,080	545,105	0	37,976
4,306	4,665	5,274	(359)	(968)	Other MOH Revenue - Funder	36,603	37,320	40,849	(716)	(4,245)
1,286	0	0	1,286	1,286	COVID Revenue from MOH	14,172	0	0	14,172	14,172
50	45	171	4	(121)	Other Revenue	1,110	362	782	748	328
2,908	2,936	2,682	(28)	226	IDF Inflows PHOs	24,136	23,487	22,362	649	1,774
18,310	18,517	17,552	(207)	758	IDF Inflows 19/20 Wash-up Prov	145,848	148,132	134,771	(2,284)	11,077
99,744	**99,048**	**93,817**	**697**	**5,928**	**Total Revenue**	**804,950**	**792,381**	**743,869**	**12,569**	**61,081**
					Internal Provider Payments					
824	824	958	0	134	DHB Governance & Administration	6,589	6,589	7,665	0	1,076
48,180	48,316	45,480	135	(2,701)	DHB Provider Arm Internal Costs - HHS	418,268	420,123	378,783	1,855	(39,485)
7,767	7,752	8,692	(16)	924	DHB Provider Arm Internal Costs - MH	62,140	62,012	70,035	(127)	7,896
1,311	1,942	2,118	631	807	DHB Provider Arm Internal costs - Corp	11,090	13,688	17,928	2,598	6,838
547	0	0	(547)	(547)	DHB Provider Arm Internal costs - COVID	1,921	0	0	(1,921)	(1,921)
58,629	**58,833**	**57,247**	**203**	**(1,382)**	**Total Internal Provider**	**500,008**	**502,412**	**474,411**	**2,405**	**(25,597)**
					External Provider Payments:					
5,379	5,703	5,872	323	493	- Pharmaceuticals	53,109	45,622	46,974	(7,486)	(6,135)
6,702	6,645	6,397	(57)	(305)	- Capitation	53,604	53,162	51,072	(442)	(2,532)
6,649	7,354	6,768	705	119	- Aged Care and Health of Older Persons	57,541	58,835	55,948	1,294	(1,593)
2,740	2,862	2,520	122	(220)	- Mental Health	23,606	22,896	19,722	(710)	(3,885)
887	807	746	(80)	(141)	- Child, Youth, Families	6,471	6,457	5,507	(15)	(964)
557	509	477	(48)	(79)	- Demand driven Primary Services	4,502	4,757	4,295	255	(207)
2,073	2,356	2,299	284	226	- Other services	18,931	18,851	18,328	(80)	(603)
3,727	3,725	3,156	(1)	(571)	- IDF Outflows Patients to other DHBs	29,813	29,803	26,380	(11)	(3,433)
5,242	5,240	4,913	(2)	(328)	- IDF Outflows Other	42,348	41,920	39,705	(427)	(2,642)
33,956	**35,202**	**33,149**	**1,247**	**(806)**	**Total External Providers**	**289,926**	**282,304**	**267,931**	**(7,623)**	**(21,995)**
1,375	0	0	(1,375)	(1,375)	- COVID in Community PHO, Pharms, ARC	10,253	0	0	(10,253)	(10,253)
93,959	**94,035**	**90,397**	**76**	**(2,188)**	**Total Expenditure**	**800,187**	**784,716**	**742,342**	**(15,471)**	**(57,845)**
5,785	**5,012**	**3,420**	**772**	**2,365**	**Net Result**	**4,763**	**7,665**	**1,527**	**(2,902)**	**3,236**

Funder Financials – Variance Explanations

Revenue

SPP Funder Revenue Variances	Mth $000's	YTD $000's
COVID-19 Community funding	391	9,479
COVID-19 Pharmaceuticals	347	2,772
COVID-19 Managed in Quarantine	547	1,921
PHOs volume change funding	60	1,274
Mental Health, Aged Care, Family CFAs	(114)	2,023
CWD IDF 2020/21 below target	(207)	(2,284)
Capital Charge reduced funding	(327)	(2,616)
Year to Date Revenue Variances	**697**	**12,569**

External Revenue Variances

- COVID-19 actual funding and accrued provision of $14.2m YTD is in support of GP assessment testing, pharmaceutical costs, quarantine hotel staffing plus response funding for Maori and Pacific groups. Cost offsets currently exceed paid funding. Ongoing discussions with the Ministry indicate that the DHB will be fully funded for all COVID community costs.

- PHO funding wash-ups and volume funding of $1.2m. There are increased costs of ($941k) offsetting this revenue. New funding for Mental Health and Child & Youth services of $2m has been contracted to NGO Providers.

Internal Revenue Variances

- Provision for 20/21 IDF wash up revenue is down by ($2.3m) due to Provider Arm not achieving the targets set. The ministry reduced the capital charge funding due to a reduction in the interest rate charged. YTD reduction is ($2.6m).

Payments to Internal and External Providers

SPP Funder Payment Variances	Mth $000's	YTD $000's
COVID-19 Community funding	(1,287)	(10,165)
Pharms increased volumes incl COVID	770	(3,911)
Pharms savings not achieved	(447)	(3,575)
COVID-19 MIQ HHS	(547)	(1,921)
PHOs volume variances offset	(108)	(941)
Other Community NGOs	928	589
CWD PVS below target	439	1,837
Capital Charge reduced funding	327	2,616
Year to Date Payment Variances	**76**	**(15,471)**

External Provider Payments:

- Community COVID-19 costs paid ($10.2m) mainly due to ongoing GP test assessment claims in support of the COVID-19 response as directed by MOH.

- Pharmaceuticals costs have been impacted by COVID-19 with increasing costs unfavourable to budget by ($3.9m). The DHB has received additional COVID funding which offsets this cost pressure. The DHB had budgeted for pharmaceutical savings in 2020/21 pre COVID. Budgeted YTD savings of ($3.5m) have not been achieved.

- PHO Capitation expenses are ($941k) unfavourable. Additional costs due to volume changes are offset by additional revenue. Effect is expected to be neutral at year end.

- Other Community NGO contracts have a net YTD variance of $589k. New funded NGO contracts offset lower volume trends due to COVID in NGO contracted services such as immunisations and aged care costs.

Internal Provider Payments:

- An amount of $1.8m, was not paid to the Provider Arm due to under achievement of targets at YTD Feb 2021. Reduced capital charge funding of $2.6m as per the Ministry has been passed through to Provider. Provider has been paid for MIQ provisional costs of ($1.9m).

Inter District Flows (IDF)

DHB of Domicile	YTD February estimated inpatient inflow wash-up
Taranaki DHB	-$1,200,508
Other under-delivered (8 DHBs)	-$1,385,765
Other over-delivered (7 DHBs)	$952,119
Hutt Valley DHB	$935,711
Total undelivered inpatient IDF CWD	-$698,443

Changed Recognition:

- The DHB is back to standard recognition of IDFs from the start of the financial year rather than the COVID-19 approach taken last year.
- We have recognised non-delivery of IDF inflows with an unfavourable result of ($1.2m) YTD, a ($400k) decrease to last month.

IDF Inflow (revenue):

- Inpatient Case weight IDF inflows are unfavourable by ($698k) which is driven by lower elective IDF flows.
- The majority of the lower IDF inflows (actuals) are caused by elective inpatient lower volumes:
  - Acute: $72k: Cardiology ($1.2m), followed by Gen Med ($728k) and Oncology ($567k). Offset by Cardiothoracic $1m (with significant outsource earlier in the year), NICU $1.2m, Neuro $936k
  - Elective: ($770k); Vascular $838k offset by Cardiothoracic ($1.6m)

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

Commissioning: Families & Wellbeing

What is this measure?

- 75% of pregnant women registered with a Lead Maternity Carer (LMC)
- 80% of infants exclusively or fully breastfed at two weeks
- 85% of newborns enrolled in a PHO by 3 months

Why is this important?

- Early engagement with an LMC begins the primary maternity continuity of care relationship between a woman and her LMC, as well as enabling opportunity for screening, education and referral.
- The early years of life set the foundation for lifelong health and wellbeing. Breastfeeding is associated with a range of lifelong physical and psychological benefits for babies.
- Enrolment close to birth helps to ensure that childhood immunisations are given on time and maximise the child's health as they grow. It also supports access to free healthcare services.

How are we performing?

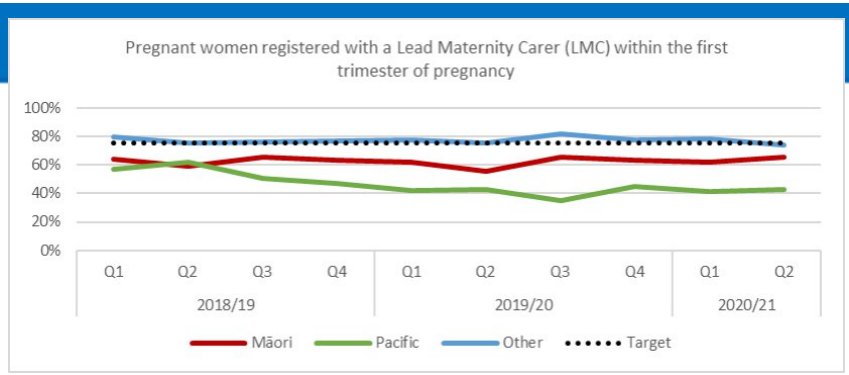
- Engagement with an LMC is below target for Māori and Pacific; performance is improving.
- The proportion of infants who are exclusively or fully breast-fed at 2 weeks has been decreasing for all groups, and is lowest for Māori and Pacific babies.
- In Q1 2020/21, PHO enrolment was below target for Māori 3 month olds, but performance was improving.

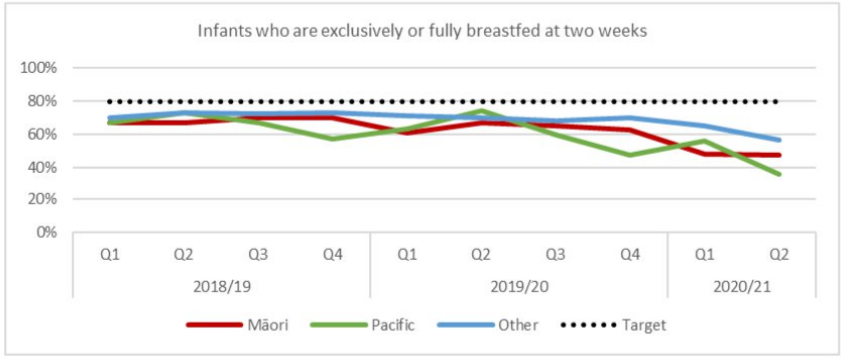
What is driving performance?

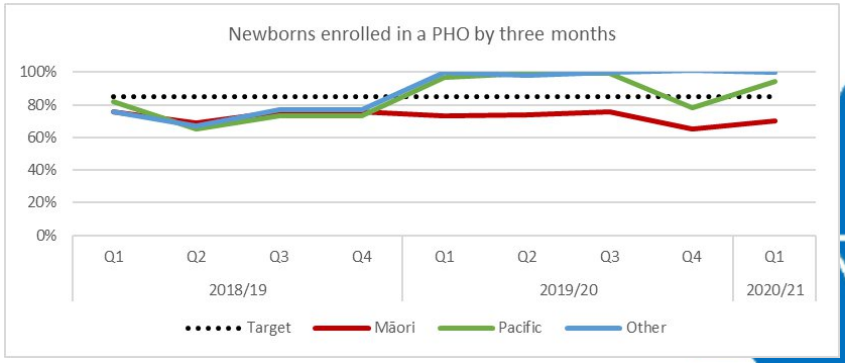
- Low engagement with LMCs in the 1st trimester is related to a lack of Māori and Pacific LMC in CCDHB.
- Maternity services at CCDHB have experienced significant workforce pressures including the retirement of three Lactation Consultants. Decreasing breastfeeding rates are related to access to LMCs.
- Newborn enrolments in a PHO require administration support from PHOs, this administration was not prioritised during the emergency COVID-19 response. We can now see primary care catching up.

Management comment

- CCDHB has invested in a new Māori and Pacific midwifery collective in Porirua which will improve access to antenatal care in Porirua and across the DHB catchment.
- We have initiated a community breastfeeding education programme focussed on supporting Māori and Pacific women, and are supporting the training of Māori and Pacific Lactation Consultants. This will support performance in the long term. In the short term, our provider arm has a series of activity underway to increase maternity workforce.
- We have seen increased in Māori and Pacific enrolments, particularly for Ora Toa PHO. We continue to work with maternity services and PHOs to improve performance for new-born enrolments.







Commissioning: Primary & Complex Care

What is this measure?

Management of Long-Term Conditions (LTC):

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

Why is this important?

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

How are we performing?

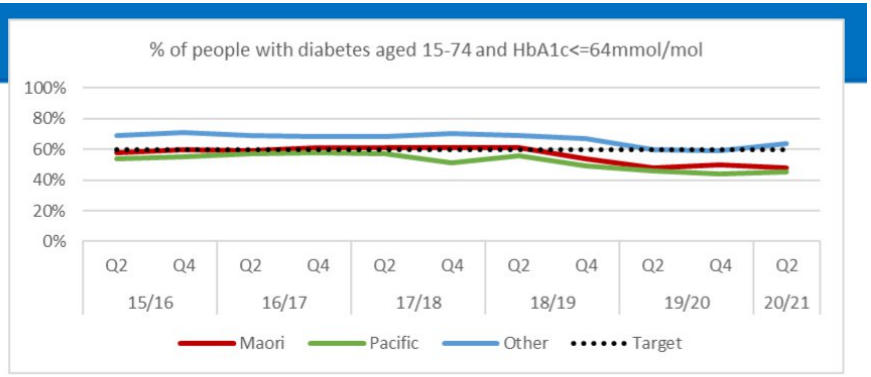
- The proportion of people with diabetes with an HbA1c ≤64mmol/mol is higher for non-Māori, non-Pacific people; and Māori and Pacific are consistently below target
- The rate of ASH for both cardiovascular and respiratory diseases is significantly higher for Maori and Pacific 45-64 year olds, with the highest rate of hospitalisations for Pacific people
- There has been a slight decrease in ASH rates for Maori and Pacific people for (non-infectious) respiratory conditions (asthma and bronchiectasis).

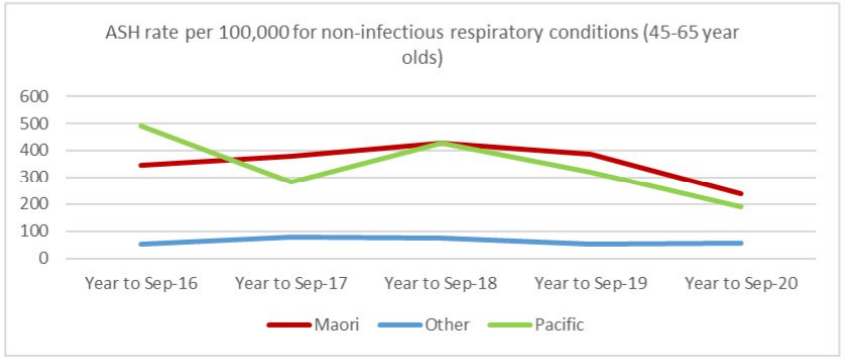
What is driving performance?

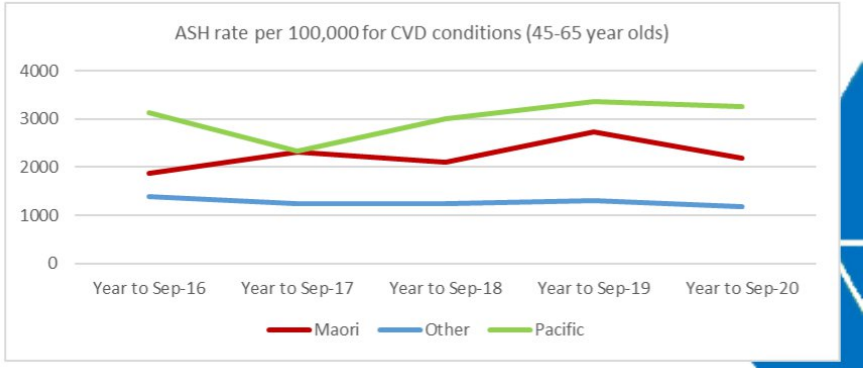
- The reduction in good diabetes control is attributed to COVID-19 lockdowns. General Practices resources were redirected to support the COVID-19 response.
- PHOs invite eligible patients to receive CVD risk-assessments. Community teams are available to provide flexible options to complete CVDRA. Ora Toa PHO invites Māori men (30+) to attend Saturday screenings.

Management Comment

- The Diabetes Clinical Network have identified opportunities to reconfigure Network membership and apply and equity lens to work going forward to implement Quality Standards of Diabetes Care 2020
- There are a range of Pacific providers working collaboratively to address inequities and the level of high unmet needs in Pacific communities; focused on supporting Pacific families with complex health and social needs to access primary health care services.







Commissioning: Hospital & Speciality Services

What is this measure?

- Planned care waiting list improvement action plan to recover waiting lists post COVID-19 level 4 lockdown in 2020. Performance against 3 measures within the $4.2 million service delivery funding are shown.

Why is this important?

