# Public Board Meeting

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| **Meeting:** | Thursday, 26 September 2019 |
| **Start time:** | 9.00 am |
| **Venue:** | Board room<br>Pilmuir House<br>Hutt Valley DHB |

# Hutt Valley District Health Board

*Whanau Ora ki te Awakairangi*
*Healthy People, Health Families, Healthy Communities*

## Our Values

**Always caring** – respectful, kind and helpful
**Can-do** – positive, learning and growing and appreciative
**In Partnership** – welcoming, listens, communicates and involves
**Being our Best** – innovating, professional and safe.

## Hutt Valley DHB Strategic Directions and Enablers

Support living well
Shift care closer to home
Deliver shorter, safer, smoother care
Adaptable workforce
Smart infrastructure
Effective commissioning

## Central Region Strategic Objectives 2018/19

Cancer services
Cardiac services
Ensuring a digitally enabled health system
Regional care arrangements
Mental health and addictions
An enabled and capable workforce
A clinically and financially sustainable health system

## Government Priorities 2018/19

Primary Care Access
Public Delivery of Health Services
School-based Health Services
Disability Support Services
Improving Quality
Waste Disposal
Health Targets
Mental Health
Child Health
Healthy Ageing
Pharmacy Action Plan
Climate Change
Budget '18 Initiatives
Cross-Government Targets
Delivering the Regional Services Plan

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| HUTT VALLEY DHB | **AGENDA**<br>Held on Thursday, 26 September 2019<br>Boardroom, Pilmuir House, Hutt Hospital<br>Commencing at 9.00 am |
| **BOARD** | **PUBLIC SESSION** |

| | Item | Action | Presenter | Min | Time | Pg |
|---|---|---|---|---|---|---|
| **1.** | **PROCEDURAL BUSINESS** | | | 30 | 9.00 am | |
| 1.1 | Karakia | | | | | **4** |
| 1.2 | Apologies | ACCEPT | Chair | | | |
| 1.3 | Continuous Disclosure | ACCEPT | Chair | | | |
| | 1.3.1 Hutt Valley DHB Interest Register | | | | | **5** |
| | 1.3.2 Conflicts of Interest | | | | | **7** |
| 1.4 | HVDHB Minutes of Previous Meetings – 29 August 2019 | ACCEPT | Chair | | | **9** |
| 1.5 | HVDHB Matters Arising from Previous Meeting | NOTE | Chair | | | **17** |
| 1.6 | 2019 HVDHB Board Work Plan | NOTE | Chair | | | **18** |
| 1.7 | Chair's Report (Verbal) | NOTE | Chair | | | |
| 1.8 | Chief Executive's Report (Verbal) | NOTE | Chief Executive | | | |
| **2** | **PRESENTATION** | | | | | |
| 2.1 | Patient Story | NOTE | D Gell | 10 | 9.30 | **19** |
| **3.** | **DHB PERFORMANCE** | | | | | |
| 3.1 | HVDHB July Financial Performance Report | NOTE | GM Finance & Corporate Services | 10 | 9.40 | **20** |
| | 3.1.1 HVDHB Financial Performance Report | NOTE | GM Finance & Corporate Services | 10 | 9.50 | **23** |
| 3.2 | HVDHB Operational Performance Report | NOTE | Chief Operating Officer | 10 | 10.00 | **44** |
| 3.3 | Vision for Change Performance Dashboard | NOTE | GM Strategy, Planning & Outcomes | 10 | 10.10 | **60** |
| **4.** | **DISCUSSION** | | | | | |
| 4.1 | Health & Safety Report | NOTE | GM Service Quality & Innovation | 10 | 10.20 | **61** |
| | 4.1.1 Infection Control Policy | NOTE | GM Service Quality & Innovation | 10 | 10.30 | **73** |
| 4.2 | Clinical Services Plan Update | NOTE | GM Strategy, Planning & Outcomes | 10 | 10.40 | **86** |
| | 4.2.1 Clinical Services Plan Progress Update | NOTE | GM Strategy, Planning & Outcomes | 10 | 10.50 | **87** |
| **5.** | **COMMITTEE REPORTING** | | | | | |
| 5.1 | HVDHB Clinical Council Report September 2019 | NOTE | Chief Medical Officer | 10 | 11.00 | **91** |
| 5.2 | 3DHB DSAC Minutes 10 September 2019 | NOTE | DSAC Chair | 5 | 11.10 | **94** |
| **6.** | **OTHER** | | | | | |
| 6.1 | General Business | | Chair | 5 | 11.15 | |
| 6.2 | Resolution to Exclude the Public | APPROVE | Chair | 5 | 11.20 | **99** |
| 6.3 | Board to Board Session with Mana Whenua Relationship Board. Topics:<br>• Leadership Structure<br>• Resourcing Te Pae Amorangi<br>• Maori Mental Health<br>• Strategic Accountabilities for Te Pae Amorangi<br>• Standing Agenda items for board meetings | | | 35 | 11.25 | |
| **DATE OF NEXT MEETING:** Thursday, 31 October 2019 | | | | **CLOSE** | **12.00** | |

# Karakia – Whakataka te hau

Whakataka te hau ki te uru
*(Cease the winds from the west)*

Whakataka te hau ki te tonga
*(Cease the winds from the south)*

Kia mākinakina ki uta
*(Let the breeze blow over the land)*

Kia mātaratara ki tai
*(Let the breeze blow over the ocean)*

E hī ake ana te atakura
*(Let the red-tipped dawn come with a sharpened air)*

He tio, he huka, he hau hū
*(A touch of frost, a promise of the glorious day)*

Tīhei mauri ora!

## Hutt Valley Board INTEREST REGISTER

| Name | Interest |
|---|---|
| Graeme Andrew Blair<br>*Chair* | • Chair, Capital & Coast DHB<br>• Chair, Hutt Valley DHB<br>• Chair, Hutt Valley DHB Hospital Advisory Committee<br>• Member, Hutt Valley DHB Finance, Risk and Audit Committee<br>• Member, 3DHB combined Disability Support Advisory Committee<br>• Member, Hutt Valley DHB Community and Public Health Advisory Committee<br>• Member, Capital & Coast DHB Finance, Risk and Audit Committee<br>• Member, Capital & Coast DHB Health Systems Committee<br>• Owner and Director of Andrew Blair Consulting Ltd<br>• Former member of the Hawke's Bay DHB (2013-2016)<br>• Former Chair, Cancer Control (2014-2015)<br>• Former CEO, Acurity Health Group Limited<br>• Advisor to Southern Cross Hospitals Ltd and Central Lakes Trust in relation to establish an independent surgical hospital facility in the Queenstown Lakes region<br>• Chair, Queenstown Lakes Community Housing Trust<br>• Member of the Governing Board for the Health Finance, Procurement & Information Management System business Case<br>• Advisor to the Board of Breastscreen Auckland Ltd<br>• Advisor to the Board of St Marks Women's Health (Remuera) Ltd |
| Wayne Guppy<br>*Deputy Chair* | • Upper Hutt City Council Mayor<br>• Deputy Chair, Hutt Valley District Health Board<br>• Deputy Chair, Hutt Valley District Health Board Finance, Risk and Audit Committee<br>• Member, Hutt Valley District Health Board Hospital Advisory Committee<br>• Wife employed by various community pharmacies in the Hutt Valley<br>• Trustee - Orongomai Marae<br>• Director MedicAlert<br>• Chair – Wellington Regional Mayoral Forum<br>• Chair – Wellington Regional Strategy Committee |
| Lisa Bridson<br>*Member* | • Member, Hutt Valley District Health Board<br>• Member, Hutt Valley District Health Board Hospital Advisory Committee<br>• Member, 3DHB combined Disability Support Advisory Committee<br>• Member, Hutt Valley District Health Board Community and Public Health Advisory Committee<br>• Hutt City Councillor<br>• Chair, Kete Foodshare |
| Ken Laban<br>*Member* | • Member, Hutt Valley District Health Board<br>• Member, Hutt Valley District Health Board Finance, Risk and Audit Committee<br>• Member, Hutt Valley District Health Board Hospital Advisory Committee<br>• Trustee, Hutt Mana Charitable Trust<br>• Member, Ulalei Wellington<br>• Chairman, Hutt Valley Sports Awards<br>• Member, Greater Wellington Regional Council<br>• Commentator, Sky Television<br>• Broadcaster, Numerous Radio Stations<br>• Member, Christmas in the Hutt Committee<br>• Trustee, Te Awakairangi Trust<br>• Member, Computers in Homes |
| David Ogden<br>*Member* | • Member, Hutt Valley District Health Board<br>• Member, Hutt Valley District Health Board Finance, Risk and Audit Committee |