- Access to planned care was disrupted during the COVID-19 level 4 lockdown in 2020. In Budget 2020 the Government made available investment for DHBs to recover waiting lists by providing additional surgery, appointments, and radiology visits. CCDHB requested to focus our $4.2million service delivery investment on the following areas which had long waiting lists as a result of or exacerbated by the lockdown:

General Surgery elective discharges	Dermatology and respiratory first specialist appointments;	Ophthalmology and respiratory follow up assessments	CT and MRI scans	Sleep apnoea assessments and intraocular injections

How are we performing?

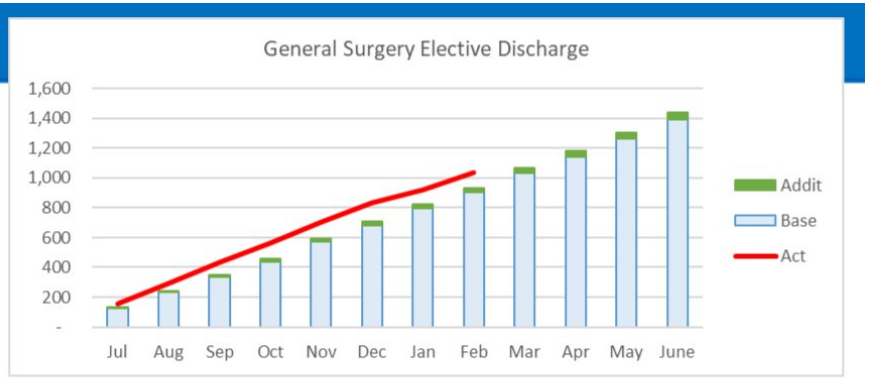
- General surgery are ahead of plan for delivering the additional discharges.
- MRI additional volumes are being delivered in line with plan.
- Respiratory is behind on provision of first specialist appointments (1st attendance).

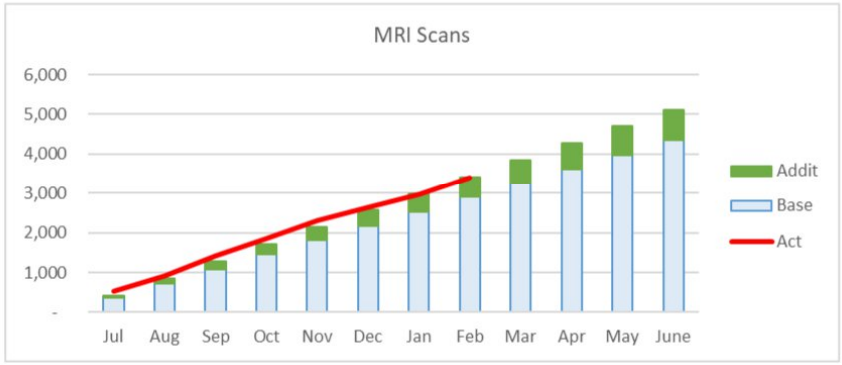
What is driving performance?

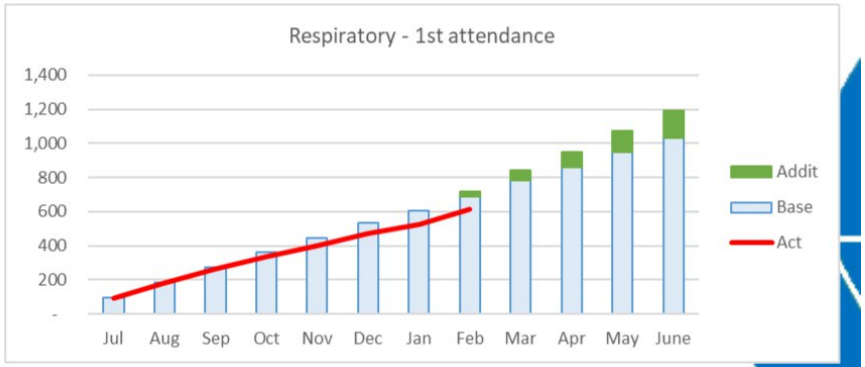
- General surgery demand remains high both acute and elective cases.
- Additional MRI scans are being delivered with a mixture of in-house activity and outsourcing, however demand remains high which impacts performance on the number of scans completed within 42 days.
- Respiratory appointments are slightly behind schedule however locum SMOs have been recruited to deliver additional clinics in the coming months. In addition, the service is investigating the potential for a one stop clinic for first specialist appointment, diagnostics, and treatment clinic at Kenepuru site in an effort to decrease the high DNA rate for the service and provide care closer to home.

Management comment:

- CCDHB has chosen to focus our $4.2 million service delivery funding in areas of greatest need, and are focused on areas of increasing demand, inequities and historical performance.
- The 2DHBs are focusing on a bed and theatre capacity project to ensure access to planned care is maintained in 2021 and beyond.
- Destravis has been engaged to provide options on the best use of facilities across HVDHB and CCDHB in the 2DHB Hospital Network in the medium to long term.







Commissioning: Mental Health & Addictions

What is this measure?

Shorter waits for non-urgent mental health and addiction services for 0-19 year olds

- 80% seen ≤3 weeks
- 95% seen ≤8 weeks

Why is this important?

- Those with mental health and addictions concerns have timely access to services.
- Shorter waits help to drive continuity of care by providing uninterrupted care over time.
- Earlier treatment in the progression of illness links to better outcomes and healthcare quality.

How are we performing?

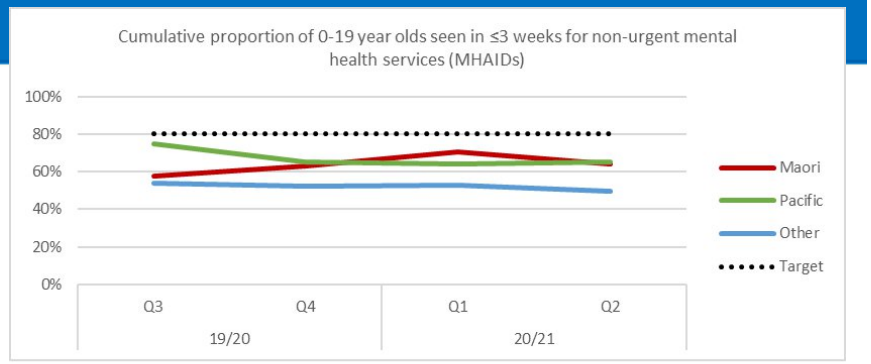
- The proportion of 0-19 year olds who are seen within 3 weeks is below target (80%) for all ethnic groups, and improvements have not been made. By 8 weeks since referral, a higher proportion have been seen, but this continues to be below the 95% target for all groups.
- Performance is better for referrals to non-urgent alcohol and drug services, with the proportion of visits for Māori and Pacific 0-19 year olds seen within 3 weeks largely at or above target. Performance for non-Māori, non-Pacific remains below target.

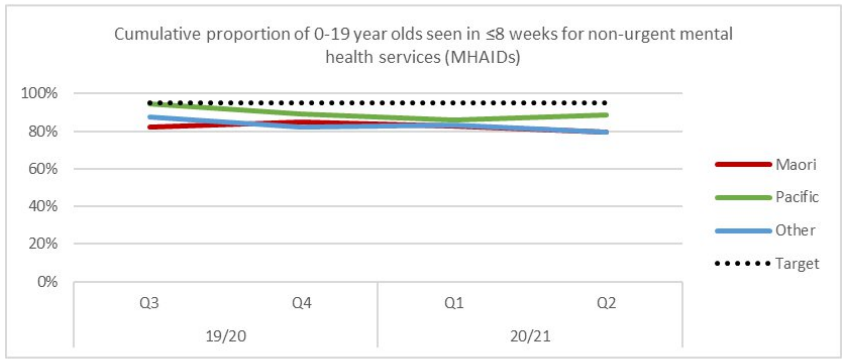
What is driving performance?

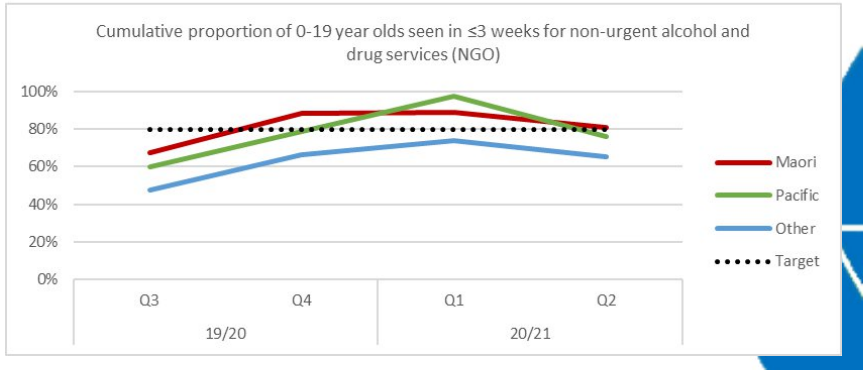
- Ongoing issues with recruitment and teams carrying vacancies impacts on our ability to meet targets. We continue to actively recruit our vacancies.
- More recently, increases in acute referrals have resulted in redirected resources and waiting time increases.

Management comment

- We actively look at flow through our CAMHS services, and have been provided with some specific training from Werry Workforce on this to assist us in managing flow within our teams as effectively as possible.
- CAMHS teams undertake work with families prior to meeting the youth client which is counted as the first face-to-face activity.







Section 2.2

Hospital Performance

Executive Summary – Hospital Performance

- Fundamentally the underlying causes for our continued delays in waiting times in ED are well canvassed - our acute front door (ED and acute assessment units) is undersized for the population served and not configured for contemporary models of care; there are recognised bed and theatre deficit on the Wellington Regional Hospital campus. All this is exacerbated by operating parallel processes in our in-patient wards to manage COVID case definition vs. non-COVID patients .

- We continue our across a number of streams to improve flow alongside approaches to redesign the Front of Whāre (ED and acute assessment units) to facilitate delivery of contemporary models of care and ensure facilities are appropriately sized to meet demand. This latter work has commenced within a project structure . Winter planning is running parallel to this preparing for the upcoming winter months and surge of acute demand.

- Planned care – the delivery of Specialist assessments or Treatment within 120 days continues to be a major challenge. Our outsourcing volume is still being affected by contractual constraints however our in-house elective surgical discharges were just 13 adverse to our planned 484 despite high volumes of cancellations due to increased acute demand in February. Our focus remains on scheduling our longest waiting patients in all specialities, and ensuring our theatre sessions are fully utilised. The installation of new operating lights in Kenepuru theatres has commenced. It is planned that one theatre will be closed for a four month period until the work is completed. Staff from Kenepuru theatres are being relocated to theatre 13 in Wellington so work can continue. Recruitment of anaesthetists to our current vacancies is making progress.

- Our Maternity Units across the region continue to struggle with midwifery vacancies and high occupancies - we are continually refining and reviewing processes to manage demand during busy periods and continue to work closely with our staff and union partners on workforce planning within the national frameworks.

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

CCDHB Activity Performance

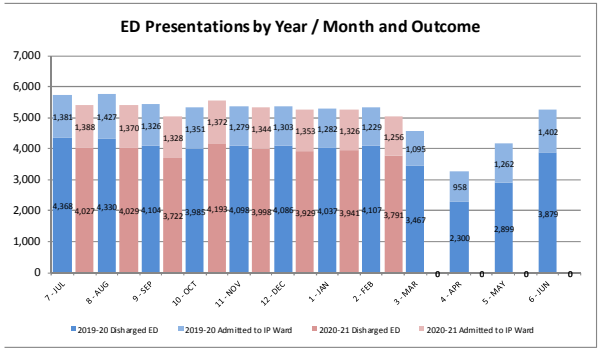
Capital and Coast DHB: February 2021

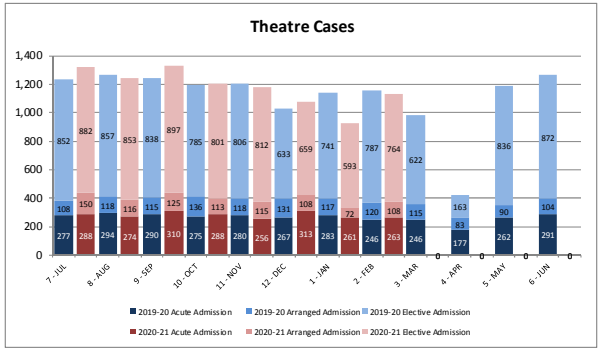
ED Presentations

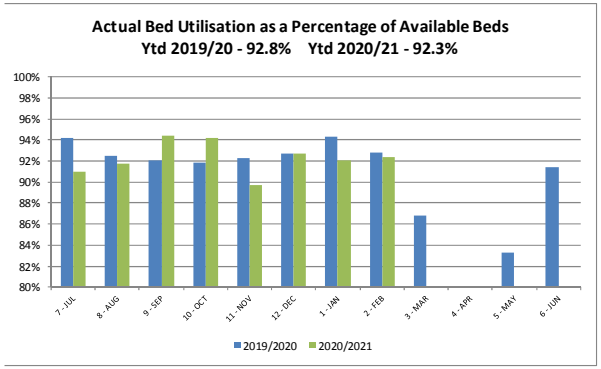
	2019/20	2020/21
YTD Totals	43,693	42,367
Change		-1,326
% Change		-3%

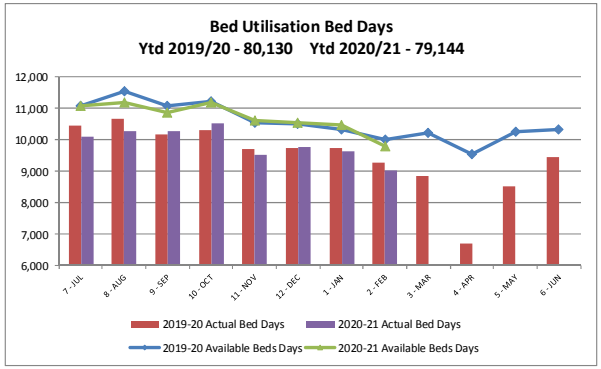
Theatre Cases

	2019/20	2020/21
YTD Totals	9,474	9,421
Change		-53
% Change		-1%









- The number of ED presentations in February 2021 is lower than the number recorded in the same month in the previous financial year.
- The difference between the two years is 333 presentations but February 2020 was a leap year with the additional day inflating the variance by 166 presentations. This equates to approximately 6 less presentations per day.
- Through the first 8 months of 2020/21 Wellington ED has experienced a significant reduction (1,107) in the number paediatric presentations compared to the same period in the previous year. The total reduction across all age groups is 1,326 compared to the previous year.
- The utilisation of available of adult beds in core wards in February 2021 is 92.4% which is lower than the 92.8% rate recorded in February 2020.
- The number of Elective theatre cases has decreased for the month of February 2021 by 3.4% (28 cases) when compared to January 2020. The decreases are spread across a number of specialties in particular Orthopaedics (19), General Surgery (18) and Urology (16) but countered by increases in Ophthalmology (29) and Paediatric Surgery (10).

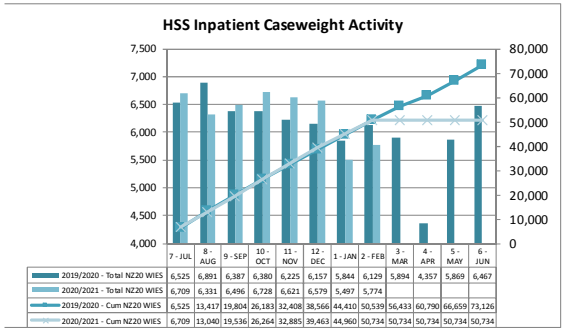
CCDHB Activity Performance

Capital and Coast DHB: February 2021

HSS Inpatient Caseweight Activity

	2019/20	2020/21
YTD Totals	50,539	50,734
Change		195
% Change		0.4%

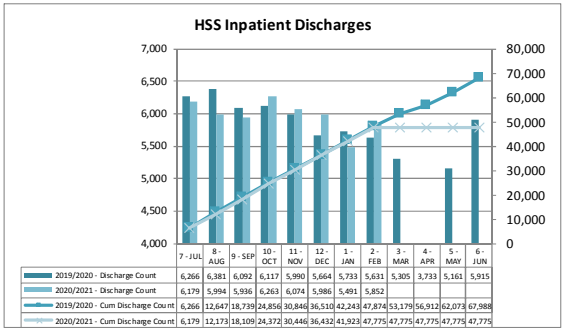
** This includes all Hospital Acitivty including ACC, Non Resident, Non-Casemix but excludes Mental Health*



HSS Inpatient Discharges

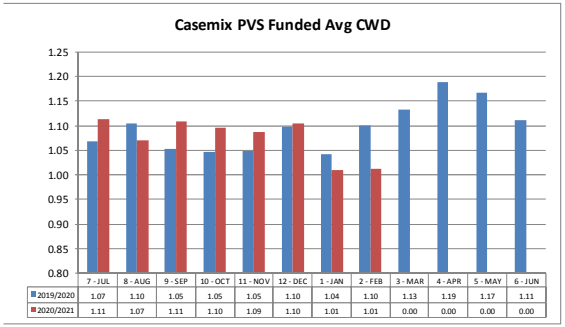
	2019/20	2020/21
YTD Totals	47,874	47,775
Change		-99
% Change		-0.2%

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



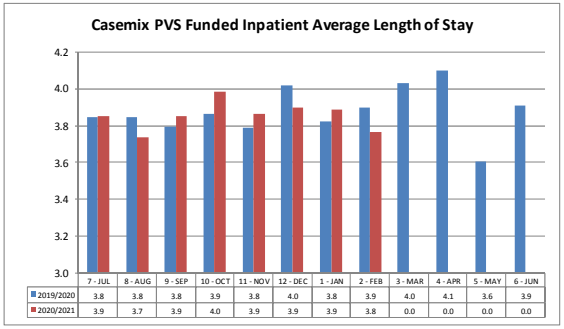
Casemix PVS Funded Avg CWD

	2019/20	2020/21
YTD Totals	1.09	1.08
Change		-0.02
% Change		-1%



Casemix PVS Funded Inpatient Average Length of Stay

	2019/20	2020/21
YTD Totals	3.87	3.86
Change		-0.01
% Change		-0.4%



Comparisons with same period last year:

- Local acute CWDs are lower than previous financial year (-726 CWDs) with a decrease in discharges; a lower ALOS and a similar average CWD. The discharge decrease is driven primarily by General Medicine, Paediatric Medicine and ENT. The CWD decrease is driven primarily by Neonatal, General Medicine Paediatric Medicine, Respiratory and Orthopaedics.
- Local Elective CWDs are higher than the previous financial year (92 CWDs) with a decrease in discharges; a similar ALOS and average CWD. The discharge decrease is driven primarily by Ophthalmology and Orthopaedics. The CWD increase is driven primarily by Cardiology, General Surgery and Neurosurgery.
- IDF acute CWDs are higher (179 CWDs) than the previous financial year also with an increase in discharges; a similar ALOS and average CWD. The discharge increase is driven primarily by Emergency Medicine and Neurology. The CWD increase is driven primarily by Neonatal, Oncology, Haematology and Neurology.
- IDF Elective CWDs are higher than the previous financial year (492 CWDs) with more discharges; a lower ALOS and a LOWER average CWD. The discharge increase is driven primarily by Vascular Surgery, Ophthalmology and Neurosurgery. The CWD increase is driven primarily by Cardiothoracic, Cardiology and Neurosurgery.
- In combination these four admission groups equate to an increase of 37 CWDs compared to the previous year. The services that most significantly impact this shift are Cardiothoracic (340), Emergency Medicine (314), Neurosurgery (279) and Neurology (216) but countered by deceases in General Medicine (-310), Orthopaedics (-285), Paediatric Medicine (-253), and Respiratory Medicine (-133).
- The reduction in General Medicine (-319 CWDs) will have also been impacted in the WRH AHOP counting change and Paediatric Medicine (-253 CWDs) who will be heavily impacted by the reduction in the number of presentations to the Emergency department (1,107 Ytd).