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|---|---|
| | • Member, Hutt Valley District Health Board Hospital Advisory Committee<br>• Regional Councillor<br>• Principal, Oak Chartered Accountants Limited<br>• Accountant, affiliated, with Simple Accounting Services Limited, which has various clients involved in the Health Sector<br>• Daughter is a Doctor in Clinical Psychology and working within a District Health Board outside of the Central Region<br>• Former Mayor and Councillor, Hutt City Council. |
| John Terris<br>*Member* | • Member, Hutt Valley District Health Board<br>• Member, Hutt Valley District Health Board Hospital Advisory Committee<br>• Member, 3DHB combined Disability Support Advisory Committee<br>• Member, Hutt Valley District Health Board Community and Public Health Advisory Committee<br>• National President of Media Matters in NZ – a viewer advocacy group work in the area of TV and the internet, and incorporating Children's Media Watch<br>• Patron – Hutt Multicultural Council Inc |
| Prue Lamason<br>*Member* | • Member, Hutt Valley District Health Board<br>• Member, Hutt Valley District Health Board Hospital Advisory Committee<br>• Member, Hutt Valley District Health Board Finance, Risk and Audit Committee<br>• Member, 3DHB Combined Disability Support Advisory Committee<br>• Member, Hutt Valley District Health Board Community and Public Health Advisory Committee<br>• Deputy Chair, Hutt Mana Charitable Trust<br>• Councillor, Greater Wellington Regional Council<br>• Chair, Greater Wellington Regional Council Holdings Company<br>• Daughter is a Lead Maternity Carer in the Hutt |
| Yvette Grace<br>*Member* | • Member, Hutt Valley District Health Board<br>• Member, Hutt Valley District Health Board Hospital Advisory Committee<br>• Deputy Chair, 3DHB combined Disability Support Advisory Committee<br>• Chair, Hutt Valley District Health Board Community and Public Health Advisory Committee<br>• General Manager, Rangitane Tu Mai Ra Treaty Settlement Trust<br>• Husband, Family Violence Intervention Coordinator Wairarapa DHB<br>• Sister in law, Nurse at Hutt Hospital<br>• Sister in Law, Private Physiotherapist in Upper Hutt |
| Tim Ngan Kee<br>*Member* | • Member, Hutt Valley District Health Board<br>• Member, Hutt Valley District Health Board Finance, Risk and Audit Committee<br>• Member, Hutt Valley District Health Board Hospital Advisory Committee<br>• Member, Hutt Valley District Health Board Community and Public Health Advisory Committee<br>• General Practitioner, Churton Park Medical Care<br>• Partner, Churton Park Medical Care |
| Kim von Lanthen | • Member, Hutt Valley District Health Board<br>• Member, Hutt Valley District Health Board Finance, Risk and Audit Committee<br>• One third shareholding Kim von Lanthen and Associates Ltd<br>• One half shareholding Commodity Markets (NZ) Ltd<br>• One third shareholding NZ Bio Forestry Ltd |

**Hutt Valley DHB Executive Leadership Team**

# Interest Register

| Name | Interest |
|---|---|
| Fionnagh Dougan<br>*Chief Executive*<br>*Hutt Valley & Capital and Coast DHB* | • Board member, Children's Hospital foundation<br>• Adjunct Professor University of Queensland<br>• Member, Wellington Hospital Foundation |
| Nigel Fairley<br>*General Manager, 3DHB Mental Health Addictions & Intellectual Disability Service* | • Fellow, NZ College of Clinical Psychologists<br>• President, Australian and NZ Association of Psychiatry, Psychology and Law<br>• Trustee, Porirua Hospital Museum<br>• Director and Shareholder, Gerney Limited |
| Melissa Brown<br>*Acting Chief Operating Officer* | • Member of the Australian College of Midwives |
| Tofa Suafole Gush<br>*Director Pacific Peoples Health* | • Member of the Te Awakairangi Health Board<br>• Pacific Member, Board of Compass Health<br>• Husband is an employee of Hutt Valley DHB |
| Dr Sisira Jayathissa<br>*Chief Medical Officer* | • Member of the Medicine Adverse Reaction Committee MedSafe (MOH)<br>• Member Standing committee on Clinical trials (HRC)<br>• Member Editorial Advisory Board NZ formulary<br>• Member Internal medicine Society of Australia and NZ<br>• Australian and New Zealand Society for Geriatric Medicine<br>• Writer NZ internal Medicine Research Review<br>• Clinical Senior Lecturer and Module convenor Clinical Skills module (HUTT campus), University of Otago |
| Judith Parkinson<br>*General Manager, Finance and Corporate Services* | • Director of Allied Laundry |
| Bridget Allan<br>*Chief Executive, Te Awakairangi Health Network (PHO)* | • Chief Executive, Te Awakairangi Health Network (PHO)<br>• Board member of Vibe<br>• Healthy Families Lower Hutt Leadership Group member |
| Helen Corrigan<br>*Acting Communications Manager* | • First cousin is sitting Member of Parliament |
| Rod Bartling<br>*Acting General Manager Strategy Planning & Outcomes* | • No interests declared |
| Fiona Allen<br>*General Manager Human Resources & Organisational Development* | • No interests declared |

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|---|---|
| Kerry Dougall<br>*Director of Māori Health* | • Board Chair, Kokiri Marae Māori Women's Refuge<br>• Board member, Ta Kirimai te Ata Whanau Collective |
| Chris Kerr<br>*Director of Nursing* | • Member and secretary of Nurse Executives New Zealand (NENZ)<br>• Relative is HVDHB Human resources team leader<br>• Relative is a senior registered nurse in SCBU<br>• Relative is HVDHB Bowel Screening Programme Manager<br>• Adjunct Teaching Fellow, School of Nursing, Midwifery and Health Practice, Victoria University of Wellington |
| Debbie Gell<br>*General Manager Quality, Service Improvement and Innovation* | • Member of consumer council for Healthy Homes Naenae |
| Christine King<br>*Director of Allied Health, Scientific and Technical* | • Brother works for Medical Assurance Society (MAS)<br>• Sister is a Nurse for Southern Cross |
| Tracy Voice<br>*Chief Information Officer*<br>*ICT 3DHB* | • Secretary, New Zealand Lavender Growers Association<br>• Board Member, Primary Growth Partnership with PGG Wrightsons/Grassland Seed Technology Innovation |

**BOARD** **PUBLIC**

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| HUTT VALLEY DHB | **MINUTES**<br>Held on Thursday, 29 August 2019<br>Te Aro Room, Front+Centre, 69 Tory Street, Wellington<br>**Commencing at 11.05am** |
| **BOARD** | **PUBLIC SECTION** |

## PRESENT

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|---|---|
| Andrew Blair | Chair, Hutt Valley and Capital & Coast DHBs |
| Lisa Bridson | Board Member |
| Yvette Grace | Board Member |
| Ken Laban | Board Member |
| Prue Lamason | Board Member |
| Tim Ngan Kee | Board Member |
| Kim von Lanthen | Board Member |
| David Ogden | Board Member |
| John Terris | Board Member |