Discharges:

- Publicly funded case mix discharges for the month of February 2021 have increased by 164(3.1%) in comparison to the number of discharges recorded in v 2020..
- The increase in discharges is spread across a number of specialties with the increases most evident in Emergency Medicine (170), Obstetrics (35 Mother, 31 Babies) and Haematology (28 Acute).
- The number of discharges was countered by reductions in General Medicine (52 Acute) General Surgery (43 Acute, 3 Elective) and Vascular Surgery (12 Acute, 18 Elective).
- The number of outsourced discharges in private facilities increased from 100 in February 2020 to114 in February 2021 an increase of 14 discharge (14% increase) with CCDHB now utilising Boulcott Hospital, Bowen Hospital, Southern Cross Hospital and Wakefield Hospital.

HHS Operational Performance Scorecard – period Feb 20 to Feb 21

Domain	Indicator	2020/21 Target	2020-Feb	2020-Mar	2020-Apr	2020-May	2020-Jun	2020-Jul	2020-Aug	2020-Sep	2020-Oct	2020-Nov	2020-Dec	2021-Jan	2021-Feb
Care	Serious Safety Events	Zero SSEs	12	7	7	10	5	16	6	10	5	12	7	7	4
	Total Reportable Events	TBD	1,109	1,207	725	906	1,085	1,167	1,269	1,370	1,356	1,414	1,507	1,413	1,454
Patient and Family Centred	Complaints Resolved within 35 calendar days	TBD	86.5%	92.4%	100.0%	93.5%	91.8%	86.4%	94.3%	93.9%	94.9%	92.0%	83.0%	92.9%	97.7%
	% Discharges with an Electronic Discharge summary	TBD													
Access	Emergency Presentations		5,336	4,562	3,258	4,161	5,281	5,415	5,399	5,050	5,565	5,342	5,282	5,267	5,047
	Emergency Presentations Per Day		184	147	109	134	176	175	174	168	180	178	170	170	180
	Emergency Length of Stay (ELOS) % within 6hrs	≥95%	75.5%	78.7%	84.7%	82.8%	74.6%	72.6%	68.5%	65.6%	65.1%	67.6%	65.9%	68.6%	62.5%
	ELOS % within 6hrs - non admitted	TBD	81.2%	84.6%	90.7%	90.4%	82.6%	79.8%	76.8%	75.2%	73.6%	73.7%	73.7%	75.8%	70.3%
	ELOS % within 6hrs - admitted	TBD	58.6%	61.8%	70.5%	66.3%	54.6%	53.5%	46.8%	41.3%	42.3%	51.3%	46.0%	49.6%	42.4%
	Total Elective Surgery Long Waits	Zero Long Waits	148	177	400	432	349	246	106	98	183	206	307	492	578
	Additions to Elective Surgery Wait List		1,411	1,272	553	1,098	1,506	1,521	1,385	1,545	1,399	1,392	1,282	905	1,063
	% Elective Surgery treated in time	TBD	86.0%	89.0%	92.7%	76.3%	71.3%	73.0%	84.2%	90.3%	89.0%	86.3%	88.5%	75.4%	75.6%
	No. surgeries rescheduled due to specialty bed availability	TBD	8	1	1	1	12	5	9	13	14	1	6	2	6
	Total Elective and Emergency Operations in Main Theatres	TBD	1,101	927	378	1,103	1,202	1,237	1,192	1,254	1,130	1,118	1,002	878	1,076
	Faster Cancer Treatment 31 Day - Decision to Treat to Treat	85%	82.0%	89.0%	91.0%	92.0%	91.0%	93.0%	85.0%	87.0%	82.0%	85.0%	86.0%	81.0%	89.0%
	Faster Cancer Treatment 62 Day - Referral to Treatment	90%	89.0%	97.0%	92.0%	77.0%	85.0%	94.0%	83.0%	88.0%	88.0%	83.0%	89.0%	91.0%	72.0%
	Specialist Outpatient Long Waits	Zero Long Waits	324	488	1,079	1,286	1,450	1,076	571	314	185	225	314	353	Tbc
	% Specialist Outpatients seen in time	Zero Long Waits	83.9%	82.0%	87.1%	81.0%	74.2%	74.3%	85.1%	90.2%	88.8%	92.3%	93.0%	89.1%	88.2%
	Outpatient Failure to Attend %	TBD	7.4%	7.7%	4.4%	7.1%	6.6%	7.1%	6.7%	7.0%	7.6%	7.6%	7.8%	7.2%	7.0%
	Maori Outpatient Failure to Attend %	TBD	14.1%	15.2%	8.1%	13.9%	13.7%	14.7%	13.9%	15.3%	15.4%	16.0%	16.7%	16.2%	15.1%
	Pacific Outpatient Failure to Attend %	TBD	15.6%	16.5%	7.8%	16.5%	16.0%	16.9%	14.4%	14.5%	16.3%	16.2%	18.6%	19.4%	17.2%
Financial Efficiency	Forecast full year surplus (deficit) ($million)		($29.5m)	($29.5m)	($47.5m)	($47.5m)	($44.2m)	($39.8m)	($39.8m)	($62.0m)	($62.0m)	($62.0m)	($62.0m)	($62.4m)	($62.4m)
	Contracted FTE (Internal labour)		4,837	4,847	4,893	4,930	4,973	4,976	5,035	5,238	5,268	5,265	5,261	5,261	5,354
	Paid FTE (Internal labour)		5,195	5,198	5,188	5,199	5,310	5,317	5,368	5,607	5,606	5,649	5,691	5,690	5,779
	% Main Theatre utilisation (Elective Sessions only)	85.0%	81.0%	80.0%	78.1%	82.0%	81.0%	83.0%	82.0%	82.0%	82.0%	80.0%	78.2%	81.0%	80.0%
Discharge and Occupancy	% Patients Discharged Before 11AM	TBD	24.3%	22.7%	19.3%	20.4%	21.9%	24.4%	23.1%	25.4%	22.2%	25.3%	22.6%	23.0%	22.1%
	Adult Long Stay Patients Not Yet Discharged (>14 days) WLG	TBD	39	29	19	24	29	30	35	51	33	34	37	37	38
	Adult Overnight Beds - Average Occupied WLG	TBD	358	331	273	323	357	362	363	382	378	363	360	356	373
	Adult Long Stay Patients Not Yet Discharged (>14 days) KEN	TBD	18	10	17	16	17	19	19	18	23	18	17	16	15
	Adult Overnight Beds - Average Occupied KEN	TBD	69	62	46	55	63	71	72	74	76	67	64	67	71
	Child Overnight Beds - Average Occupied	TBD	21	18	15	18	23	24	23	22	23	24	22	17	19
	NICU Beds - ave. beds occupied	36	28	34	38	30	29	28	31	38	36	33	35	38	39
ALOS	Overnight Patients - Average Length of Stay (days)	TBD	3.90	4.03	4.10	3.61	3.91	3.85	3.74	3.85	3.98	3.86	3.90	3.88	3.76
Care	Rate of Presentations to ED within 48 hours of discharge	TBD	4.2%	3.7%	4.1%	3.3%	3.8%	3.7%	3.7%	4.3%	4.6%	3.2%	3.2%	4.1%	4.0%
	Presentations to ED within 48 hours of discharge	TBD	225	168	133	139	203	199	201	215	254	171	170	218	202
Staff Experience	Staff Reportable Events	TBD	139	137	91	109	161	139	155	140	181	173	176	149	170
	% sick Leave v standard	TBD	2.6%	3.5%	2.2%	2.5%	3.5%	4.0%	4.0%	3.6%	3.5%	3.4%	3.1%	2.0%	2.6%
	Nursing vacancy	TBD	211.6	206.6	193.0	171.0	157.6	248.1	265.3	251.1	247.4	267.5	268.3	266.4	218.1
	% overtime v standard (medical)	TBD	1.6%	1.9%	1.4%	1.4%	1.6%	1.7%	1.9%	2.1%	1.9%	2.0%	1.8%	1.8%	1.9%

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

Shorter Stays in ED (SSIED)

What is this measure?

- The purpose of this paper is to provide the Board with information on CCDHB's performance against key hospital and health system target measures for the month of February 2021.

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 February 2021 was 62.6%. This result is a decrease on the 68.6% recorded last month (January 2021) and a decrease on the 76% recorded in February 2020. The performance of patients who were seen, treated and discharged by ED for February 2021 was 73%. The performance of patients who were seen and admitted to hospital for February 2021 was 46%.
- A factor that affects our SSiED performance is the occupancy/bed utilisation in our wards. The average occupancy for February 2021 was 92%. The occupancy rate is based on core Adult Wards (Wellington and Kenepuru) excluding Ward 4 North and ICU. The number of available adult beds in February 2021 was 349.

What is driving performance?

- Our performance being less than target continues to be due to the increase of elective and acute surgical work. There has also been the seasonal increase in admissions to our Cancer/Haem/Renal ward.
- For February 2021, the average bed days utilised by acute admissions (233) increased by 5 beds per day compared to December 2020 (228). We also have in place ongoing processes related to COVID-19 screening and precautions.
- We continue to operate parallel processes in our in-patient wards to manage COVID case definition vs. non-COVID patients. Our acute flow programme of work is focusing on medical teams identifying and discharging patients earlier in the day. This then frees beds for those being admitted from ED to move to the ward in a timelier manner and thus improves our SSiED performance.

Performance	NOV	DEC	JAN
2019-20	77%	80%	76%
2020-21	66%	69%	63%

Breaches	NOV	DEC	JAN
2019-20	1,137	997	1,180
2020-21	1,655	1,507	1,678

ED Volumes	NOV	DEC	JAN
2019-20	5,020	4,998	4,822
2020-21	4,840	4,807	4,489

Management Comment

The following work streams continue to be progressed and implemented including:

- •During the month of February 2021 there were nil presentations where the patient(s) was suspected of having COVID-19.
- •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 in Ward 3 reopened to admissions from 1 February 2021. The Acute Frailty Unit will be located in Ward 3 / CTU until 29 March 2021, and again from 1 May 2021.
- •The Advancing Wellness at Home Initiative (AWHI) project is an early supported discharge for people whose level of function has declined on admission and has involved making changes to the Patient Care Coordination service to identify potential patients needing intervention earlier in admission with the goal of reduction in the over 10 day stays for complex patients in general medicine and reducing need for in-hospital stay.
- •Project group to review patients who have been in hospital more than 10 days, continues to identify barriers to discharge and address these with our teams.
- •Activities continue across the organisation to improve discharge processes.
- •Work group established to identify space to create additional acute assessment beds.
- •Work underway to relocate Kenepuru Day ward creating additional surgical and Rehabilitation beds on the Kenepuru Hospital site.

Planned Care – Inpatient Surgical Discharges/Minor Procedures

What is this measure?

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

Why is this important?

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

How are we performing?

- Total planned care results year to date have us reporting (590) unfavourable to our planned 7,146.

- February month end result is unfavourable (102) to a plan of 898. The main driver of this result is our outsource delivery was 80 adverse to our planned 174 month target. Outsourcing volume is still being affected by contractual constraints. Our in-house elective surgical PUC was just 13 adverse to our planned 484 despite high volumes of cancellations due to increased acute demand in February.

- Our IDF outflow position is reported positive 10 for February, the over delivery in IDF elective surgical arranged, 28 ahead of the planned 66 offset under delivery in our IDF non-surgical and arranged measures. Minor procedures are 46 ahead of our month plan of 391.

What is driving performance?

Our Outsourced and Arranged Surgical purchase unit contracts are the main contributors to our adverse year to date result.

Management Comment

- Our focus remains on scheduling our longest waiting patients in all specialities, and ensuring our theatre sessions are fully utilised. The installation of new operating lights in Kenepuru theatres has commenced. It is planned that one theatre will be closed for a four month period until the work is completed. Staff from Kenepuru theatres are being relocated to theatre 13 in Wellington so work can continue.

- Outsource contracts are still being negotiated but we have managed to secure an interim agreement on some procedures, but we are unable to outsource at the required capacity to meet our outsourced planned care target this year.

- SMOs continue to be involved with planning surgery based on those with greatest clinical urgency and long waiting times.

MRI and CT Waiting Times

What is this measure?

A percentage measure that shows the proportion of CT or MRI outpatient referrals that are scanned 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.

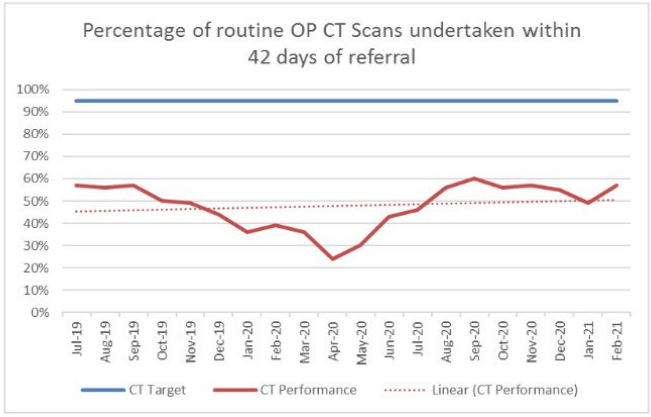
How are we performing?

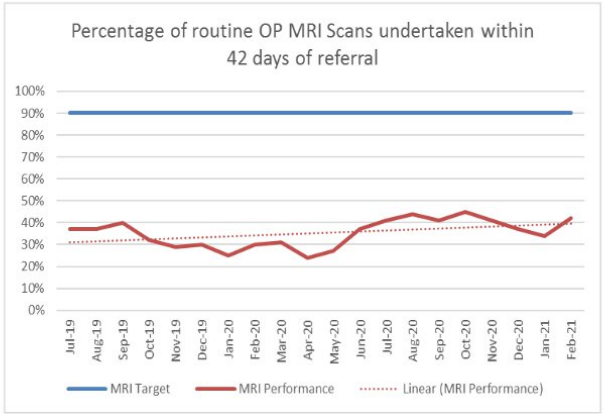
Waiting times for CT and MRI remain high as a result of historical insufficient capacity to meet demand. Subsequently, the percentage measure is low and has been for a long time.

Due to the planned care funding directly from the MOH confirmed December 2020, increased outsourcing and improved performance can be expected throughout the remainder of FY 20/21.

What is driving performance?

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





Management Comment

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

Of note, unexpected high demand for Inpatient and ED services is creating additional pressure on elective slots for CT scanning. Our demand aligns with the increased demand on ED and IP services seen across hospital services.

Actions currently underway to address waiting times:

- Planned care funding packet for CCDHB has been approved by the MOH. Due to workforce challenges it is unlikely that we will be able to recruit and establish weekend elective lists this FY. However, increased outsourcing has begun and will continue through the next 3 months which will improve performance.

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). After a period of high leave during December/January, we are starting to see an improvement in results for February.

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 increased to 89.1% this month.

What is driving performance?