## APOLOGIES

| | |
|---|---|
| Wayne Guppy | Deputy Chair, Hutt Valley DHB |

## IN ATTENDANCE

| | |
|---|---|
| Fionnagh Dougan | Chief Executive |
| Christine Rabone | Committee Secretary |
| Kristine McGregor | Executive Officer, HVDHB |
| Judith Parkinson | General Manager - Finance and Corporate Services, HVDHB |
| Melissa Brown | Interim Chief Operating Officer, HVDHB |
| Debbie Gell | General Manager - Quality, Service Improvement and Innovation, HVDHB |
| Nigel Fairley | General Manager – 3DHB MHAIDS |

CCDHB

| | |
|---|---|
| Fran Wilde | Deputy Chair, Capital & Coast DHB |
| Kathryn Adams | Board Member |
| Roger Blakeley | Board Member |
| Eileen Brown | Board Member |
| Sue Kedgley | Board Member |
| Kim Ngarimu | Board Member |
| Rachel Haggerty | Executive Director - Strategy Innovation & Performance, CCDHB |
| Anna Chalmers | Communications Manager, CCDHB |
| Michael McCarthy | Chief Financial Officer, CCDHB |
| Tracy Voice | Chief Digital Officer, CCDHB |
| Arish Naresh | Executive Director Allied Health, Scientific and Technical, CCDHB |
| Carey Virtue | Executive Director Operations, Medicine, Cancer and Community, CCDHB |
| Sandy Blake | General Manager, Quality Improvement and Patient Safety, CCDHB |
| Andrew Wilson | Acting General Manager, People and Capability, CCDHB |

## GUESTS

1 x member of the public

**BOARD** **PUBLIC**

# 1. PROCEDURAL BUSINESS

## 1.1 KARAKIA

The meeting opened with a karakia.

The Board thanked Kristine McGregor for her service and support over the past 3.5 years and wished her all the very best for her future endeavors.

The Board welcomed Christine Rabone who will be acting Executive Assistant to the Board Chair, Board Secretary and Hutt Valley DHB support for the Chief Executive Officer whilst the new Office of the Executive is being established.

The Board Chair noted an item of general business would be tabled by Mr Terris for discussion.

## 1.2 APOLOGIES

The Board **NOTED** apologies from Mr W Guppy

## 1.3 CONTINUOUS DISCLOSURE

### 1.3.2 INTEREST REGISTER AND CONFLICTS OF INTEREST

The Board **NOTED** the following changes to the interest registers:

- Removal of Mr Andrew Blair's interest as member, State Services Commission Advisory Group on Crown Entity Chief Executive Remuneration from both the Capital and Coast and Hutt Valley District Health Board's interest registers.
- Ms Prue Lamason advised that her additional interest would be sent to the Committee Secretary for inclusion on the Hutt Valley District Health Board interest register and that there was no conflict for any matters at this meeting.

The Board **CONFIRMED** that it was not aware of any matters (including matters reported to, and decisions made, by the Board at this meeting) that require disclosure and that there would be an opportunity to declare any conflicts prior to discussion on each item of the agenda.

## 1.4 MINUTES OF PREVIOUS MEETING

The Board **RESOLVED** to approve the minutes of the Members' (Public) Board meeting held on 1 August 2019 as a true and accurate record of the meeting.

**MOVED:** Prue Lamason **SECONDED:** Kim von Lanthen **CARRIED**

## 1.5 ACTION LIST AND MATTERS ARISING

The Board **RECEIVED** the matters arising from the previous meeting, and **NOTED:**

- Items B2019-4 and B2019-3 are scheduled for delivery in future months;
- Item B2019-2 has been completed;
- Items BP2019-9, CPB2019-8, CPB2019-7 are scheduled for delivery at today's meeting and will be marked completed.

## 1.6 DRAFT 2019 BOARD WORK PLAN

The Board **NOTED** the updated Joint Boards 2019 Work Plan.

The Chair advised that meeting dates for 2020 and the process around committees and timetabling will be discussed during the Board only meeting.

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### 1.7 CHAIR'S REPORT

The Board Chair advised there was nothing to report and further information would be provided during the public excluded session.

There was no outgoing correspondence, and incoming correspondence consisted of:

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| 9 August 2019 (incoming) | Letter from the Director-General of Health regarding the changes to fees payable under the Cabinet Fees Framework that came into effect from 1 July 2019 |
| 20 August 2019 (incoming) | Letter from the Deputy State Services Commissioner regarding new standards for Positive and Safe Workplaces to support the development and implementation of a system wide work programme |
| 21 August 2019 (incoming) | Email from Kathryn Cook, Chair of the central region CEs regarding the Central Region's Equity Framework release on 22 August 2019 |

Meetings attended were noted as:

| | |
|---|---|
| 5 August 2019 | RGG meetings<br>Combined RGG and Central Region CEs meeting |
| 8 August 2019 | National Chairs meeting<br>Combined National Chairs and National CEs meeting<br>National Chairs Public health workshop |

### 1.8 CHIEF EXECUTIVE'S REPORT

The Chief Executive noted there was nothing to report and further information would be provided during the public excluded session.

## 2. PRESENTATION

### 2.1 PATIENT STORY

Ms Debbie Gell introduced a video which described the Hutt Valley DHB's response to a Carbapenemase-producing enterobacteriaceae (CPE) outbreak based on Claire Underwood's (CNS Infection Control) and Shelley Williams (CNM General Surgery) experiences in October of 2018. CPE is a group of bacteria that can cause serious infections in hospitalised patients and are resistant to nearly all known antibiotics.

The Board passed on their congratulations for the way in which involved staff members handled the situation, and discussed the following:

- Screening of incoming patients and their immediate isolation should a superbug be detected;
- DHB's monitoring and support for Aged Residential Care (ARC) providers, quality audit monitoring and the procedures in place should a future outbreak occur.
- Any future outbreak being treated as an emergency and warranting an organisation wide response, which would include the setting up of emergency coordination (as noted in the review post outbreak).

**Action:** The Board requested management provide information that addresses monitoring of ARC providers and whether current policies/procedures include the testing of staff members, with the DHBs policies/procedures on isolation and screening attached.

**Action:** The Board requested that the Primary Care Clinical Governance Committee add ARC monitoring as a standing agenda item to their meeting agenda.

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# 3. AGENDA FOR CHANGE

## 3.1 FRAC TERMS OF REFERENCE

The paper was taken as **READ**.

The Board:

a) **NOTED** the Terms of Reference for the concurrent FRAC have been updated as requested at the June and July FRAC meetings;

b) **NOTED** there are separate terms of reference for HVDHB and CCDHB however they are the same;

c) **APPROVED** the updated terms of reference for the HVDHB FRAC.

**MOVED:** Andrew Blair **SECONDED:** Prue Lamason **CARRIED**

# 4. DHB PERFORMANCE

## 4.1 HVDHB JUNE FINANCIAL PERFORMANCE REPORT

The paper was taken as **READ.**

The Board:

a) **NOTED** June year to date had an unfavourable variance to budget of ($290k) **excluding** one off items against the annual budget deficit of $8 million;

b) **NOTED** the June year to date result included one off items for: FPIM impairment of $2,216k and holidays act compliance provision of $9,321k, including these items the final deficit was $19,876k;

c) **NOTED** the June result is still subject to audit before it can be finalised;

d) **NOTED** the Funder result for June year to date was $4,694K favourable, Governance ($138K) unfavourable and Provider ($4,846K) unfavourable to budget excluding one off items;

e) **NOTED** the key variances to budget outlined in this report including overspends in Medical personnel due to the strikes, nursing (including use of minders), the impact of MECA step increases, and outsourced services off set by additional MoH, ACC and IDF revenue and IDF outflow underspend;

f) **NOTED** the Inter district flows (IDF) for June year to date with Inflows up by $461k and outflows down by $2,498k;

g) **NOTED** the IDF inflows for June were below budget by ($571k) and outflows above budget by ($1,334k) including high cost infants of $1,505k.