- Remaining just below target has been influenced by SMO leave (Annual and Parental)

Management Comment

- A total of 4 weeks SMO Leave was taken over February. We also currently have two consultants on parental leave, with gaps in interventional cover arrangements until staff are available. Patient cancellations or deferment related to social or medical issues (3 patients), patient seen acutely but not taken off elective list (1 patient) are included in those breaching the target. Others missed the 90 day target by a short time - due operator availability (Annual Leave).

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?

Door to cath. <= 3 days January results (Target is ≥70%):

National Performance	75.6%	
Central Region		76.7% (99/129)
CCDHB	88.5% (23/26)	
Hawkes Bay	45.5% (10/22)	
Hutt Valley	75.0% (6/8)	
Mid Central	73.9% (17/23)	

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

What is driving performance?

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

Management Comment

- Increased lab capacity resulting from the new SMO roster and redistribution of interventional lab sessions, has allowed better lab utilisation, although staffing has been a challenge this month due to two SMO's on parental leave and a number of operators taking annual leave. The underlying issue remains access to beds, increased by Cardiology having access to short stay beds reduced. This has resulted in less flexibility and impacts on the service's ability to transfer regional patients in a timely manner when busy. Trans-oesophageal Echocardiograms and CTCA patients have been moved out of the IRW space, utilising the Transit Lounge and Clinical Management Unit for this work to free up bed space in IRW and Ward 6 South to help mitigate this issue. We are currently investigating other procedures that can be managed this way.

Faster Cancer Treatment

What is this measure?

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

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

Why is this important?

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

How are we performing?

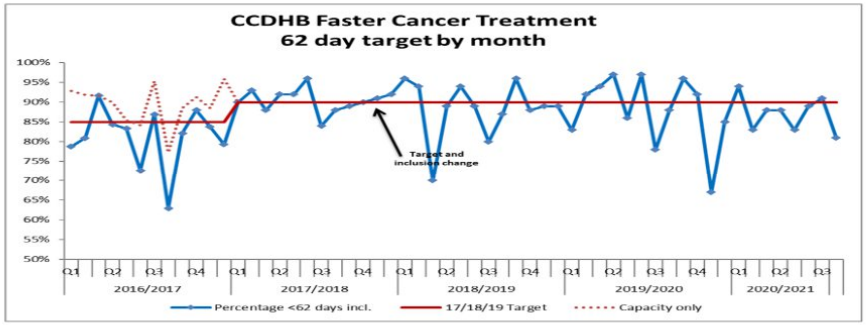
- CCDHB is non-compliant with the 62 day target for February at 81% compared to the aim of 90% of patients receiving their first cancer treatment within 62 days of being referred with a high suspicion of cancer. CCDHB has been non-compliant in February the last four years and has struggled since early 2020 to consistently achieve the target.
- CCDHB is compliant with the 31 day indicator for February at 89% vs the aim of 85% of patients commencing treatment within 31 days from decision to treat.
- Patient numbers for both measures have improved but remain 15% lower than expected. This likely indicates reduced services over December/January.

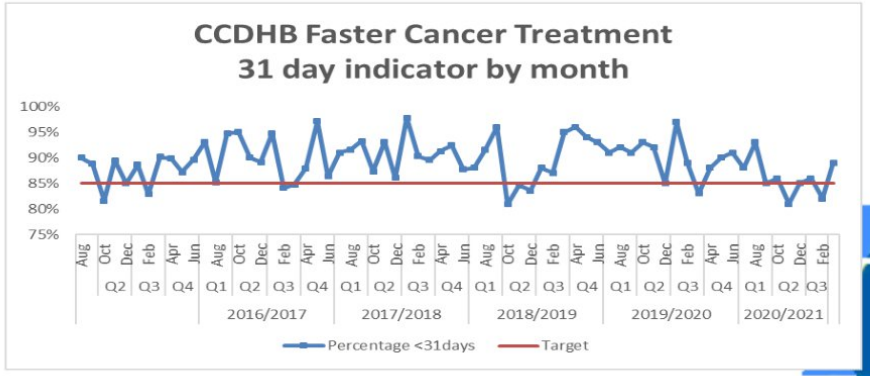
What is driving performance?

- Breaches in the 62 day target were those who experienced a delay in the front end of the pathway i.e. delay to FSA or delay in diagnostic procedures (hysteroscopy and MRI). Three breaches occurred in the gynaecological tumour stream with surgery as first treatment and one in lower GI with radiation as first treatment.
- Four of the seven breaches in the 31 day indicator was due to capacity reasons – often related to access to services over Dec/Jan including surgery access due to lack of surgeon or anaesthetic resources. Two breaches were also for patient reasons – not unusual at this time of year when patients have holiday plans. One breach related to clinical reasons for comorbidity assessment prior to treatment.
- Capacity constraints related to Urology (2 pts), and Gynaecological (2 pts) tumour streams. Average delay for all 31 day breach patients was 42 days (range 32-56 days) a reduction from January's 56 days.

Management Comment

- The reduction in services over the Christmas/New Year break did, as anticipated, result in some patients having experienced increased delays.
- Aligning imaging, FSAs, surgical interventions and access to MDMs during periods of high leave and vacancy rates is challenging. Cancer Co-ordinator CNS intervene in an effort to expedite the patient's pathways but multiple priorities often overlap.





Colonoscopy

What is this measure?

Diagnostic colonoscopy

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

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

Surveillance colonoscopy

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

Why is this important?

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

How are we performing?

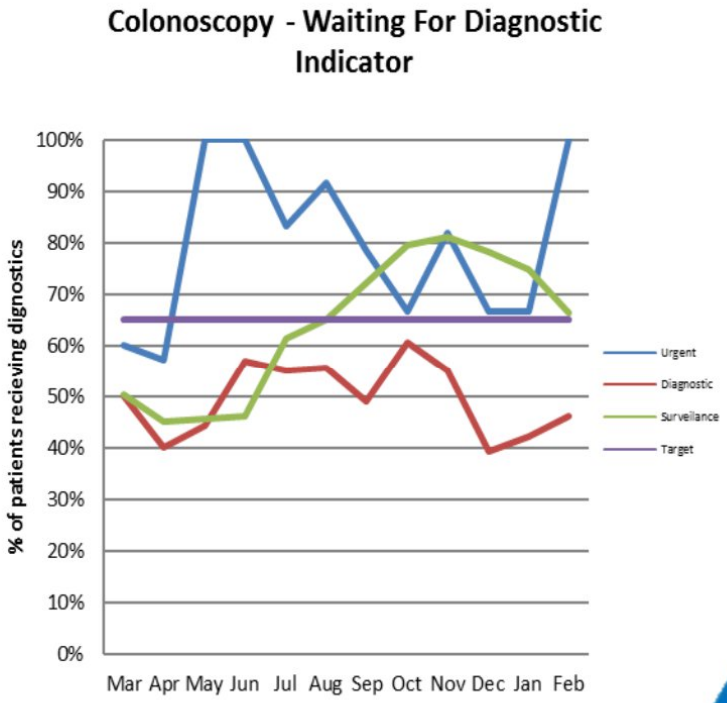
- CCDHB exceeded the Ministry of Health target for urgent colonoscopies achieving 100% (target 90%) but did not meet the target for diagnostic, achieving 46% (target 70%). This is a slight improvement from the January return of 67% and 42%.
- We did not meet the Ministry of Health target for surveillance achieving 66%, a slight drop from January.

What is driving performance?

- At the end of February there were 185 patients who had either a diagnostic or surveillance colonoscopy compared to 88 the previous month. There were 479 patients waiting for either a diagnostic or surveillance colonoscopy compared to 475 the previous month.

Management Comment

- There was an increase in the number of lists in February which contributed to an improved performance. Work continues in-house to improve the number of patients per list and capital was approved to order replacement endoscopes to ensure a fully operational fleet for the department.
- The limitations to maximising the capacity are attributed to the layout of the department, which is inconsistent with contemporary standards for an endoscopy unit. A business case is being prepared for a design team to scope out the work required.



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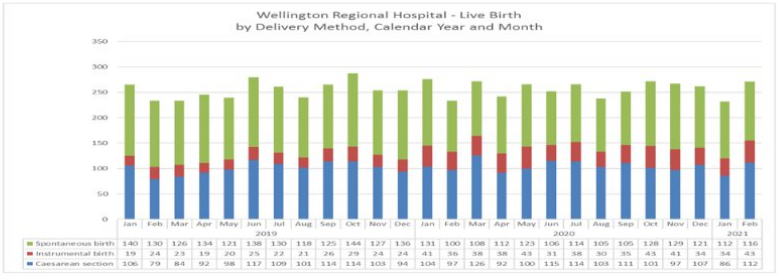
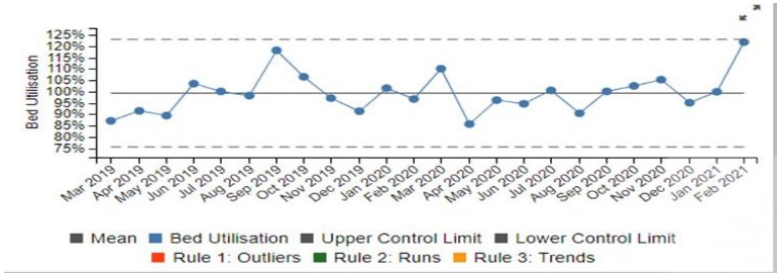
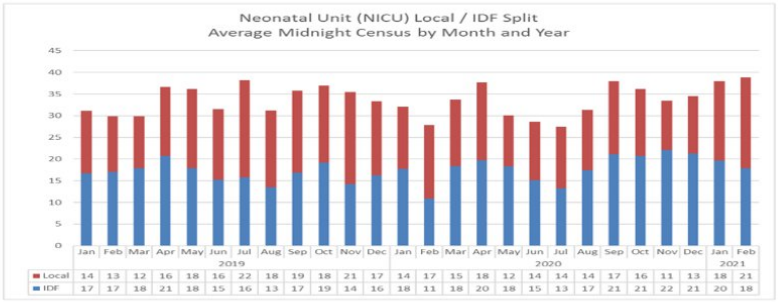
Maternity and Neonatal Intensive Care services







What is the issue?

- The regions maternity units are experiencing increasing pressure due to high demand for inpatient services and workforce challenges.
- The Wellington Regional Hospital Maternity and Delivery Suite and continues to experience a high acuity and bed utilisation. Also impacted by this trend is our Neonatal Intensive Care service.
- As reported both Wellington Regional Hospital (WRH) and Kenepuru maternity unit, have significant Registered Midwifery vacancies (circa 27%) this includes 11 FTE new roles that have been created by CCDM FTE calculations but not yet filled. The NICU had an increase of 27FTEs from CCDM calculation last year but continue to struggle with over occupancies – NB resourced beds are 35.
- Escalation plans are in place and are followed but are being challenged with continued presentations, high acuity, and continued shortages.
- We continue to work closely with our staff and union partners on workforce planning across the region noting this issue as requiring national solutions.

Section 2.3

Mental Health Addiction & Intellectual Disability

Executive Summary – Mental Health Performance

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

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

Indicator	2020/21 Target	13 Months Performance Report												
		2020-Feb	2020-Mar	2020-Apr	2020-May	2020-Jun	2020-Jul	2020-Aug	2020-Sep	2020-Oct	2020-Nov	2020-Dec	2021-Jan	2021-Feb
Access Rate	3%	3.6%		3.7%			3.8%							
Shorter waits for non-urgent Mental Health services <= 3 weeks (Younger Persons Community & Addictions Sector)	80%	51.4%	32.7%	29.8%	43.8%	46.5%	45.6%	45.5%	45.8%	50.8%	42.4%	46.9%		
Shorter waits for non-urgent Mental Health services <= 3 weeks (Adult Community & Addictions Sector)	80%	63.2%	57.7%	47.1%	63.4%	57.2%	55.7%	50.5%	52.9%	49.2%	56.3%	46.7%		
Shorter waits for non-urgent Mental Health services <= 8 weeks (Younger Persons Community & Addictions Sector)	95%	76.5%	48.5%	74.0%	88.1%	81.8%	79.7%	78.8%	76.9%	81.9%	85.4%	80.5%		
Shorter waits for non-urgent Mental Health services <= 8 weeks (Adult Community & Addictions Sector)	95%	86.5%	72.4%	77.2%	93.3%	92.3%	91.0%	88.3%	89.2%	87.6%	86.3%	87.0%		
Community service users seen in person in last 90 days	95%	76.4%	68.8%	54.8%	56.1%	62.9%	76.7%	82.9%	83.8%	81.9%	83.4%	80.8%	77.3%	76.3%
Community DNA rate	<= 5%	7.8%	7.0%	4.0%	5.1%	6.6%	6.9%	6.6%	7.4%	7.3%	8.3%	7.2%	6.7%	7.4%
Maori under Section 29 CTO (Rate per 100,000 population) 2019/20 Target: 10% reduction of rate of previous year (405)		404		395			415							
Wellness Plan Compliance	95%	43.1%		47.3%			45.9%							
Wellness Plans - Acceptable Quality	95%	78.9%		79.3%			82.5%							
Community Services Transition (Service Exit) Plan Compliance	95%	47.6%		53.4%			49.6%							
Community Services Transition (Service Exit) Plans - Acceptable Quality	95%	61.9%		71.6%			71.2%							

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	2020-Feb	2020-Mar	2020-Apr	2020-May	2020-Jun	2020-Jul	2020-Aug	2020-Sep	2020-Oct	2020-Nov	2020-Dec	2021-Jan	2021-Feb
Pre-Admission Community Care	75%	75.5%	70.7%	76.3%	70.2%	76.6%	85.0%	65.3%	81.4%	75.5%	80.4%	78.9%	72.1%	72.7%
Post-Discharge Community Care	90%	88.9%	80.7%	81.5%	89.6%	95.7%	86.8%	72.7%	86.6%	79.5%	82.5%	77.1%	91.7%	69.1%
Acute Inpatient Readmission Rate (28 Day)	<= 10%	7.9%	3.1%	11.9%	8.5%	5.1%	5.0%	4.7%	6.4%	7.5%	3.2%	8.9%	11.0%	6.2%
Inpatient Services Transition Plan	95%	70.5%		72.4%			74.1%							
Inpatient Services Transition Plan - Acceptable Quality	95%	82.7%		74.4%			82.4%							
Clinically Safe Acute Inpatient Occupancy Rate Te Whare Ahuru		102.4%	98.1%	78.1%	77.8%	99.7%	94.6%	97.7%	98.8%	94.0%	99.0%	72.6%	84.4%	86.6%
Clinically Safe Acute Inpatient Occupancy Rate Te Whare O Matairangi		105.1%	101.1%	100.0%	93.2%	106.2%	108.2%	109.3%	105.1%	95.6%	107.9%	96.4%	95.8%	97.7%
Seclusion Hours	Aspirational goal of zero seclusion by 31 December 2020	622	995	733	632	965	590	878	295	383	868	1,007	202	561
Seclusion Hours - Māori		254	682	317	282	620	133	294	85	281	128	267	125	177
Seclusion Hours - Pacific Peoples		289	74	136	116	195	91	72	10	0	229	47	0	106
Seclusion Events		21	32	29	28	27	20	37	27	28	30	23	13	31
Seclusion Events - Māori		13	15	13	14	12	7	12	7	16	12	8	7	12
Seclusion Events - Pacific Peoples		4	4	3	4	9	3	3	1	0	4	3	0	3

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

MHAIDS Quality & Safety Monthly Update Feb 2021

EFFECTIVE SAFETY SYSTEMS TO RECOGNISE RISK AND REDUCE HARM

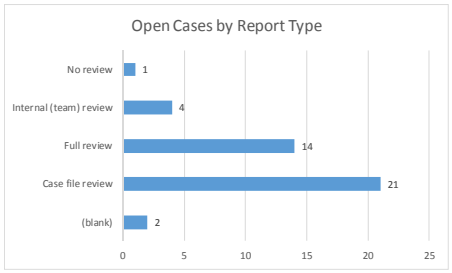
Serious Adverse Events

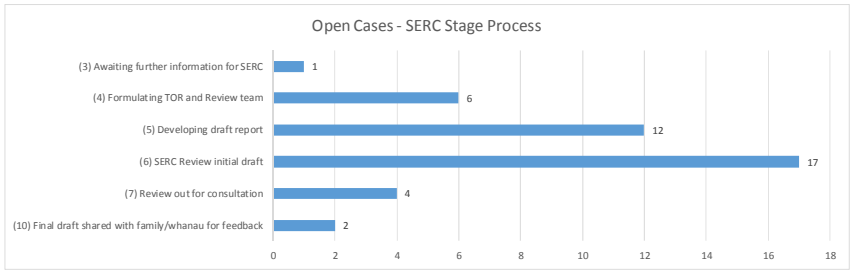
SERC Dashboard - Open Cases

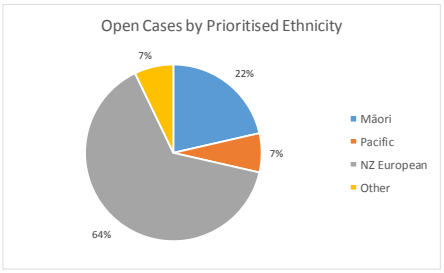
Data Updated: 4/03/2021

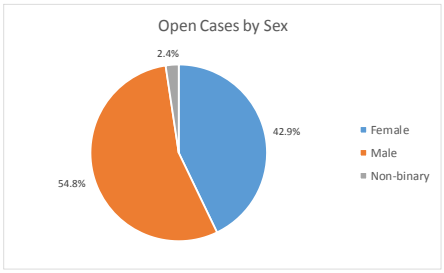
Current Open Cases	SAC 1	SAC 2	SAC N/A or Awaiting Clarification
42	4	23	15