## 4.3 HVDHB OPERATIONAL PERFORMANCE REPORT

The paper was taken as **READ.**

The Board:

a) **NOTED** that Hutt Valley DHB's performance against the *Improved Access to Elective Surgery* health target as of August 2019 was 100.1% for discharges and 95.1% for case weighted discharges;

b) **NOTED** that Hutt Valley DHB's performance against the *Faster Cancer Treatment* target for July was 90.9% percent for the 60 day target;

c) **NOTED** that for the first quarter of 2019-2020 FY so far, Hutt Valley DHB achieved only 81.7% percent against the *Shorter Stays in ED* health target;

d) **NOTED** that Hutt Valley DHB's performance against the radiology targets for July/August was 97% for ultrasound, 66% for MRI and 88% for CT;

e) **NOTED** that for the first quarter of 2019-2020 FY so far, Hutt Valley DHB achieved 94% against the target of offering smokers information and advice to quit;

f) **NOTED** actions being taken to achieve agreed targets.

The Board also noted and thanked Ms J Parkinson and Mr M McCarthy who are working on the development of dashboard reporting to replace the current report.

In response to Ms Y Grace's query around the possibility of ethnicity data being collected from across the organisations' and included under the equity heading, the Chief Executive advised that Maori and Pacific leads are now active partners to ELT members, who will support and challenge them around the areas of accountability to ensure inclusion across functions.

**Action:** The Chief Executive undertook to add relevant data to the new dashboard reports.

### 4.5 HVDHB QUALITY AND SAFETY REPORT

The paper was taken as **READ.**

The Board

a) **NOTED** the report for August 2019;

b) **NOTED** the workforce development initiatives;

c) **NOTED** the higher rate of cardiac arrests per 1,000 admissions, noting the actual number is low;

d) **NOTED** the consumer council update.

*The Chair noted My W Guppy's apology retrospectively*

## 5. COLLABORATIVE ACTIVITY

### 5.1 DISABILITY UPDATE

The paper was taken as **READ.**

The Board

a) **NOTED** the recommendations from the Sub Regional Disability Forum;

b) **NOTED** changes to the Disability Team including people with disability;

c) **NOTED** progress against key activities related to the implementation of the Disability Strategy;

d) **NOTED** the commitment to strengthen links between the Sub Regional Disability Advisory Group, the Maori Disability Roopu and the Pacific Disability Steering Group to enhance our ability to deliver on the recommendations from the Forum.

### 5.2 3DHB MHAIDS REPORT

The paper was taken as **READ.**

The Board

a) **NOTED** that work is on track in Te Whare o Matairangi (TWOM) to repair the significant fire damage in February, with a return to business as usual expected for 6 September 2019;

b) **NOTED** MHAIDS have convened a Critical Point Group to address Medical shortages and impacts of the TWOM fire;

c) **NOTED** The Governance group for the co-response pilot are working towards a Go-Live for the Wellington Pilot 4 November 2019.

The Board discussed and noted:

<u>MHAIDS</u>

- The MHAIDS review and need for a clear leadership and management model for a single 2DHB MHAIDS.
- Future approach which may include a systemic approach that includes delivery of a MHAIDS continuum given the need to partner with multiple providers to leverage required funding to deliver on the living well agenda. This would be supported by research KPI's for success.

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DSAC

- 3DHB DSAC is currently monitoring through their work programme and will provide a report that covers both strategic and operational issues and how these are aligned with the government's priorities/expectations in due course.
- Work currently underway to address the impact of poverty within the region and the lack of Māori and Pacific support within the community.

**Action:** Management to advise Mr Terris on the process for smaller public organisations to be considered for funding.

## 5.3 2DHB PEOPLE AND CAPABILITY REPORT

The paper was taken as **READ.**

The Board

a) **NOTED** the progress of HVDHB and CCDHB against the regional priorities of the Central Region General Managers Human Resources (GMs HR);

b) **NOTED** the performance of HVDHB and CCDHB against a number of the key HR metrics included in the Central Region Workforce dashboard

The Board discussed:

- Sharing of information at both a regional and national level around violence in the workplace.
- Opportunity for hiring managers to increase level of understanding of additional value skilled Maori employees bring to the organisation.

## 5.4 3DHB ICT REPORT

The Board welcomed Tracey Voice who has recently commenced as the 3DHB Chief Digital Officer.

The paper was taken as **READ**

a) **NOTED** that Tracy Voice, the new 3DHB Chief Digital Officer, commenced her role on 29 July 2019;

b) **NOTED** that the availability of key (category one) ICT systems over the reporting period measured 97.15 percent against a target of 99.9 percent. The average availability over the last 12 months measured 98.74 percent;

c) **NOTED** that all planned data backups were completed successfully during the reporting period.

The Board discussed:

- Security around Phishing scams and how risks will be mitigated in the future.
- Escalation of under resourcing within ICT due to the number of initiatives underway and unforeseen issues.
- The need to focus on value add initiatives and information sharing between DHB's.

## 5.5 SUB-REGIONAL PUBLIC HEALTH SERVICES UPDATE

The paper was taken as **READ.**

The Board

a) **NOTED** the commencement of the Regional Child Oral Health Service in partnership with Pasifika Early Childhood Centres supervised tooth brushing programme;

b) **NOTED** the proposal for the high risk strategy intervention for the Regional Child Oral Health Service's most vulnerable children through a Kāiawhina driven fluoride application programme;

c) **NOTED** the ongoing commitment by the Regional Child Oral Health Service to eliminate service arrears by end of 2020;

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d) **NOTED** that Regional Public Health will execute the Memorandum of Understanding from the Drinking Water Joint Working Group (DWJWG) on behalf of the Boards;

e) **NOTED** that updates from the DWJWG will be prepared by Regional Public Health for the two Boards' respective Māori Governance Groups.

The Board discussed:

Implementation of warm water in schools and the benefit it provides, which will be rolled out to other regions in due course. Chris Faafoi is raising with the Minister of Education.

**Action:** Staff vaccinations for measles to be reported on during the next Capital and Coast District Health Board's Board meeting.

# 6. OTHER

## 6.1 GENERAL BUSINESS

Mr J Terris raised the recent news article around Hutt Valley DHB's vending supply agreement with Coca-Cola Amatil. Management advised that what is supplied complies with the Ministry of Health's national healthy food and drink policy guidelines.

## 6.2 RESOLUTION TO EXCLUDE THE PUBLIC

The Board **RESOLVED** to **AGREE** that as provided by Clause 32(a), of Schedule 3 of the New Zealand Public Health and Disability Act 2000, the public are excluded from the meeting for the following reasons:

| SUBJECT | REASON | REFERENCE |
|---|---|---|
| Public Excluded Minutes and Public Excluded Matters Arising from previous meeting | For the reasons set out in the 31 July Capital & Coast DHB, and 1 August 2019 Hutt Valley DHB Board agendas | |
| HVDHB financial performance report | Information contained in the paper may be subject to change as the information has not yet been reviewed by the Boards' FRACs | Section 9(2)(f)(iv) |
| CCDHB financial performance report | | |
| Sub-committee draft minutes | Papers contain information and advice that is likely to prejudice or disadvantage negotiations | Section 9(2)(j) |
| Joint Long Term Investment Plan/Hospital Network Planning update | Papers contain information and advice that is likely to prejudice or disadvantage commercial activities and/or disadvantage negotiations. | Section 9(2)(i)(j) |
| New investment to address Mental Health Acute Care continuum | | |
| Holidays Act compliance | | |
| New Zealand Health Partnerships Shareholders Review Group report | | |
| Registers of Board Chair executed documents | | |
| 2DHB Employment Relations update | | |
| Members' legal responsibilities and risks and indemnity insurance | Paper contains legal advice | Section 9(2)(h) |
| Final draft 2019/20 Regional Services Plan | Subject to Ministerial and/or Cabinet approval | Section 9(2)(f)(iv) |
| Risk management strategies for 2019/20 | | |

* Official Information Act 1982.

**MOVED:** Andrew Blair **SECONDED:** Kim von Lanthen **CARRIED**

**BOARD** **PUBLIC**

## 7. DATE OF NEXT MEETING

The next meeting will be held on Thursday, 26 September 2019, in the Boardroom, Pilmuir House, Hutt Valley DHB, commencing at 9.00 am.

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

**DATED** this day of 2019

ANDREW BLAIR
**CHAIR**
**HUTT VALLEY DISTRICT HEALTH BOARD**

**BOARD** **PUBLIC**

## MATTERS ARISING FROM PREVIOUS MEETINGS

| Original Meeting Date | Ref | Topic | Action | Resp | How Dealt with | Delivery date | Completed Date |
|---|---|---|---|---|---|---|---|
| 29 August | CB2019-5 | Patient Story | The Board requested management provide information that addresses monitoring of ARC providers and whether current policies/procedures include the testing of staff members, with the DHBs policies/procedures on isolation and screening attached. | General Manager Quality, Service Improvement and Innovation | Details to be included in health and Safety Report | September 2019 | September 2019 |
| | CB2019-6 | 3DHB MHAIDS Report | Management to advise Mr Terris on the process for smaller public organisations to be considered for funding. | General Manager Mental Health, Addictions & Intellectual Disability | Information to be sent directly to Mr Terris | September 2019 | |
| 01 August 2019 | B2019-4 | Health, Roundtable Performance Report | The Board requested management provide ongoing quarterly performance updates with a focus on Maternity and Emergency Department KPI's | Chief Operating Officer | Paper/presentation provided to HVDHB Board on a quarterly basis | October 2019 | |
| | B2019-3 | Chief Executives Report | The Board requested management report back on the strategies being implemented to reduce the use of minders | Director of Nursing | Details to be included in Operational Performance Report | September 2019 | September 2019 |

**Hutt Valley DHB Board work plan 2019**

| Regular monthly items: | | | | |
|---|---|---|---|---|
| **Public** | Chair's report | CEO's report | Resolution to exclude the public | |
| **Public Excluded** | Chair's report | CEO's report | FRAC report back | FRAC minutes |

| Strategy, Planning and Outcomes updates to include: | | |
|---|---|---|
| • ALT update | • Palliative Care update | • Obesity prevention |
| • Primary Care update | • Child & Youth health | • Smoking cessation services |

| | January | February | March | April | May | June | July | August | September | October | November | December |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Decision | Combined Boards workshop | | First draft 2019/20 Annual Plan | 2019/20 Funder Commitments | | Internal audit plan 2019/20 | | | ~~Allied Laundry AGM~~ | HVDHB 2018/19 Draft Annual report | | Child Health |
| | | | Lead DHB model for MHAIDS | | | Final 2019/20 Operating and Capital budgets | | | ~~Hospital dental system replacement business case*~~ | Final 2019/20 Annual Plan | | |
| | | | | | | Insurance renewal | | | Radiology Equipment Upgrades and Refurbishment business case | Final 2019/20 RSP | | |
| | | | | | | AoG contract for the supply of electricity and associated services | Final Draft Annual Plan | | Laboratory Contract | Electronic order of and signoff of other diagnostics * | | |
| | | | | | | | | | | Theatre Capacity | | |
| | | | | | | | | | | IT backup system replacement | | |
| | | | | | | | | | | Concerto Transition Phase 1 Business Case | | |
| Discussion | | | Hospital & Health Services report | Strategy, Planning & Outcomes update | | Hospital & Health Services report | Strategy, Planning & Outcomes update | | ~~Hospital & Health Services report~~ | Strategy, Planning & Outcomes update | | Operational performance report |
| | | | | | | | | | Operational performance report | Operational performance report | | Financial performance report |
| | | | | | | | | | Financial performance report | Financial performance report | | Health & Safety report |
| | | | Health & Safety report | Maori Health update | | Health & Safety report | Maori Health update | | Health & Safety report | Maori Health update | | RSP progress update |
| | | | Q2 performance | Quality and Safety report | | Facilities & Infrastructure | Quality and Safety report | | Facilities & Infrastructure | Quality and Safety report | | Facilities & Infrastructure |
| | | | | Progress update 2018/19 Annual Plan actions | | ~~Staff turnover~~ | Clinical Council report/minutes | | Clinical Council report | Clinical Council report | | External Audit report |
| | | | | Update on Phases 1 and 2 – ICT Resilience Programme | | ~~Maternity refurbishment update~~ | Consumer Council report/minutes | | Living Life Well / CSP Update | Consumer Council report/minutes | | Clinical Council report |
| | | | | Recognition of long serving staff | | Clinical Council report/minutes | Maternity refurbishment update | | Vision for Change dashboard | CPHAC Minutes | | Consumer Council report/minutes |
| | | | | Clinical Council report | | Consumer Council report/minutes | Health Roundtable performance | | | | | |
| | | | | Consumer Council report/minutes | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| Presentation | | | Closer to home | Clinical Services Plan | | Iwi Relationship Board | | | Iwi Relationship Board | NZ Police – Whangaia Nga Pa Harakeke: reducing and preventing family harm and its impact on families/whanau | | Iwi Relationship Board |
| Visits | | | OPRS | Te Whare Ahuru | | Visit to Te Omanga Hospice | | | | IHI Patient Safety Congress Conference Feedback (Sisira) 20 mins | | |

**Commented [CR[1]:** Removed as not applicable to Board

**Commented [CR2]:** Added following phone call with Helene Carbonatto

**Commented [CR[3]:** Removed as per request from COO

**Commented [KM[4]:** * Timing subject to Hutt Valley and Wairarapa business cases being progressed concurrently

**Commented [KM[5]:** Hospital & Health Services reports replaced by monthly operational performance report

**Commented [KM[6]:** Financial performance reports added at the request of the CE

**PUBLIC**

| | |
|---|---|
| **Date:** 20 September 2019 | **BOARD INFORMATION** |
| **Author** | General Manager, Quality, Service Improvement and Innovation - Debbie Gell |
| **Subject** | **Patient Story** |

**RECOMMENDATIONS**

It is **recommended** that the Board:

(a) Note the contents of this paper.

## 1. INTRODUCTION

### 1.1 Purpose

This paper is provided as background to the patient story being presented at the Hutt Valley DHB Board meeting on Thursday, 26 September 2019.

## 2. BACKGROUND

### 2.1 Overview of Patient Stories

Patient stories are presented as a means to assist us in exploring and understanding how a patient and / or their family / whānau experience care being delivered by Hutt Valley DHB.

The aim is to provoke conversations and reflection that will highlight areas for learning and improvement in a complex health system.

All patients / family / whānau have given informed consent for their story to be presented and are provided with feedback following the Hutt Valley DHB Board meeting.

### 2.1.1 Current Patient Story

The current story is about a patient who underwent surgery and, during their hospitalisation, required care and treatment at Wellington Regional Hospital.

The story reflects on the patients journey of care between the two hospitals, what they identified as a successful outcome, and focuses on 'what mattered' to them.

This story is being presented to highlight the importance of working towards developing patient reported outcome measures.

## 3. DISCUSSION

### 3.1 Key areas for consideration:

- How we capture data on patient reported outcomes.
- The importance of the seamless transfer of care and how that impacts on successful outcomes for patients.

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| | |
|---|---|
| HUTT VALLEY DHB | **BOARD DISCUSSION PAPER** |
| | **Date: 17 September 2019** |

| | |
|---|---|
| **Authors** | General Manager Finance & Corporate Services - Judith Parkinson |
| **Reviewed/approved by** | Chief Executive Hutt Valley and Capital & Coast DHBs - Fionnagh Dougan |
| **Subject** | **HVDHB FINANCIAL PERFORMANCE REPORT JULY 2019** |

**RECOMMENDATIONS**

It is recommended that the Board:

a) **NOTES** the July year to date result is an unfavourable variance to budget of ($240k) against the annual budget deficit of $8.1 million;

b) **NOTES** the Funder result for July year to date was $138K favourable, Governance $48K favourable and Provider ($426K) unfavourable to budget;

c) **NOTES** the key variances to budget outlined in this report including overspends in Nursing personnel (including use of minders), Support staff MECA settlement and outsourced clinical services partially offset by additional MoH revenue;

d) **NOTES** the quantified financial risks for 2019/20 of up to $7.3 million;

e) **NOTES** the Inter district flows (IDF) inflows and outflows for July are estimates and detailed information will be provided for next month;

f) **NOTES** the Holidays Act provision was booked in the June 2019 accounts and based on the same estimate an unbudgeted increase in the provision for July of $70k has been included under non-treatment related costs.