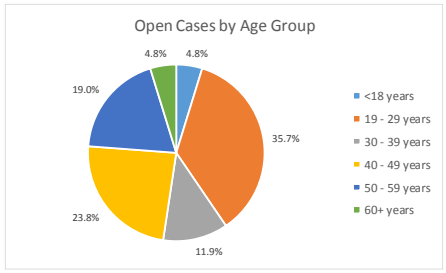
Cases Awaiting Triage	Cases Awaiting Further Info for SERC	Suspected Suicides
0	1	23









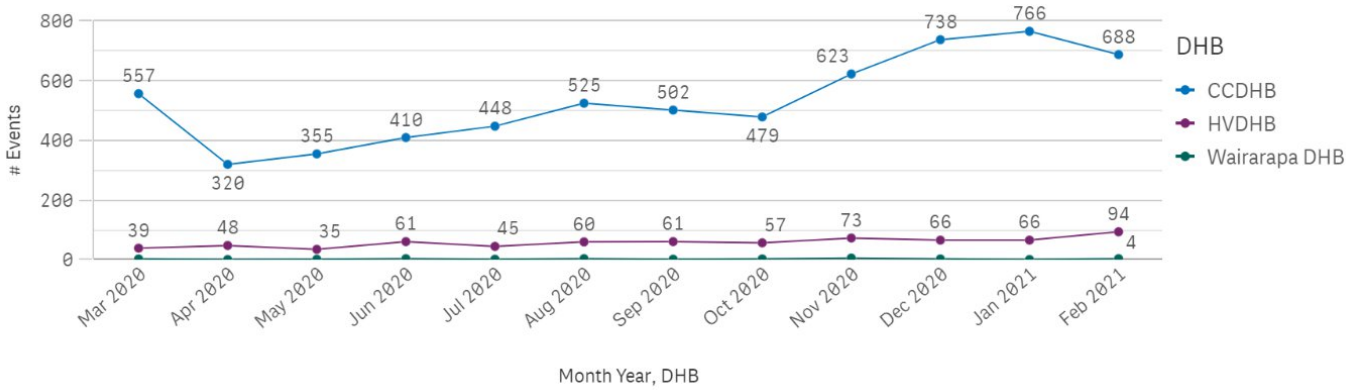


New SER Cases – Feb 2021	
RE Number	SAC Rating
RE99515	Awaiting
RE103143	SAC 2
RE102855	SAC 2
RE103680	N/A
Closed SER Cases – Feb 2021	
RE81971	N/A
RE76164	SAC 2
RE68791	SAC 2

EFFECTIVE SAFETY SYSTEMS TO RECOGNISE RISK AND REDUCE HARM

Reportable Events

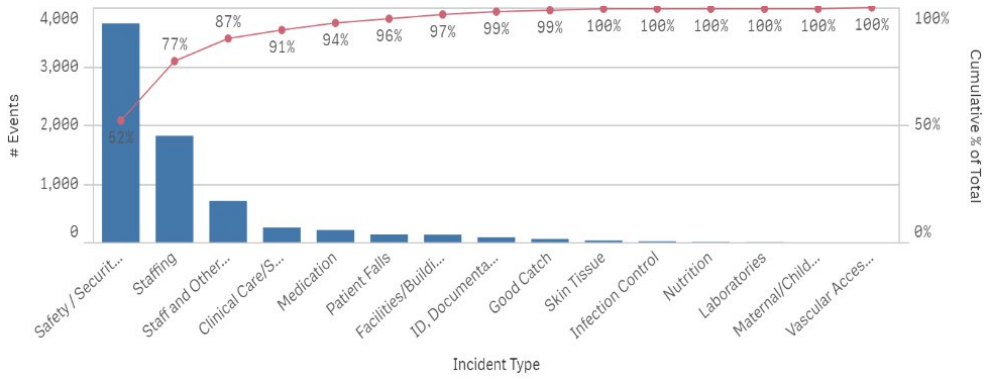
Reportable Events Line Chart - Last 12 Months



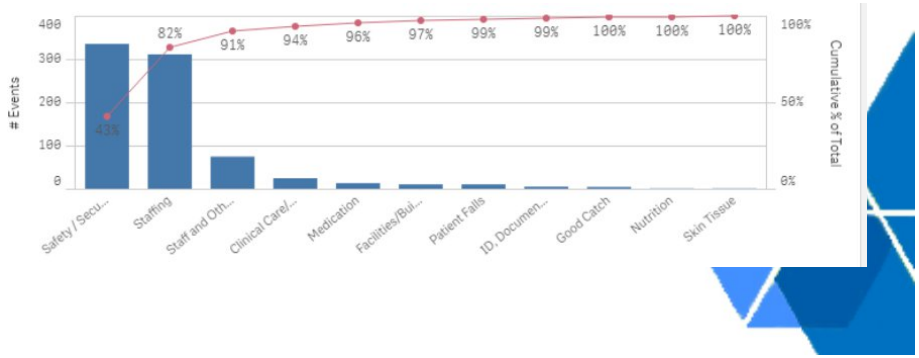
Key Points:

- Safety Security Event type back to top percentage in February - 43%
- Staffing events – 39%
- Increase in number of events reported by both HVDHB and WrDHB teams

Reportable Events by Incident Type - Last 12 Months



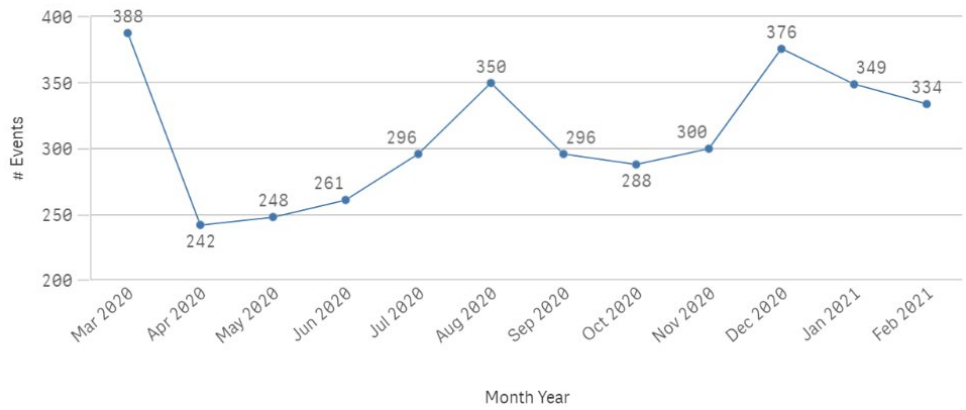
Reportable Events by Incident Type - February



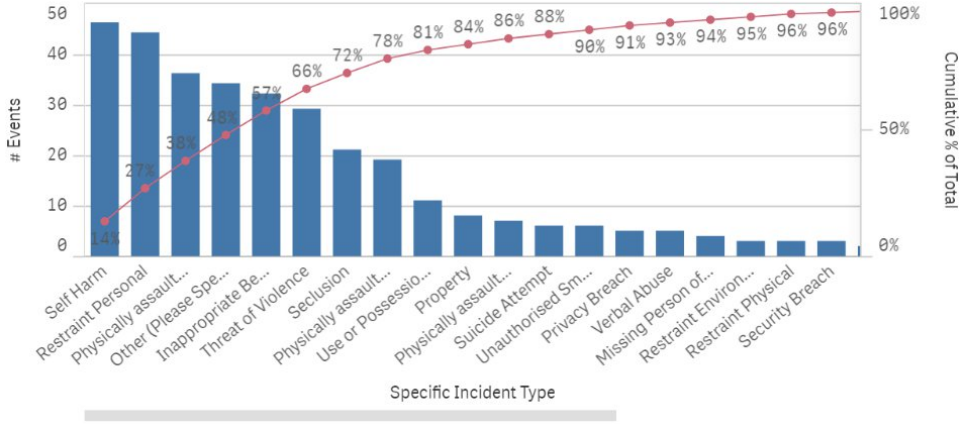
EFFECTIVE SAFETY SYSTEMS TO RECOGNISE RISK AND REDUCE HARM

Reportable Events Continued - Safety

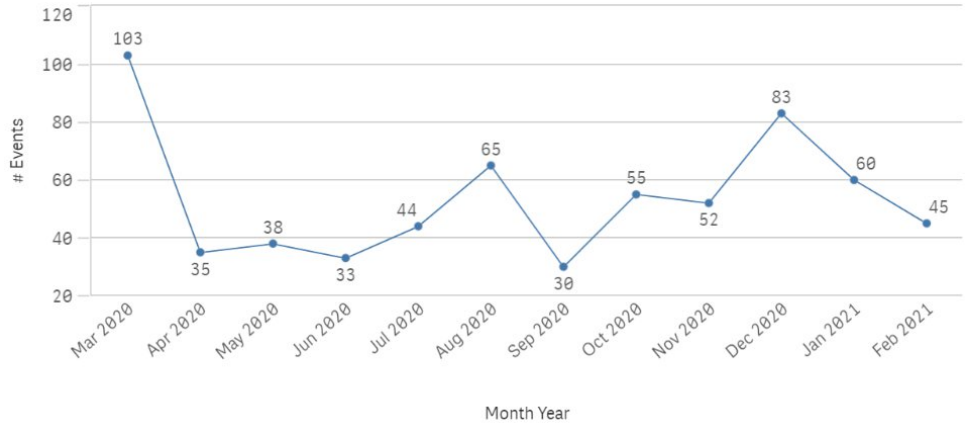
Safety Security & Privacy Events Monthly Comparison last 12 months



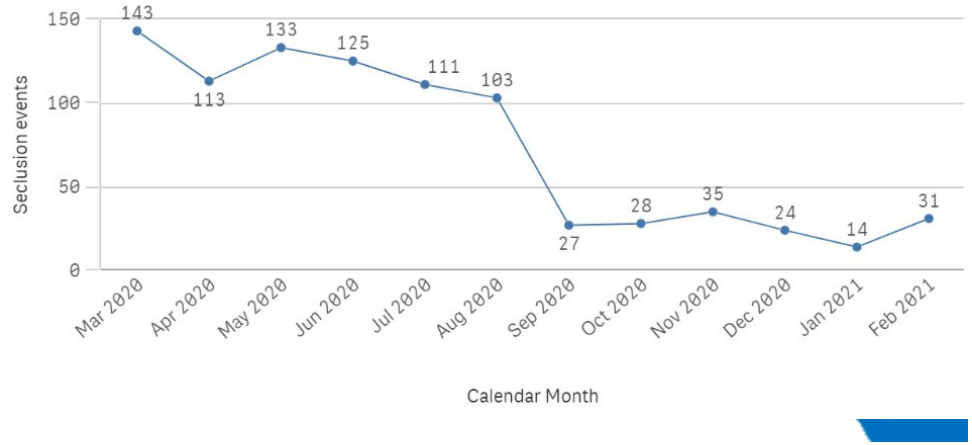
Safety Security & Privacy Events by Type for Feb 2021



Personal Restraint Events Monthly Comparison last 12 months



Seclusion Events Last 12 Months

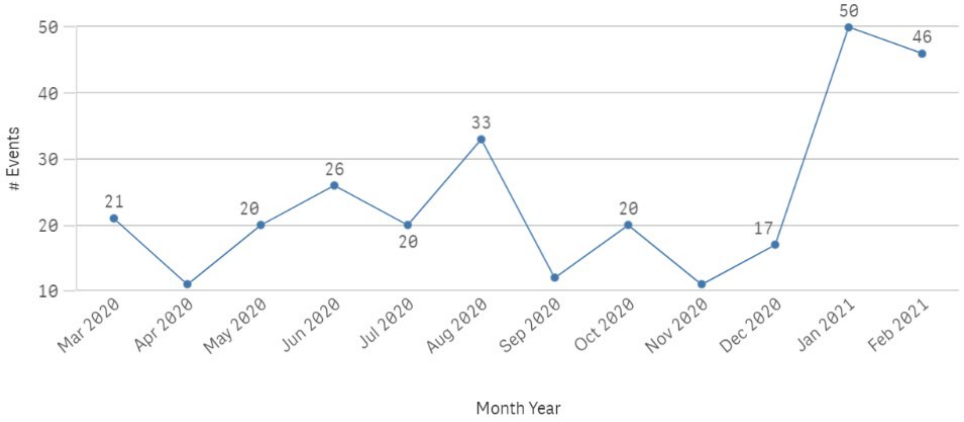


EFFECTIVE SAFETY SYSTEMS TO RECOGNISE RISK AND REDUCE HARM

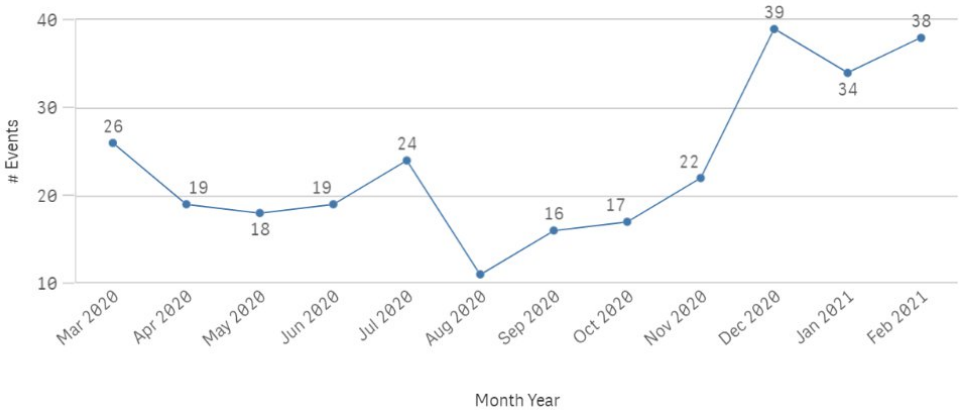
Reportable Events Continued - Safety

Inappropriate Behaviour Events Monthly Comparison last 12 months

Self-Harm Events Monthly Comparison last 12 months



Threat of Violence Events Monthly Comparison last 12 months



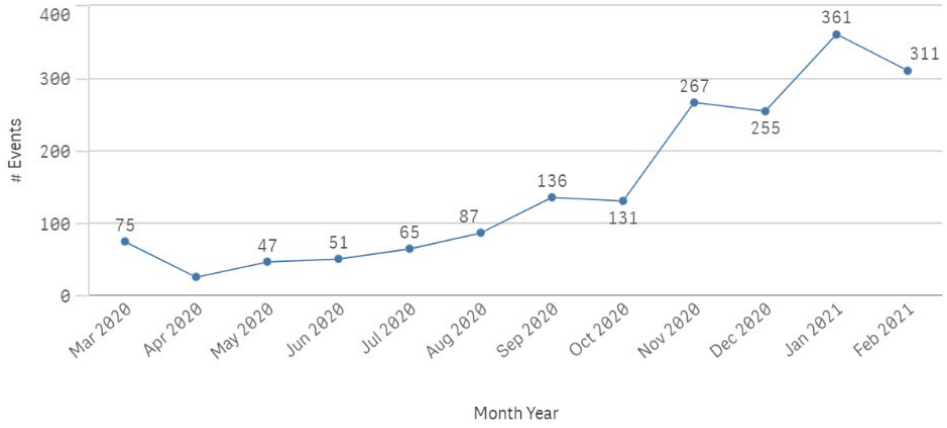
Key Points – Safety & Security Events:

- Drop in Personal Restraint events reported in February. IRS accounting for 73% of these. RRAIS reporting highest number of 14 and Te Whare Ahuru 13.
- Seclusion events increased with 86% of these occurring in IRS.
  10-TWA, 7- TWoM, 1 RRAIS.
- RRAIS reported 31 (67%) of the self harm events.
- Forensic & Rehab reported 16 (44%) of the Inappropriate behaviour events.
- Intellectual Disability Services reported 14 (48%) of Threat of violence events.