**APPENDICES**

1. Finance Report July 2019

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## 1. PURPOSE / STRATEGIC FIT


This report provides an update on the following key finance-related activities that relate to the DHB Strategic enablers; *Effective Commissioning*, *Smart infrastructure*, and *Adaptable Workforce*:

- Financial result summary for July 2019;
- Financial risks 2019/20.

## 2. GOVERNMENT PRIORITIES

This paper reports on the DHBs progress in relation to the Government's key directions including:

- DHB performance and sustainability.

## 3. STEWARDSHIP OF RESOURCES

This paper addresses our strategic imperative for good stewardship of resources by providing an update on the financial position of the DHB, key financial risks and progress on actions related to risk mitigation.

## 4. JULY 2019 FINANCIAL RESULT

The month of July had a total unfavourable variance to budget of ($204k).

### 4.1 Key results year to date (July 2019):

- Funder favourable by $138k;
- Governance favourable by $48k;
- Provider unfavourable by ($426k).

### 4.2 Material Variances year to date

**Total revenue favourable $263k:**

- Devolved MoH revenue $208k favourable;
- Non Devolved revenue $100k favourable, driven by Personal Health side contracts;
- ACC Revenue $11k favourable this month;

- Other revenue $67k favourable this month;
- IDF inflows unfavourable ($90k) for the month predominately driven by Mental Health;
- Inter DHB Revenue unfavourable ($32k), mainly timing differences.

**Personnel and outsourced personnel unfavourable ($164k):**

- Medical personnel incl. outsourced favourable $262k. Outsourced costs are $169k favourable Medical Staff Internal are $93k favourable.
- Nursing including outsourced ($226k) unfavourable. Employee costs are ($170k) unfavourable, driven by Senior Nurses ($16k), Internal Bureau Nurses ($106k) and Health Service Assistants ($125k), partly offset by Registered Nurses $119k. Outsourced was unfavourable ($56k), mostly driven by Nurses Adult Community Services ($10k), CATT ($24k) and Central Region Eating Disorders ($5k) with other minor variances.
- Allied Health incl. outsourced $142k favourable, driven largely by vacancies.
- Support incl. outsourced unfavourable ($198k) driven by MECA back-pay exceeding funding by ($146k).
- Management & Admin incl. outsourced unfavourable ($145k); internal staff unfavourable ($95k), Outsourced unfavourable ($50k). This includes savings targets.
- Sick leave for the July was 4%, which is higher than the same time last year, which was 3.6%.

**Outsourced** other unfavourable ($243k) for the month, driven by Outsource Clinical Services ($271k) mainly Ophthalmology, Plastics and endoscopy.

**Treatment related costs** unfavourable ($160k), driven by Instruments and Equipment ($125k), Implants and Prostheses ($47k), Treatment disposables ($187k), offset by Pharmaceuticals $267k.

**Non Treatment Related costs** unfavourable ($39k) driven by the ongoing monthly provision for Holidays Act Compliance ($70k).

**IDF Outflows** $18k favourable for the month.

**Other External Provider costs** unfavourable ($53k).

**Interest, Depreciation & Capital Charge** favourable $137k, driven largely by the lower than expected Depreciation $130k.

**Cash Position** averaged $18.7m for July, and $21.1m for June and was $0.4m in funds at the end of July. The cash flow forecast is becoming tight and the DHB went into overdraft in July as per the previous forecast.

**Appendix one** - Finance report for July 2019.

## 5. FINANCIAL RISKS 2019/20

Financial risks of up to $7.3 million have been estimated including; the impact of future MECA settlements, Holidays Act compliance, rate increase on Annual leave accruals, outsourced services, price increases and remaining savings targets.

A programme of work is underway to look at further efficiencies to help mitigate the financial risks.

# Finance Report

# July 2019

**Strategic enabler;** ***Effective Commissioning***

Fionnagh Dougan
Chief Executive

Judith Parkinson
General Manager Finance & Corporate Service

# CONTENTS

# Financial Performance Overview

## Summary of the financial performance of the DHB for July 2019

| Month | | | | | Hutt Valley DHB Operating Report for the month of July 2019 | Year end Result | | | | | Annual | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | Budget | Variance | Last Year | Variance | $000s | Actual | Budget | Variance | Last Year | Variance | Budget | Last Year |
| | | | | | **Revenue** | | | | | | | |
| 37,811 | 37,603 | 208 | 35,669 | 2,142 | Devolved MoH Revenue | 37,811 | 37,603 | 208 | 35,669 | 2,142 | 450,868 | 434,235 |
| 1,651 | 1,551 | 100 | 1,565 | 86 | Non Devolved MoH Revenue | 1,651 | 1,551 | 100 | 1,565 | 86 | 19,446 | 19,742 |
| 619 | 608 | 11 | 587 | 33 | ACC Revenue | 619 | 608 | 11 | 587 | 33 | 7,341 | 7,539 |
| 972 | 906 | 67 | 618 | 355 | Other Revenue | 972 | 906 | 67 | 618 | 355 | 10,891 | 6,987 |
| 8,512 | 8,602 | (90) | 8,333 | 178 | IDF Inflow | 8,512 | 8,602 | (90) | 8,333 | 178 | 103,225 | 101,806 |
| 295 | 326 | (32) | 297 | (2) | Inter DHB Provider Revenue | 295 | 326 | (32) | 297 | (2) | 3,915 | 4,577 |
| **49,860** | **49,597** | **263** | **47,068** | **2,791** | **Total Revenue** | **49,860** | **49,597** | **263** | **47,068** | **2,791** | **595,687** | **574,886** |
| | | | | | **Expenditure** | | | | | | | |
| | | | | | **Employee Expenses** | | | | | | | |
| 5,140 | 5,233 | 93 | 4,480 | (660) | Medical Employees | 5,140 | 5,233 | 93 | 4,480 | (660) | 59,826 | 56,594 |
| 6,167 | 5,997 | (170) | 5,357 | (810) | Nursing Employees | 6,167 | 5,997 | (170) | 5,357 | (810) | 69,893 | 69,463 |
| 2,600 | 2,747 | 147 | 2,399 | (201) | Allied Health Employees | 2,600 | 2,747 | 147 | 2,399 | (201) | 32,008 | 29,882 |
| 813 | 663 | (150) | 605 | (208) | Support Employees | 813 | 663 | (150) | 605 | (208) | 7,642 | 7,392 |
| 2,683 | 2,588 | (95) | 2,268 | (415) | Management and Admin Employees | 2,683 | 2,588 | (95) | 2,268 | (415) | 29,481 | 27,228 |
| **17,403** | **17,228** | **(175)** | **15,109** | **(2,294)** | **Total Employee Expenses** | **17,403** | **17,228** | **(175)** | **15,109** | **(2,294)** | **198,850** | **190,558** |
| | | | | | **Outsourced Personnel Expenses** | | | | | | | |
| 52 | 221 | 169 | 134 | 82 | Medical Personnel | 52 | 221 | 169 | 134 | 82 | 2,649 | 3,600 |
| 142 | 87 | (56) | 164 | 22 | Nursing Personnel | 142 | 87 | (56) | 164 | 22 | 1,039 | 2,268 |
| 34 | 29 | (5) | 55 | 21 | Allied Health Personnel | 34 | 29 | (5) | 55 | 21 | 344 | 502 |
| 68 | 20 | (48) | 8 | (60) | Support Personnel | 68 | 20 | (48) | 8 | (60) | 244 | 323 |
| 92 | 42 | (50) | 81 | (11) | Management and Admin Personnel | 92 | 42 | (50) | 81 | (11) | 502 | 1,299 |
| **388** | **398** | **11** | **442** | **54** | **Total Outsourced Personnel Expenses** | **388** | **398** | **11** | **442** | **54** | **4,778** | **7,991** |
| 920 | 677 | (243) | 820 | (100) | Outsourced Other Expenses | 920 | 677 | (243) | 820 | (100) | 7,498 | 8,486 |
| 2,469 | 2,309 | (160) | 2,243 | (226) | Treatment Related Costs | 2,469 | 2,309 | (160) | 2,243 | (226) | 26,099 | 24,879 |
| 1,623 | 1,584 | (39) | 1,381 | (242) | Non Treatment Related Costs | 1,623 | 1,584 | (39) | 1,381 | (242) | 18,458 | 29,932 |
| 8,416 | 8,434 | 18 | 8,078 | (337) | IDF Outflow | 8,416 | 8,434 | 18 | 8,078 | (337) | 101,203 | 95,136 |
| 18,302 | 18,250 | (53) | 17,114 | (1,188) | Other External Provider Costs | 18,302 | 18,250 | (53) | 17,114 | (1,188) | 218,591 | 211,615 |
| 2,194 | 2,331 | 137 | 2,098 | (97) | Interest, Depreciation & Capital Charge | 2,194 | 2,331 | 137 | 2,098 | (97) | 28,352 | 26,163 |
| **51,714** | **51,211** | **(503)** | **47,285** | **(4,429)** | **Total Expenditure** | **51,714** | **51,211** | **(503)** | **47,285** | **(4,429)** | **603,828** | **594,761** |
| **(1,854)** | **(1,614)** | **(240)** | **(217)** | **(1,638)** | **Net Result** | **(1,854)** | **(1,614)** | **(240)** | **(217)** | **(1,638)** | **(8,141)** | **(19,876)** |
| | | | | | **Result by Output Class** | | | | | | | |
| (358) | (495) | 138 | 586 | (944) | Funder | (358) | (495) | 138 | 586 | (944) | (5,906) | 4,534 |
| 35 | (13) | 48 | 18 | 17 | Governance | 35 | (13) | 48 | 18 | 17 | (210) | (134) |
| (1,531) | (1,105) | (426) | (821) | (711) | Provider | (1,531) | (1,105) | (426) | (821) | (711) | (2,025) | (24,276) |
| **(1,854)** | **(1,614)** | **(240)** | **(217)** | **(1,638)** | **Net Result** | **(1,854)** | **(1,614)** | **(240)** | **(217)** | **(1,638)** | **(8,141)** | **(19,876)** |