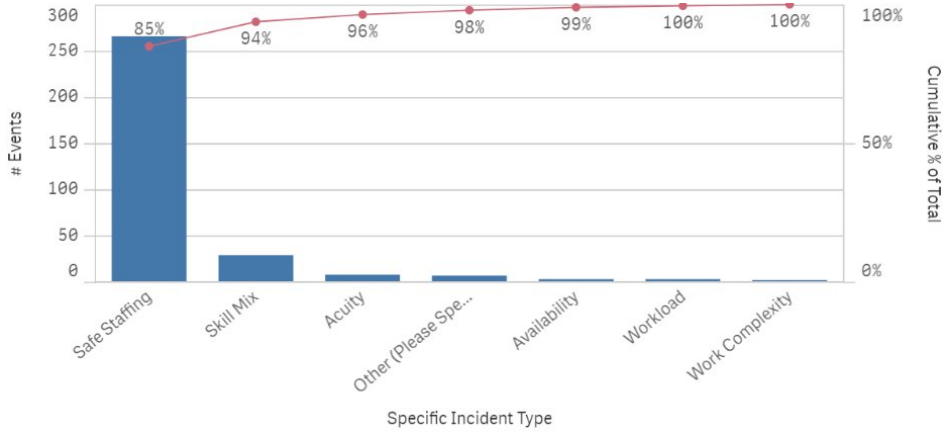
EFFECTIVE SAFETY SYSTEMS TO RECOGNISE RISK AND REDUCE HARM

Reportable Events Continued - Staffing

Staffing Events Monthly Comparison last 12 months



Staffing Events by Type for Feb 2021

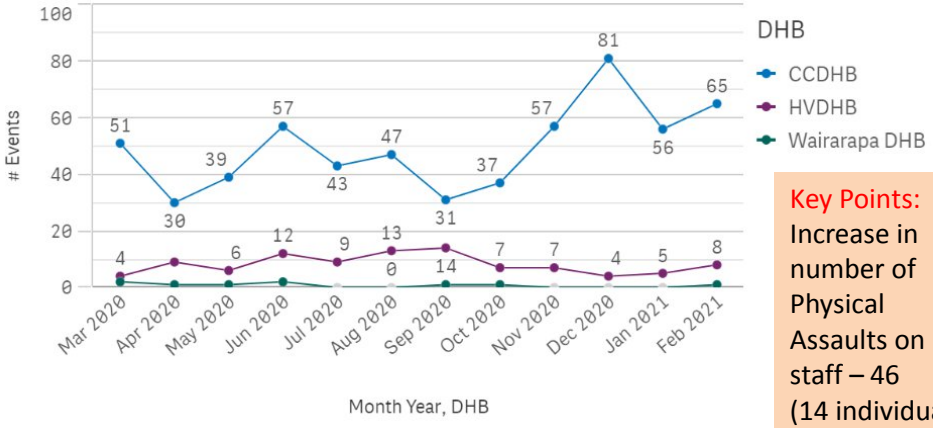


Key Points:

- Small reduction in number reported in February
- 190 safe staffing events reported by ID services (72%)
- 46 – IRS (Ra Uta-18, TWA-17, RRAIS-7, CRS-2, TWoM-2)
- 28 – Forensic & Rehab. (Tane Mahuta-23)

EFFECTIVE SAFETY SYSTEMS TO RECOGNISE RISK AND REDUCE HARM

Health and Safety Events Monthly Comparison last 12 months



Reportable Events Health and Safety Measures – Feb 2021

All Staff and Other Health and Safety Events
74

BBFE Events
0

Slips, Trips and Falls
3

All Manual Handling Events
1

Manual Handling Patient
1

Manual Handling Object
0

Physical Assaults on Staff
46

Key Points:

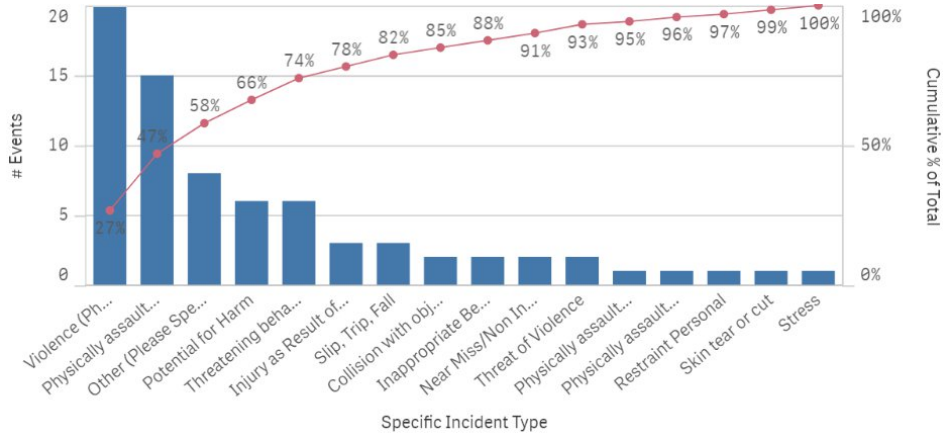
Increase in number of Physical Assaults on staff – 46 (14 individuals responsible for these)

20 events reported by Older Persons Service.

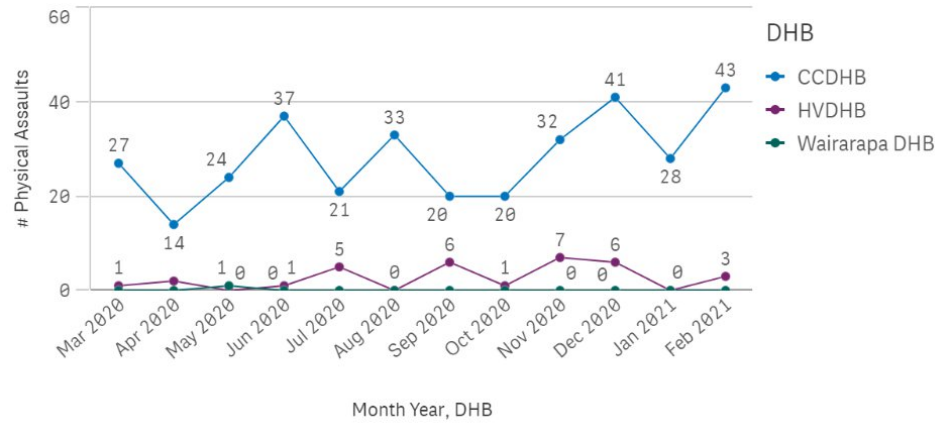
7 events reported by Youth Secure Forensic Unit (1 individual responsible for 5 events)

Reportable Events Continued – Health & Safety

Health and Safety Events by Type for Feb 2021



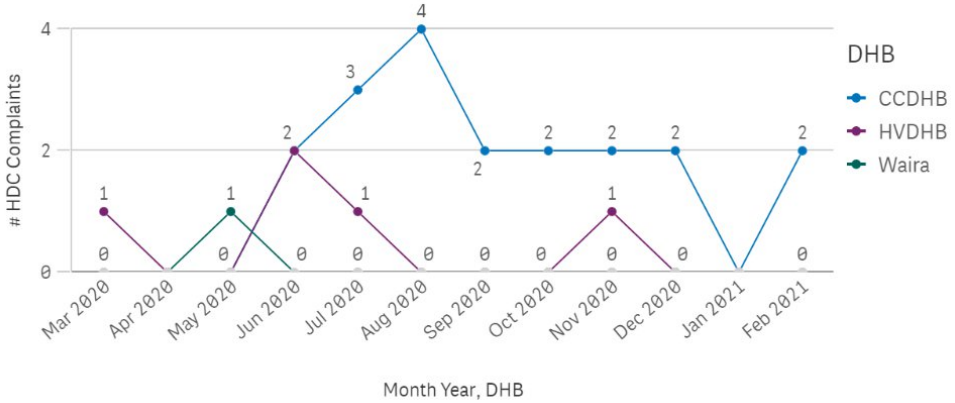
Physical Assaults on Staff Monthly Comparison last 12 months



PERSON & WHĀNAU CENTRED CARE

HDC Complaints

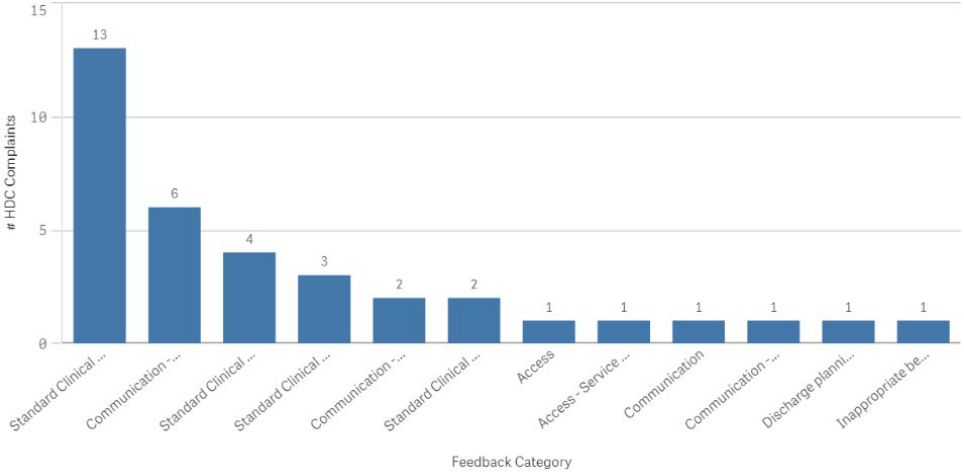
HDC Complaints last 12 months



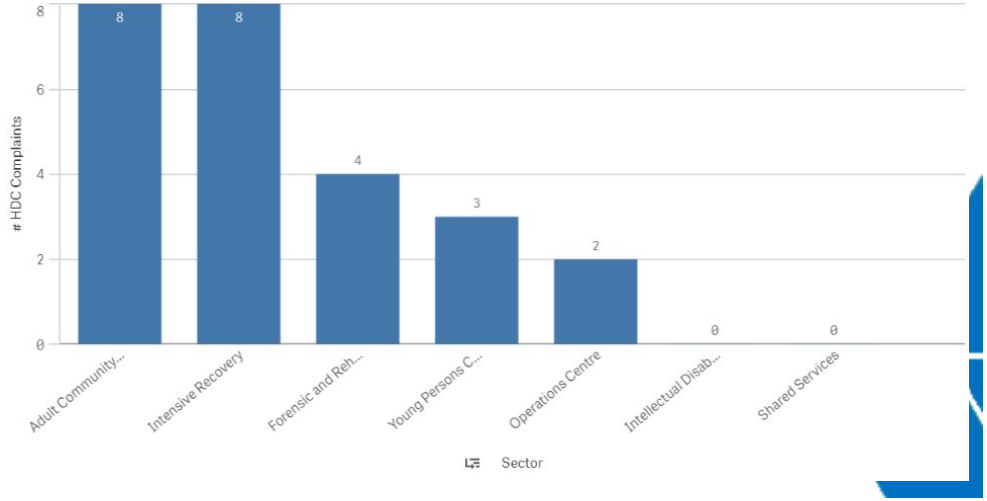
Key Points – HDC Complaints:

- 2 HDC complaints received
- 4 Closed by HDC
  - 3 with no action
  - 1 to be used as anonymized case study and MHAIDS to consider further improvements to transition process. (Work already underway on this)

HDC Complaints by Feedback Category - last 12 months



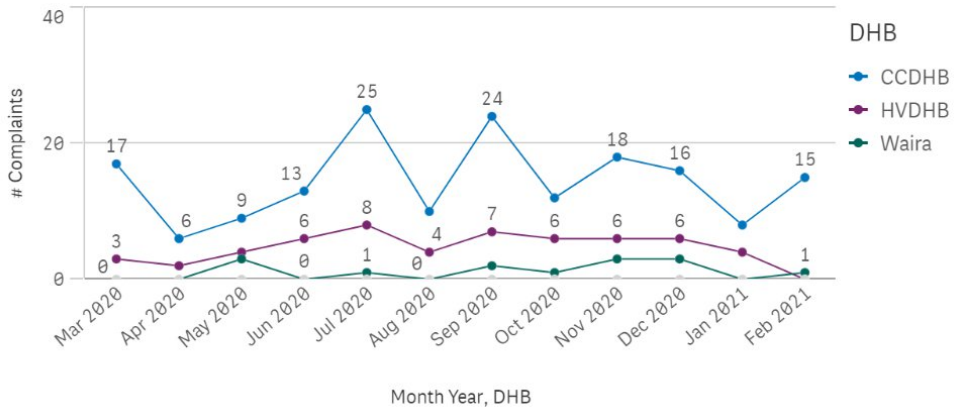
HDC Complaints by Sector / Team - last 12 months



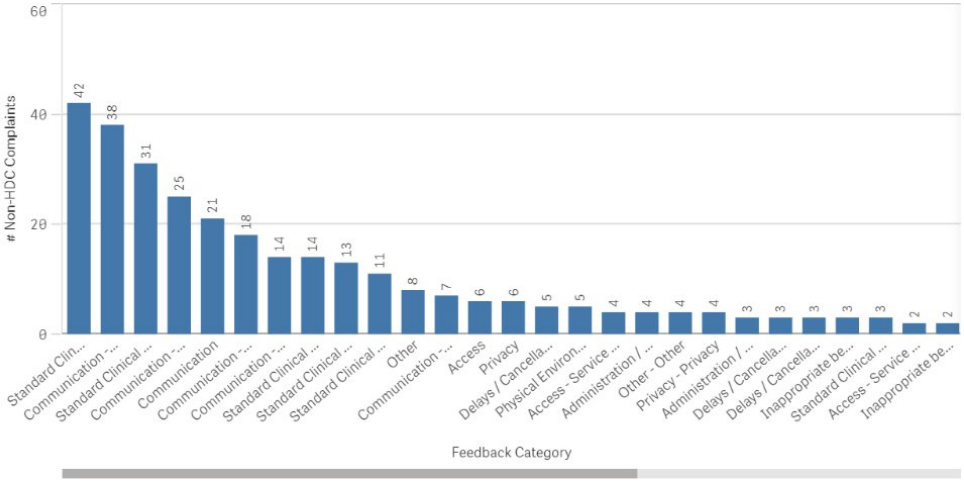
PERSON & WHĀNAU CENTRED CARE

Non-HDC Complaints

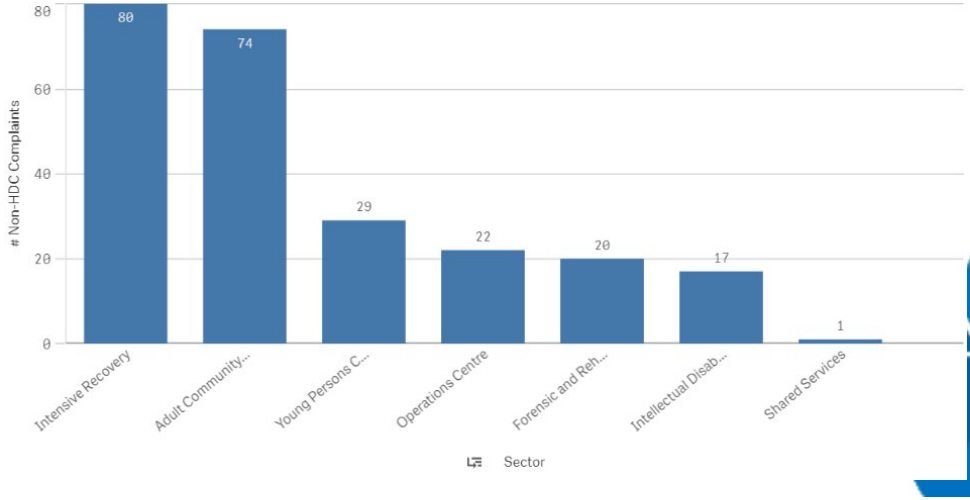
Non-HDC Complaints last 12 months



Non-HDC Complaints by Feedback Category - last 12 months



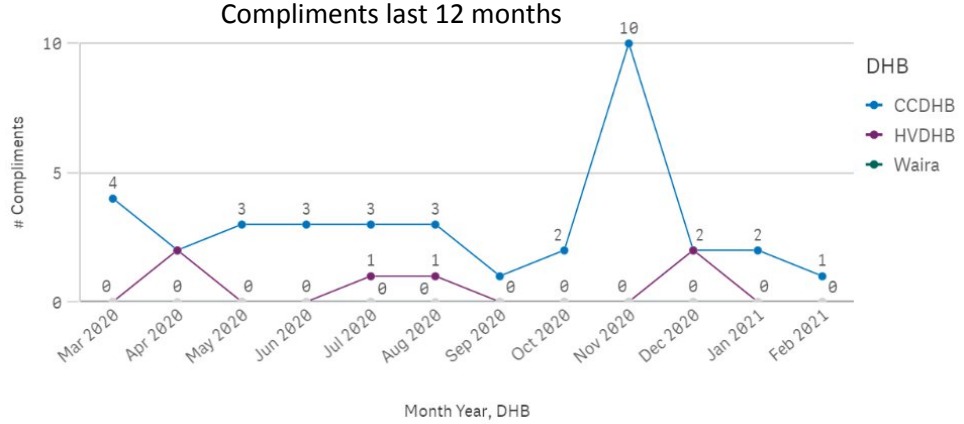
Non-HDC Complaints by Sector / Team - last 12 months