There may be rounding differences in this report

# July Month Results:

Unfavourable variance to budget of ($240k) for the month; the main variances are detailed below:

1. **Revenue:** Total revenue favourable $263k for the month.
   Devolved MoH revenue $208k favourable.
   Non Devolved revenue $100k favourable, driven by Personal Health side contracts.
   ACC Revenue $11k favourable this month.
   Other revenue $67k favourable this month.
   IDF inflows unfavourable ($90k) for the month predominately driven by Mental Health.
   Inter DHB Revenue unfavourable ($32k), mainly timing differences.

2. **Total Personnel** including outsourced unfavourable ($164k) for the month.
   - Medical personnel incl. outsourced favourable $262k. Outsourced costs are $169k favourable Medical Staff Internal are $93k favourable.
   - Nursing incl. outsourced ($226k) unfavourable. Employee costs are ($170k) unfavourable, driven by Senior Nurses ($16k), Internal Bureau Nurses ($106k) and Health Service Assistants ($125k), partly offset by Registered Nurses $119k. Outsourced was unfavourable ($56k), mostly driven by Nurses Adult Community Services ($10k), CATT ($24k) and Central Region Eating Disorders ($5k) with other minor variances.
   - Allied Health incl. outsourced $142k favourable, driven largely by vacancies.
   - Support incl. outsourced unfavourable ($198k) driven by MECA back-pay exceeding funding by ($146k).
   - Management & Admin incl. outsourced unfavourable ($145k); internal staff unfavourable ($95k), Outsourced unfavourable ($50k). This includes savings targets.
   - Sick leave for the July was 4%, which is higher than the same time last year, which was 3.6%.

3. **Outsourced other** unfavourable ($243k) for the month, driven by Outsource Clinical Services ($271k) mainly Ophthalmology, Plastics and endoscopy.
4. **Treatment related costs** unfavourable ($160k), driven by Instruments and Equipment ($125k), Implants and Prostheses ($47k), Treatment disposables ($187k), offset by Pharmaceuticals $267k.
5. **Non Treatment Related costs** unfavourable ($39k) driven by the ongoing monthly provision for Holidays Act Compliance ($70k).
6. **IDF Outflows** $18k favourable for the month based on estimated information.
7. **Other External Provider** costs unfavourable ($53k).
8. **Interest, Depreciation & Capital Charge** favourable $137k, driven largely by the lower than expected Depreciation $130k.

**Cash Position** averaged $18.7m for July, and $21.1m for June and was $0.4m in funds at the end of July. The cash flow forecast is becoming tight and the DHB went into overdraft in July as per the previous forecast.

## Funder Financial Statement of Performance

**DHB Funder (Hutt Valley DHB)**
**Financial Summary for the month of July 2019**

| Month | | | | | $000s | Year to Date | | | | | Annual | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | Budget | Variance | Last Year | Variance | | Actual | Budget | Variance | Last Year | Variance | Budget | Last Year |
| | | | | | **Revenue** | | | | | | | |
| 34,735 | 34,735 | (1) | 33,092 | 1,642 | Base Funding | 34,735 | 34,735 | (1) | 33,092 | 1,642 | 416,455 | 397,109 |
| 3,076 | 2,818 | 258 | 2,577 | 499 | Other MOH Revenue | 3,076 | 2,818 | 258 | 2,577 | 499 | 33,820 | 37,126 |
| 437 | 448 | (10) | 51 | 386 | Other Revenue | 437 | 448 | (10) | 51 | 386 | 5,372 | 654 |
| 8,512 | 8,602 | (90) | 8,333 | 178 | IDF Inflows | 8,512 | 8,602 | (90) | 8,333 | 178 | 103,225 | 101,806 |
| **46,760** | **46,603** | **157** | **44,054** | **2,707** | **Total Revenue** | **46,760** | **46,603** | **157** | **44,054** | **2,707** | **558,872** | **536,694** |
| | | | | | **Expenditure** | | | | | | | |
| 383 | 383 | 0 | 272 | (111) | DHB Governance & Administration | 383 | 383 | 0 | 272 | (111) | 4,597 | 3,467 |
| 20,017 | 20,032 | 16 | 18,003 | (2,013) | DHB Provider Arm | 20,017 | 20,032 | 16 | 18,003 | (2,013) | 240,388 | 221,939 |
| | | | | | **External Provider Payments** | | | | | | | |
| 3,622 | 2,950 | (672) | 3,113 | (509) | Pharmaceuticals | 3,622 | 2,950 | (672) | 3,113 | (509) | 35,275 | 37,728 |
| 4,232 | 4,329 | 97 | 4,240 | 7 | Laboratory | 4,232 | 4,329 | 97 | 4,240 | 7 | 51,954 | 51,172 |
| 2,532 | 2,479 | (53) | 2,258 | (274) | Capitation | 2,532 | 2,479 | (53) | 2,258 | (274) | 29,747 | 26,925 |
| 885 | 1,044 | 159 | 923 | 38 | ARC-Rest Home Level | 885 | 1,044 | 159 | 923 | 38 | 12,245 | 11,476 |
| 1,603 | 1,638 | 35 | 1,499 | (103) | ARC-Hospital Level | 1,603 | 1,638 | 35 | 1,499 | (103) | 19,231 | 18,224 |
| 1,862 | 2,045 | 183 | 1,853 | (9) | Other HoP | 1,862 | 2,045 | 183 | 1,853 | (9) | 25,068 | 23,493 |
| 629 | 771 | 141 | 718 | 89 | Pay Equity | 629 | 771 | 141 | 718 | 89 | 9,166 | 9,918 |
| 762 | 821 | 59 | 732 | (30) | Mental Health | 762 | 821 | 59 | 732 | (30) | 9,892 | 9,034 |
| 743 | 757 | 13 | 734 | (10) | Palliative Care / Fertility / Comm Radiology | 743 | 757 | 13 | 734 | (10) | 9,079 | 8,808 |
| 1,417 | 1,417 | (0) | 1,045 | (372) | Other External Provider Payments | 1,417 | 1,417 | (0) | 1,045 | (372) | 16,934 | 14,824 |
| 8,416 | 8,434 | 18 | 8,078 | (337) | IDF Outflows | 8,416 | 8,434 | 18 | 8,078 | (337) | 101,203 | 95,136 |
| 15 | 0 | (15) | 0 | (15) | Provision for IDF Wash-ups | 15 | 0 | (15) | 0 | (15) | 0 | 15 |
| **47,118** | **47,099** | **(19)** | **43,468** | **(3,650)** | **Total Expenditure** | **47,118** | **47,099** | **(19)** | **43,468** | **(3,650)** | **564,778** | **532,160** |
| **(358)** | **(495)** | **138** | **586** | **(944)** | **Net Result** | **(358)** | **(495)** | **138** | **586** | **(944)** | **(5,906)** | **4,534** |