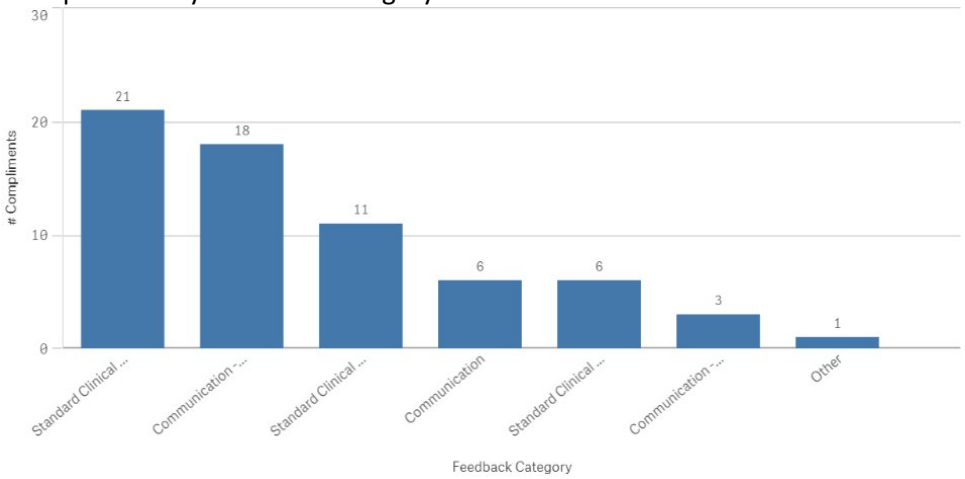
PERSON & WHĀNAU CENTRED CARE

Compliments

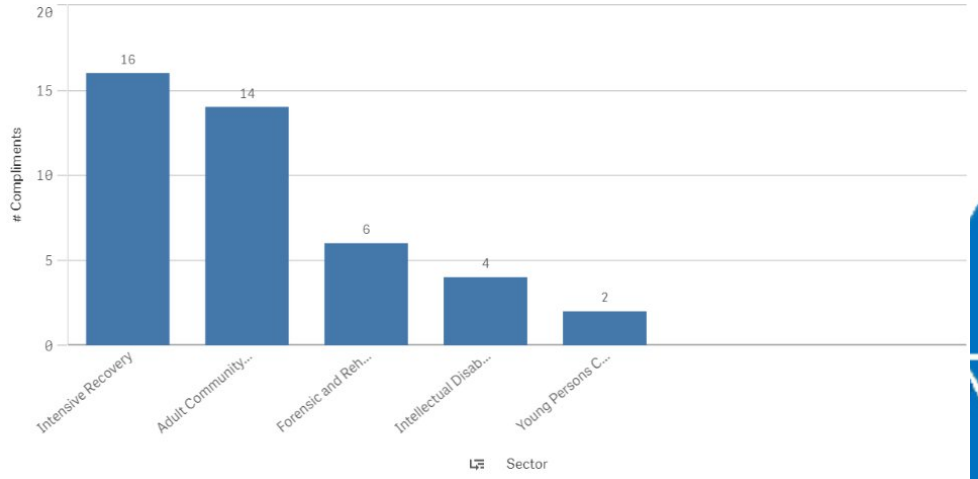
Compliments last 12 months



Compliments by Feedback Category - last 12 months



Compliments by Sector / Team - last 12 months



Audit Committee

Audits due in March:

- Hand Hygiene
- Pharmaceutical Fridge monitoring/cleaning
- Resuscitation Trolley
- Wellness Plans
- Service Exit Plans

Section 3

Financial Performance and Sustainability

Executive Summary Financial Performance and Position

- The DHB has budgeted a deficit of $39.8 million. The responsible deficit YTD was $8m 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:
  - ($11.5m); COVID-19: additional costs during COVID-19
  - ($5.3m); 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, $20.7 million relates to our YTD from both personnel vacancies, efficiency savings across all services and ICT gains through consolidation and rationalisation.
- The DHB also had a number of key safe care initiatives totalling $15.8m some of which are still due to start within the year.
- The DHB's cash is under pressure for 2020/21 due to level of deficit support lower than last years deficit and no cash funding provided for provider arm COVID-19 costs. This was mitigated at year end by a delay to payment of capital charge, increase in leave liabilities (as this is non cash) and significant delays to our capex spend (offset by non cash depreciation). The DHB by the start of February was already ($17.7m) in overdraft, offset by $13m in special fund balances. Moving to ten day payment of creditors as required has had an estimated impact of around $8m on the DHB cash balance.
- COVID-19 from the first outbreak continues to incur some additional costs and also disruption to normal BAU for some components of the hospital operation and management. We have put in place tracking and monitoring systems to enable all the costs to be captured and reported to the Ministry, the key items of which are shown on the next slide, this is in addition to the unfunded ($8m) from the prior financial year in which cash has not been provided.

COVID-19 Revenue and costs & Holidays Act

Last Year			Capital & Coast DHB Operating Results - $000s	This Year to Date			Total Provision/Expense	
COVID-19 change from Trend - Provider	COVID-19 change from Trend - Funder	Holidays Act [2003]	YTD February 2021	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	(1,621)	(12,827)		(22,764)	0
			Non-Devolved MoH Revenue				0	0
2,037			Other Revenue	693			2,730	0
			IDF Inflow				0	0
			Inter DHB Provider Revenue			(44)	0	(44)
2,037	**(8,317)**	**0**	**Total Revenue**	**(928)**	**(12,827)**	**(44)**	**(20,035)**	**(44)**
			Personnel					
(1,610)		(2,049)	Medical	(4,107)		(1,575)	(5,717)	(25,712)
(1,620)		(9,145)	Nursing	(3,425)		(2,581)	(5,045)	(42,148)
		(1,370)	Allied Health			(430)	0	(7,015)
		32	Support			(115)	0	(1,882)
		168	Management & Administration			(493)	0	(7,961)
(3,230)	**0**	**(12,365)**	**Total Employee Cost**	**(7,531)**	**0**	**(5,194)**	**(10,761)**	**(84,719)**
			Outsourced Personnel					
(51)			Medical	(88)		(16)	(139)	(16)
			Nursing				0	0
			Allied Health				0	0
			Support				0	0
			Management & Administration				0	0
(51)	**0**	**0**	**Total Outsourced Personnel Cost**	**(88)**	**0**	**(16)**	**(139)**	**(16)**
2,834			Treatment related costs - Clinical Supp	(1,654)			1,180	0
(1,952)			Treatment related costs - Outsourced	(564)			(2,516)	0
(1,921)			Non Treatment Related Costs	(1,970)		(178)	(3,891)	(178)
			IDF Outflow				0	0
	(9,917)		Other External Provider Costs (SIP)		(13,393)		(23,310)	0
			Interest Depreciation & Capital Charge				0	0
(1,039)	**(9,917)**	**0**	**Total Other Expenditure**	**(4,188)**	**(13,393)**	**(178)**	**(28,537)**	**(178)**
(4,320)	**(9,917)**	**(12,365)**	**Total Expenditure**	**(11,808)**	**(13,393)**	**(5,388)**	**(39,437)**	**(84,913)**
6,357	**1,600**	**12,365**	**Net result excl. Additional Budget**	**10,880**	**566**	**5,344**	**19,403**	**84,869**
			Additional Budget					
6,357	**1,600**	**12,365**	**Net result**	**10,880**	**566**	**5,344**	**19,403**	**84,869**

- The year to date financial position includes $11.5m additional costs in relation to COVID-19.
- Revenue of $13.8m has been received to fund additional costs for community providers however this has not been sufficient for these costs
- Additional personnel costs of $5.3m have been accrued YTD for the Holidays Act
- COVID-19 costs are spread across personnel, clinical supplies, outsourced treatment and infrastructure and non-clinical costs.

CCDHB Operating Position – February 2021

Month - February 2021									Capital & Coast DHB Operating Results - $000s	Year to Date									
			Variance		Adjustments			Variance					Variance		Adjustments			Variance
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	COVID-19 change from Trend	Holidays Act [2003]	Actuals exc COVID/HA	Actuals exc COVID vs Budget	YTD February 2021	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	COVID-19 change from Trend	Holidays Act [2003]	Actuals exc COVID-19 / HA	Actuals exc COVID vs Budget
78,477	77,550	73,412	927	5,065	1,338		77,139	(411)	Devolved MoH Revenue	633,856	620,400	585,953	13,456	47,902	14,448		619,408	(992)
3,509	3,386	3,506	123	4			3,509	123	Non-Devolved MoH Revenue	29,210	28,405	27,965	806	1,245			29,210	806
2,955	2,790	2,734	165	221	(25)		2,980	191	Other Revenue	38,339	23,055	25,980	15,284	12,359	(693)		39,032	15,977
21,218	21,452	20,081	(235)	1,136			21,218	(235)	IDF Inflow	169,984	171,619	155,915	(1,635)	14,069			169,984	(1,635)
4,063	733	800	3,330	3,263			4,063	3,330	Inter DHB Provider Revenue	25,760	6,165	6,903	19,595	18,856		44	25,760	19,595
110,222	**105,911**	**100,534**	**4,311**	**9,688**	**1,313**	**0**	**108,909**	**2,998**	**Total Revenue**	**897,149**	**849,643**	**802,717**	**47,506**	**94,432**	**13,755**	**44**	**883,393**	**33,750**
									Personnel									
14,218	14,239	13,739	21	(478)	433	182	13,603	636	Medical	123,042	121,479	115,424	(1,563)	(7,618)	4,107	1,575	117,361	4,118
20,480	18,597	17,450	(1,883)	(3,030)	318	298	19,864	(1,267)	Nursing	168,368	153,511	146,786	(14,857)	(21,582)	3,425	2,581	162,362	(8,851)
5,818	5,318	4,865	(500)	(953)		50	5,768	(450)	Allied Health	49,182	45,287	40,786	(3,895)	(8,396)		430	48,752	(3,465)
815	848	799	33	(16)		13	802	46	Support	6,968	7,261	7,025	293	57		115	6,853	408
6,716	6,009	5,638	(706)	(1,078)		56	6,660	(650)	Management & Administration	53,688	52,120	48,307	(1,567)	(5,381)		493	53,195	(1,074)
48,047	**45,012**	**42,491**	**(3,035)**	**(5,555)**	**751**	**600**	**46,696**	**(1,685)**	**Total Employee Cost**	**401,248**	**379,658**	**358,327**	**(21,590)**	**(42,920)**	**7,531**	**5,194**	**388,523**	**(8,865)**
									Outsourced Personnel									
732	421	194	(311)	(539)	(135)	0	868	(446)	Medical	6,141	3,517	3,249	(2,625)	(2,892)	88	16	6,037	(2,521)
33	24	128	(9)	95			33	(9)	Nursing	392	199	1,264	(194)	871			392	(194)
175	113	26	(62)	(149)			175	(62)	Allied Health	995	909	242	(86)	(753)			995	(86)
30	22	76	(8)	46			30	(8)	Support	279	175	814	(104)	535			279	(104)
204	76	11	(128)	(193)			204	(128)	Management & Administration	2,780	644	618	(2,136)	(2,162)			2,780	(2,136)
1,174	**656**	**435**	**(518)**	**(739)**	**(135)**	**0**	**1,310**	**(653)**	**Total Outsourced Personnel Cost**	**10,587**	**5,443**	**6,187**	**(5,145)**	**(4,400)**	**88**	**16**	**10,484**	**(5,041)**
10,485	10,577	11,096	92	612	166		10,319	258	Treatment related costs - Clinical Supp	88,121	88,191	90,430	70	2,309	1,654		86,467	1,723
2,467	2,552	474	85	(1,993)	(135)		2,602	(51)	Treatment related costs - Outsourced	16,672	18,341	5,062	1,669	(11,610)	564		16,108	2,233
8,407	6,824	11,019	(1,583)	2,611	(135)	45	8,497	(1,673)	Non Treatment Related Costs	70,088	55,192	91,049	(14,896)	20,961	1,970	178	67,939	(12,747)
8,968	8,965	(2,243)	(3)	(11,211)			8,968	(3)	IDF Outflow	72,161	71,723	(20,456)	(438)	(92,617)			72,161	(438)
26,362	26,237	33,789	(125)	7,427	1,573		24,789	1,448	Other External Provider Costs (SIP)	228,018	210,581	275,318	(17,437)	47,300	13,393		214,625	(4,044)
4,624	4,755	393	131	(4,231)			4,624	131	Interest Depreciation & Capital Charge	37,254	38,732	3,095	1,477	(34,159)			37,254	1,477
61,313	**59,910**	**56,106**	**(1,403)**	**(5,207)**	**1,469**	**45**	**59,800**	**111**	**Total Other Expenditure**	**512,315**	**482,760**	**457,126**	**(29,555)**	**(55,189)**	**17,581**	**178**	**494,555**	**(11,796)**
110,534	**105,578**	**99,032**	**(4,956)**	**(11,502)**	**2,084**	**645**	**107,806**	**(2,227)**	**Total Expenditure**	**924,150**	**867,861**	**821,640**	**(56,289)**	**(102,510)**	**25,201**	**5,388**	**893,561**	**(25,701)**
(312)	**332**	**1,501**	**(644)**	**(1,813)**	**(770)**	**(645)**	**1,103**	**771**	**Net result excl. Additional Budget**	**(27,001)**	**(18,217)**	**(18,923)**	**(8,784)**	**(8,078)**	**(11,446)**	**(5,344)**	**(10,168)**	**8,050**
0	0	0	0	0	0	0			Additional Budget	0	0	0	0	0				
(312)	**332**	**1,501**	**(644)**	**(1,813)**	**(770)**	**(645)**	**1,103**	**771**	**Net result**	**(27,001)**	**(18,217)**	**(18,923)**	**(8,784)**	**(8,078)**	**(11,446)**	**(5,344)**	**(10,168)**	**8,050**
5,785	5,012	93,384	772	(87,599)					Funder	4,763	7,665	748,464	(2,902)	(743,702)				
147	0	(5,326)	147	5,474					Governance	610	(0)	(44,027)	610	44,637				
(6,244)	(4,680)	(86,285)	(1,564)	80,041					Provider	(32,374)	(25,883)	(721,145)	(6,492)	688,771				
(312)	**332**	**1,772**	**(644)**	**(2,084)**					**Net result**	**(27,001)**	**(18,217)**	**(16,708)**	**(8,784)**	**(10,293)**				

Note two adjustments are made for

1. COVID-19 and
2. Holidays Act.

These two items form part of the DHB deficit; as revenue from MoH/Government has not been received to offset these costs, but is excluded from our responsible deficit and was excluded from our budget submission.

Executive Summary – Financial Variances

- The DHB deficit year to date is ($27m)
- Included within this result is recognition of the adjustment to the holiday act provision ($5.3m) and an estimated impact of COVID-19 of ($11.5m).
- Excluding the two items above brings the deficit for the year into deficit of ($10.2m) being $8m favourable to budget.
- Revenue is favourable by $33.7m YTD, after excluding COVID-19, lead DHB changes this is on budget. The variances are due to mental health national contracts, special fund/ research revenue offset by donation and interest revenue. Inpatient IDF revenue was recognised behind target by ($1.2m), with planned care (electives) set to target whilst the year gets underway.
- Personnel costs including outsourced is ($26.7m) YTD, excluding the Holidays Act provision ($5.2m) and the COVID-19 related costs of ($7.6m) incurred the net unfavourable variance is ($13.9m). This ($13.9m) net unfavourable variance has been more than offset by the transfer of Mental Health and ICT services to CCDHB from other DHBs ($15.9m). CCDHB receives revenue to fully cover the costs of the transferred services and this is recognised in the ytd result.
- Treatment related clinical supplies $510k drugs, prostheses, grafts and outreach clinics.
- Outsourced clinical services is favourable YTD by $1.7m; favourable movement due to outsourced surgical service delayed compared to budget plan, however this is offset by the increase in MRI, CT Scans and other radiology services.
- Non treatment related costs ($13.4m) YTD unfavourable, however after excluding COVID-19, lead DHB changes and settlement this was a $6m favourable variance; which is due to lower spend on asset maintenance, and new investment initiatives not yet commenced.
- The funder arm is unfavourable YTD due to additional spend requirements for our community COVID-19 response which are not all funded. Some new programmes in the NGO space have commenced alongside increased revenue to support these initiatives.

Analysis of the Operating Position – Revenue and Personnel

Revenue

- Revenue is on budget YTD (after lead DHB and other items indicated on previous page) despite recognising IDFs being behind target by ($1.2m)
- The variance is due to revenue for special funds/research of $628k, Interest due to overdraft situations ($345k), Donations ($675k) MHAIDS non-lead DHB revenue of $802k. The funder arm is also unfavourable by $1.6m revenue however with offsetting community cost.

Personnel (inc outsourced)

- Medical Personnel is ($21k) favourable for the month, YTD unfavourable by ($1.7m). The favourable position for the month is due to transfer of costs to CCDHB for MHAIDs services (~$336k), Holidays Act provisions ($182k) and the year to date exc MHAIDS, Holidays Act was a favourable variance of $1.6m is driven by vacancies across other services, most notably surgery and Women's and Children's services offset by COVID expenditure.
- Nursing Personnel is ($1.9m) unfavourable to budget for the month, YTD ($14.9m) unfavourable. This is driven by overspend to budget for MHAIDs, partially driven by the transfer of staff from other DHBs to CCDHB.
- Allied Personnel labour is ($500k) unfavourable to budget for the month, YTD ($3.9m) unfavourable to budget. $3m of the YTD variance results from the transfer of staff from other DHBs to CCDHB.
- Support Personnel labour month position is favourable by $293k, YTD favourable by $33k.
- Management/Admin Personnel is unfavourable in the month by $706k, YTD unfavourable by ($1.6m). $3.5m YTD of this variance has corresponding offsetting revenue within ICT, the remainder is spread across the organisation and driven largely by the use of outsourced contractors.

Section 4

Financial Position

Cash Management – February 2021

Month : Feb 2021						Capital & Coast DHB Statement of Cashflows	Year to Date				
			Variance							Variance	
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	Notes	YTD Feb 2021	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year
						Payments					
46,949	45,974	41,879	(975)	(5,070)		Payments to employees	397,093	367,792	366,073	(29,301)	(31,020)
62,436	61,113	57,228	(1,323)	(5,208)		Payments to suppliers	496,912	505,140	473,046	8,228	(23,866)
9,735	0	0	(9,735)	(9,735)		Capital Charge paid	21,845	23,465	12,297	1,619	(9,549)
(7,778)	(137)	464	7,641	8,241		GST (net)	(10,142)	1,094	(44)	11,236	10,098
111,343	**106,951**	**99,571**	**(4,392)**	**(11,772)**		**Payments - total**	**905,708**	**897,490**	**851,371**	**(8,218)**	**(54,337)**
11,654	**4,758**	**5,088**	**6,896**	**6,566**	**6**	**Net cash flow from operating Activities**	**17,685**	**(3,824)**	**183**	**21,509**	**17,502**
						Investing Activities					
4	75	119	71	115		Receipts - Interest	**154**	**600**	**762**	**445**	**608**
0	0	0	0	0		Receipts - Other	0	0	500	0	500
4	**75**	**119**	**71**	**115**		**Receipts - total**	**154**	**600**	**1,262**	**445**	**1,108**
						Payments					
0	0	0	0	0		Investment in associates	0	0	0	0	0
5,080	5,511	2,448	431	(2,631)		Purchase of fixed assets	39,954	44,087	24,223	4,133	(15,732)
5,080	**5,511**	**2,448**	**431**	**(2,631)**		**Payments - total**	**39,954**	**44,087**	**24,223**	**4,133**	**(15,732)**
(5,076)	**(5,436)**	**(2,330)**	**502**	**(2,516)**	**7**	**Net cash flow from investing Activities**	**(39,800)**	**(43,487)**	**(22,961)**	**4,578**	**(14,624)**
						Financing Activities					
0	0	0	0	0		Equity - Capital	0	0	0	0	0
0	0	0	0	0		Other Equity Movement	7,382	0	10,650	7,382	(3,268)
0	0	0	0	0		Other	0	0	(55)	0	(55)
0	**0**	**0**	**0**	**0**		**Receipts - total**	**7,382**	**0**	**10,594**	**7,382**	**(3,213)**
						Payments					
0	**0**	**0**	**0**	**0**		Interest payments	**8**	**0**	**0**	**(8)**	**(8)**
0	**0**	**0**	**0**	**0**		**Payments - total**	**8**	**0**	**0**	**(8)**	**(8)**
0	**0**	**0**	**0**	**0**	**8**	**Net cash flow from financing Activities**	**7,374**	**0**	**10,594**	**7,374**	**(3,221)**
6,578	**(678)**	**2,758**	**7,399**	**4,050**		**Net inflow/(outflow) of CCDHB funds**	**(14,741)**	**(47,312)**	**(12,183)**	**33,461**	**(343)**
(3,084)	(28,397)	(6,858)	(25,313)	(3,775)		**Opening cash**	18,236	18,236	8,083	0	(10,153)
123,000	111,783	104,778	11,360	18,453		Net inflow funds	930,929	894,265	863,411	37,555	69,734
116,422	112,462	102,019	(3,961)	(14,403)		Net (outflow) funds	945,671	941,577	875,594	(4,094)	(70,077)
6,578	**(678)**	**2,758**	**7,399**	**4,050**		**Net inflow/(outflow) of CCDHB funds**	**(14,741)**	**(47,312)**	**(12,183)**	**33,461**	**(343)**
3,495	**(29,075)**	**(4,100)**	**32,570**	**7,595**		**Closing cash**	**3,495**	**(29,075)**	**(4,100)**	**32,570**	**7,595**

Capital and Coast DHB
RECONCILIATION OF CASH FLOW TO OPERATING BALANCE

	YTD Feb 2021		
	Actual $000	Budget $000	Variance $000
Net Cashflow from Operating	**17,685**	**(3,824)**	21,509
Non operating financial asset items	**(66)**	-	(66)
Non operating non financial asset items	**(2,441)**	**(2,040)**	(401)
Non cash PPE movements			
Depreciation & Impairment on PPE	(21,784)	(21,516)	(268)
Gain/Loss on sale of PPE	0	-	0
Total Non cash PPE movements	**(21,784)**	**(21,516)**	**(268)**
Working Capital Movement			
Inventory	557	-	557
Receipts and Prepayments	40,234	12,100	28,134
Payables and Accruals	(61,185)	(2,935)	(58,250)
Total Working Capital movement	**(20,394)**	**9,165**	**(29,559)**
Operating balance	**(27,000)**	**(18,216)**	(8,784)

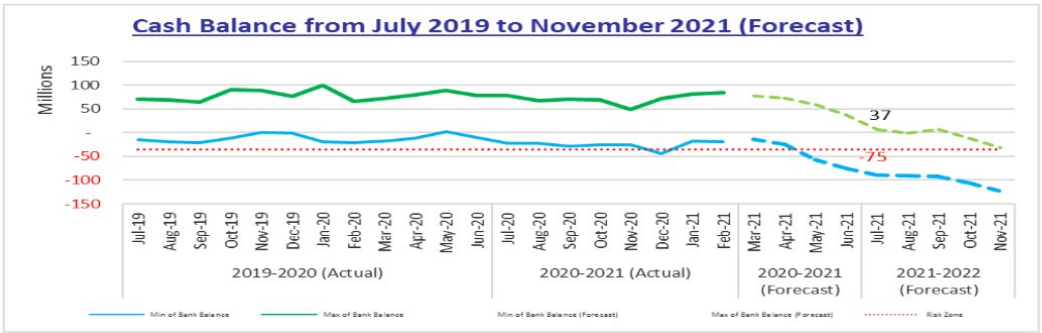
Current Ratio – This ratio determines the DHB's ability to pay back its short term liabilities.
DHB's current ratio improved to 0.34 from 0.31 last month;
Debt to Equity Ratio – This ratio determines how the DHB has financed the asset base.

DHB's total liability to equity ratio also improved to 78% from 83% because of $15.3M Capital injection for Children's Hospital.

Debt Management / Cash Forecast – February 2021

Accounts Receivable
28-Feb-21

Aged Debtors report ($'000)	Total	Current	1-30	31 - 60	61 - 90	91+	Previous Period
Ministry of Health	23,306	21,292	294	66	(1)	1,655	6,407
Other DHB's	9,567	5,536	733	118	417	2,763	22,442
Kenepuru A&M	219	28	22	22	147		233
ACC	226	119	(25)	(70)	(18)	220	(82)
Misc Other	4,082	1,874	261	88	118	1,741	4,186
Total Debtors	37,400	28,849	1,285	224	663	6,379	33,186
less : Provision for Doubtful Debts	(2,531)						(2,500)
Net Debtors	34,869						30,686



Cash Management

- The DHB may require equity injection for deficit support for FY21. Cash forecast June 21: High:+$37m, Low:-$75m

Debt Management

- **Ministry of Health:**

1. $1.6m overdue is for invoices on hold due to contracts not yet signed by MOH, reports not yet provided by CCDHB or disputed invoices.
2. $21.3m current month included $15.3m capital injection Children's Hospital

- **Other DHB's:** $2.8m overdue is for invoices on hold due to contracts not yet signed by HVDHB.
- **Kenepuru A&M:** Includes significant number of low value patient transactions. Provision of the overdue debts is $128k
- **Misc Other:** Includes non-resident debt of approx. $1.8m. About 84% 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 28 February 2021

Jan 2021	Month : Feb 2021				Variance			Capital & Coast DHB Balance Sheet
Actual	Actual	Budget	At Feb 2020	At Jun 2020	Actual vs Budget	Actual vs Feb 2020	Notes	YTD Feb 2021
31	31	31	31	31	0	0	1	Bank
106	212	(0)	0	6,523	213	212	1	Bank NZHP
13,046	12,995	11,683	12,201	11,683	1,313	795	1	Trust funds
64,008	70,448	49,375	48,631	46,342	21,073	21,817	2	Accounts receivable
9,502	9,553	8,995	9,845	8,995	557	(292)		Inventory/Stock
10,025	9,935	6,257	8,520	6,257	3,677	1,414		Prepayments
96,718	**103,173**	**76,341**	**79,228**	**79,831**	**26,832**	**23,946**		**Total current assets**
511,453	510,173	543,509	524,455	522,978	(33,336)	(14,282)		Fixed assets
14,847	14,847	14,847	9,859	11,626	0	4,988		Work in Progress - CRISP
80,429	84,026	54,096	51,451	57,317	29,930	32,575		Work in progress
606,729	**609,045**	**612,452**	**585,765**	**591,921**	**(3,407)**	**23,280**	3	**Total fixed assets**
0	0	0	0	0	0	0		Investments in New Zealand Health Partnership
1,150	1,150	1,150	1,150	1,150	0	(1)		Investment in Allied Laundry
1,150	**1,150**	**1,150**	**1,150**	**1,150**	**0**	**(1)**		**Total investments**
704,597	**713,368**	**689,942**	**666,143**	**672,901**	**23,426**	**47,225**		**Total Assets**
16,266	9,743	40,789	16,332	0	31,046	6,589		Bank overdraft HBL
94,888	102,297	64,504	69,926	76,604	(37,793)	(32,371)	4	Accounts payable, Accruals and provisions
0	0	0	0	0	0	0	7	Loans - Current portion
11,102	2,985	3,284	3,784	(252)	299	800	6	Capital Charge payable
593	593	593	593	593	0	0		Insurance liability
10,776	11,106	36,144	22,896	36,144	25,038	11,790	5	Current Employee Provisions
168,163	167,027	140,857	118,462	140,857	(26,170)	(48,565)	5	Accrued Employee Leave
10,448	12,205	7,299	8,593	7,299	(4,905)	(3,612)	5	Accrued Employee salary & Wages
312,235	**305,956**	**293,471**	**240,586**	**261,245**	**(12,486)**	**(65,370)**		**Total current liabilities**
0	0	0	0	0	0	0		Crown loans
107	99	95	85	95	(4)	(14)		Restricted special funds
605	605	605	605	605	0	0		Insurance liability
6,564	6,564	6,564	6,296	6,564	0	(269)		Long-term employee provisions
7,277	**7,268**	**7,264**	**6,986**	**7,264**	**(4)**	**(283)**		**Total non-current liabilities**
319,511	**313,225**	**300,735**	**247,572**	**268,510**	**(12,490)**	**(65,653)**		**Total Liabilities**
385,085	**400,144**	**389,207**	**418,572**	**404,391**	**10,936**	**(18,428)**		**Net Assets**
817,122	817,122	812,773	797,172	813,224	4,349	19,950		Crown Equity
0	0	0	0	(3,484)	0	0		Capital repaid
0	15,370	0	0	0	15,370	15,370		Capital Injection
130,659	130,659	130,660	131,395	130,659	(1)	(736)		Reserves
(562,697)	(563,009)	(554,226)	(509,997)	(536,008)	(8,784)	(53,012)		Retained earnings
385,085	**400,143**	**389,207**	**418,571**	**404,392**	**10,935**	**(18,427)**		**Total Equity**

Balance Sheet

1. The DHB's cash overdraft balance at the end of February is continue favourable to budget.
2. Accounts receivable is high than budget due to MoH invoice for Children Hospital ($15.3m); assume the invoice will be paid in March.
3. Accounts payable, accruals and provisions is higher than the budget mainly due to timing differences
4. Employee liabilities is high than budget due to unbudgeted employee costs (MHAIDs) approx. $3m per month;

Cash flow

1. The net cash flow from operating activities is favourable to budget. This is mainly received payment from HVDHB;
2. The net cash flow from investment activities is almost line up to budget;

Capital Expenditure Summary February 2021

			Actual spend on live projects							Forecast spend on approved projects		
Asset Category	Approved Capex Budget	PY Spend to 30 June 2020	September Quarter actual spend	December Quarter actual spend	January actual spend	February actual spend	Actual YTD Spend	Actual LTD Spend	To spend	Mar-21	Jun 21 Quarter	Forecast cash spend to Jun 21*
Buildings	10,572,149	-	225,088	820,879	135,756	120,038	1,301,761	1,301,761	9,270,389	477,825	2,201,969	3,861,516
Clinical Equipment	8,048,495	-	643,250	1,506,284	101,992	376,000	2,627,526	2,627,526	5,420,969	585,685	3,064,181	5,901,392
ICT	2,050,382	-	41,960	142,786	35,647	125,343	345,736	345,736	1,704,645	236,766	685,372	1,142,532
2020-21 projects	**20,671,026**	-	**910,298**	**2,469,950**	**273,395**	**621,381**	**4,275,023**	**4,275,023**	**16,396,003**	**1,300,276**	**5,951,522**	**10,905,440**
Buildings	17,824,813	8,814,096	1,395,429	934,819	427,755	412,890	3,170,893	11,984,988	5,839,825	683,067	999,383	4,012,697
Clinical Equipment	44,165,614	21,222,465	7,018,217	5,846,681	787,826	449,819	14,102,543	35,325,007	8,840,607	619,692	3,125,379	16,609,968
ICT	9,238,081	6,711,200	1,266,724	348,068	135,497	99,775	1,850,064	8,561,263	676,817	216,804	428,614	2,260,209
Prior Year projects	**71,228,508**	**36,747,760**	**9,680,370**	**7,129,568**	**1,351,078**	**962,484**	**19,123,499**	**55,871,259**	**15,357,249**	**1,519,563**	**4,553,375**	**22,882,875**
Total	**91,899,533**	**36,747,760**	**10,590,667**	**9,599,517**	**1,624,472**	**1,583,865**	**23,398,522**	**60,146,282**	**31,753,252**	**2,819,839**	**10,504,897**	**33,788,315**

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

Key highlights to February 2021 (excludes New Children's Hospital, Water Remediation Project & ISU for MHAIDS and MOH donated assets for Covid-19):

- The development of business cases from the 2020/21 Capital Plan are at various stages. It was anticipated that $3m-$4m be presented for approval each month. Only $20.7m in projects have been approved to February 2021. Delays in three large projects has given rise to a lower overall approval rate. Two are scheduled to be submitted for approval in May and the third in June
- Total spend to the end of February 2021 was $23.4m which mostly related to prior year approved projects
- In February 2021, $41m-$43m was forecasted as the cash spend for the year. This has been revised to $33m-$35m
- The slower spend rate is due to delays in business case development mentioned above, shipping in clinical equipment for both assessment and delivery (can take up to 14 weeks), a handful of larger projects being revised. The timing to complete some building projects will take longer than initially anticipated (CSB lift renewal & seismic upgrade, ceiling tile replacement, passive fire)
- Efforts are being made to ensure the spend rate on capital spending is improved to cash spend is in line with budget

Board Decision – Public

5 May 2021

Disability Support Advisory Committee (DSAC) Items for Board Approval and Noting from Committee meeting dated 28 April 2021

Action Required

The Boards approve:

Item 3.1 – 3DHB Alcohol and Other Drugs (AOD) Model Of Care And Priority Investment

(a) The Capital & Coast, Hutt Valley and Wairarapa Alcohol and Other Drug Model of Care (the Model of Care) and its five direction-setting, key components for implementation:

- Driving equity of access and outcomes
- Privileging the voice and contribution of those with lived experience
- Growing a whole of population approach
- Building a recovery-focused system of care
- Working collaboratively.

The Boards note:

Item 3.1 –* 3DHB *Alcohol and Other Drugs (AOD) Model Of Care And Priority Investment

(a) DSAC, through the Chair, agreed to write to the Ministry of Health raising funding delays and the impact the delays are having on the 3DHB's contribution to the transformation outlined in He Ara Oranga.

Item 3.3 – 3DHB Mental Health and Wellbeing Strategies Update

(a) The subregion's *Suicide Prevention and Postvention Action Plan* has been refreshed to align it with the Government's *He Tapu te Oranga o ia Tāngata: Every Life Matters – Suicide Prevention Action Plan 2019-2029* and the subregion's Māori Health and Pacific Health strategies.

(b) The Suicide Prevention and Postvention Action Plan governance group has endorsed the *Suicide Prevention and Postvention Action Plan* and the Plan will be presented to DSAC for endorsement at its May 2021 meeting.

(c) The good progress implementing a broad range of initiatives under *Living Life Well A strategy for mental health and addiction 2019-2025* in three service domains: whole of population; primary care; secondary specialist services; and in both the subregion and central region.

(d) The collaborative, networked approach to implementing the subregion's refreshed *Suicide Prevention Action Plan* in four service domains: health promotion; prevention; intervention; and, postvention.

(e) The roll out of COVID 19 vaccination to mental health and addiction clients partnering with our NGO and other lead providers.

Item 3.4 - 3DHB Sub-Regional Disability Strategy Update

(a) DSAC was provided an update on the implementation of the Sub Regional Disability Strategy 2017 – 2022.

Item 3.5 – 3DHB First Draft Annual Plans 2020/21

(a) DSAC considered the contents of the first draft Annual Plans 2021/2022 relevant to the work of the Committee and provided feedback to staff.

(b) DSAC endorsed in principle the contents of the first draft Annual Plans 2021/2022.

Strategic Alignment	Annual Plans, Te Pae Amorangi, Taurite Ora and Sub Regional Disability Strategy 2017-2022, Pacific Health and Wellbeing Strategy for the Greater Wellington Region
Endorsed by	Rosalie Percival, Acting 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 its meeting on 28 April 2021. 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 28 April 2021.

Strategic Considerations

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

Engagement/Consultation

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

Identified Risks

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

Attachment/s

n/a

4

Capital and Coast DHB and Hutt Valley DHB

CONCURRENT Board Meeting

Meeting to be held on 5 May 2021

Resolution to exclude the Public

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

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

TABLE

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

CCDHB March 2021 Financial and Operational Performance Report	As above	As above
Patient Story	As above	As above
Service Spotlight	As above	As above
Health and Safety Commitment Statement	As above	As above
Wellington Regional Hospital – Travel Action Plan and Carparking	As above	As above
Kenepuru Medical Day Ward	As above	As above
LED Lighting Upgrade Project	As above	As above
Ultrasound Replacement Programme	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.