There may be rounding differences in this report

**The July result for the funder was $138k favourable.**

**Revenue**

- Base Funding is on budget for the month.
- Other MoH revenue is favourable $258 for July, driven by MoH Subcontracts.
- Other revenue is unfavourable ($10k), mostly timing differences.

- IDF inflows are ($90k) unfavourable, mostly Mental Health.

**Expenditure**

- Governance and Administration is on budget.
- Provider Arm payments are $16k favourable for the month.

| Funder Changes to Provider Arm Funding July 2019 ($000s) | | | |
|---|---|---|---|
| | | Variance to budget | |
| Description | Funding Source | Month | YTD |
| **Activity Based Wash-up** | | | |
| Inpatient IDF Inflows wash-up | IDF Inflows | 0 | 0 |
| WAI - Mental Health Acute Beds | IDF Inflows | 80 | 80 |
| Air Ambulance Costs | PBF | (56) | (56) |
| **Funding Changes** | | | |
| Disability coordinator | PBF | (6) | (6) |
| WAI - Reduction in tobacco funding | IDF Inflows | (2) | (2) |
| Rounding | | - | - |
| **Provider Arm Funding Variance** | | **16** | **16** |

**External Provider Payments:**

- Pharmaceutical costs are unfavourable ($672k) to budget for July, driven by Cancer Drug costs claimed by the Hospital Pharmacy.
- Laboratory costs are favourable to budget by $97k for the month, reflecting lower than expected volumes.
- Capitation expenses ($53k) unfavourable for the month offset by additional revenue.
- Aged residential care costs are $194k favourable for the month. The residential care loan adjustment (reported within other HOP) is favourable by $12k.
- Other HOP costs are favourable by $183k for the month.

- Pay Equity costs are $141k favourable to budget for the month.

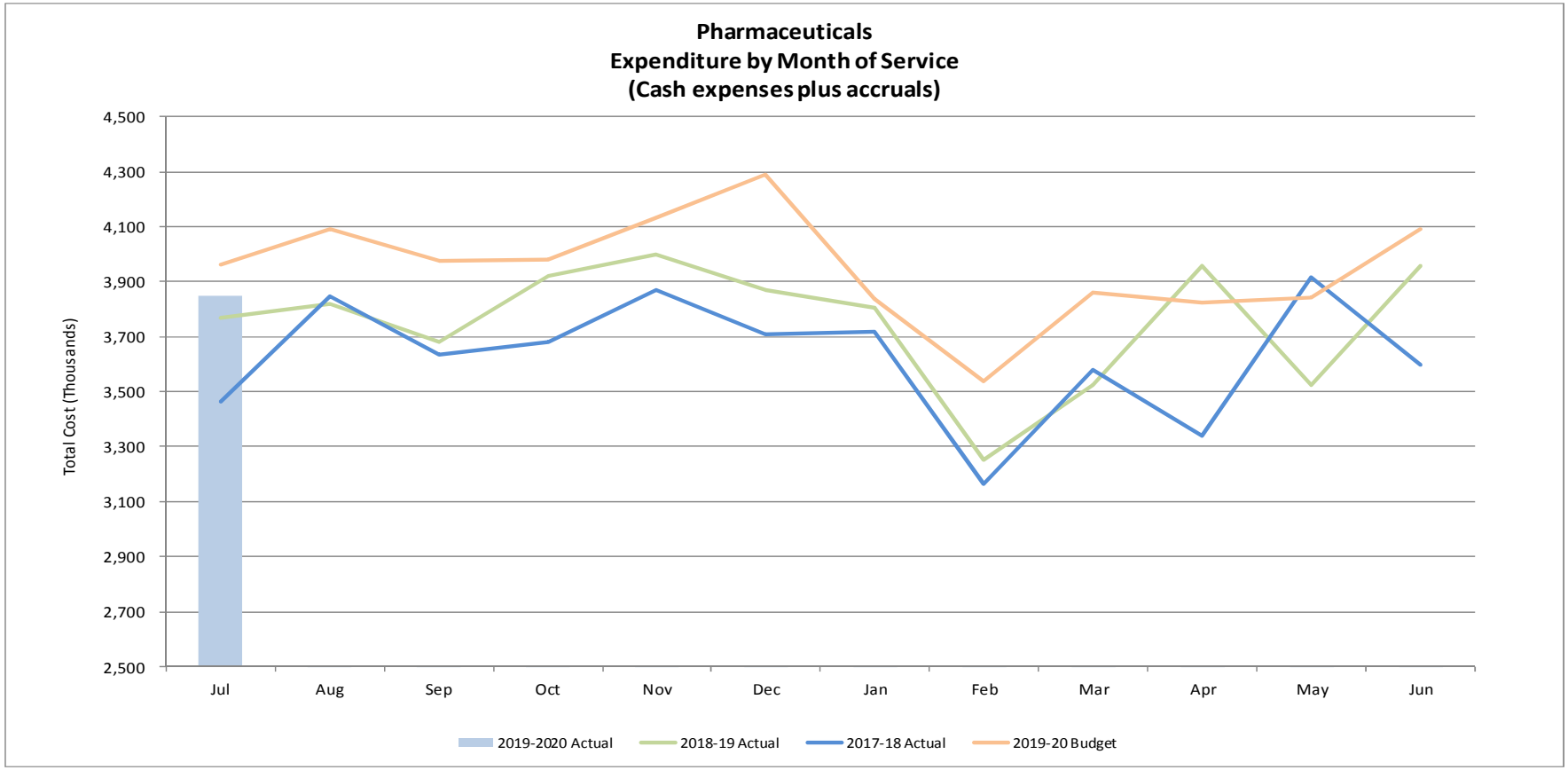
| Pay Equity Summary July 2019 | | |
|---|---|---|
| ($000s) | Variance to budget | |
| | Month | YTD |
| **Revenue** | | |
| HOP and ARC | 238 | 238 |
| Mental Health | 23 | 23 |
| **Variance on Revenue** | **261** | **261** |
| **Expenditure** | | |
| HOP and ARC | 115 | 115 |
| Mental Health | 27 | 27 |
| **Variance on Expenditure** | **141** | **141** |
| **Net Variance** | **403** | **403** |

- Mental Health costs are favourable $59k for the month.
- Palliative Care, Fertility and Community Radiology costs are on budget, with a small favourable variance of $13k for the month.
- Other external provider costs are on Budget for the month.
- IDF Outflows are overall favourable $3k for the month.

| IDF Wash-ups and Service Changes July 2019 | | |
|---|---|---|
| IDF Outflows $000s | Variance to budget | |
| | Month | YTD |
| Base | 18 | 18 |
| NZ Artificial Limb | (0) | (0) |
| Medical Outpatients | (15) | (15) |
| Rounding (timing) differences | - | - |
| **IDF Outflow variance** | **3** | **3** |

# Pharmaceutical Costs

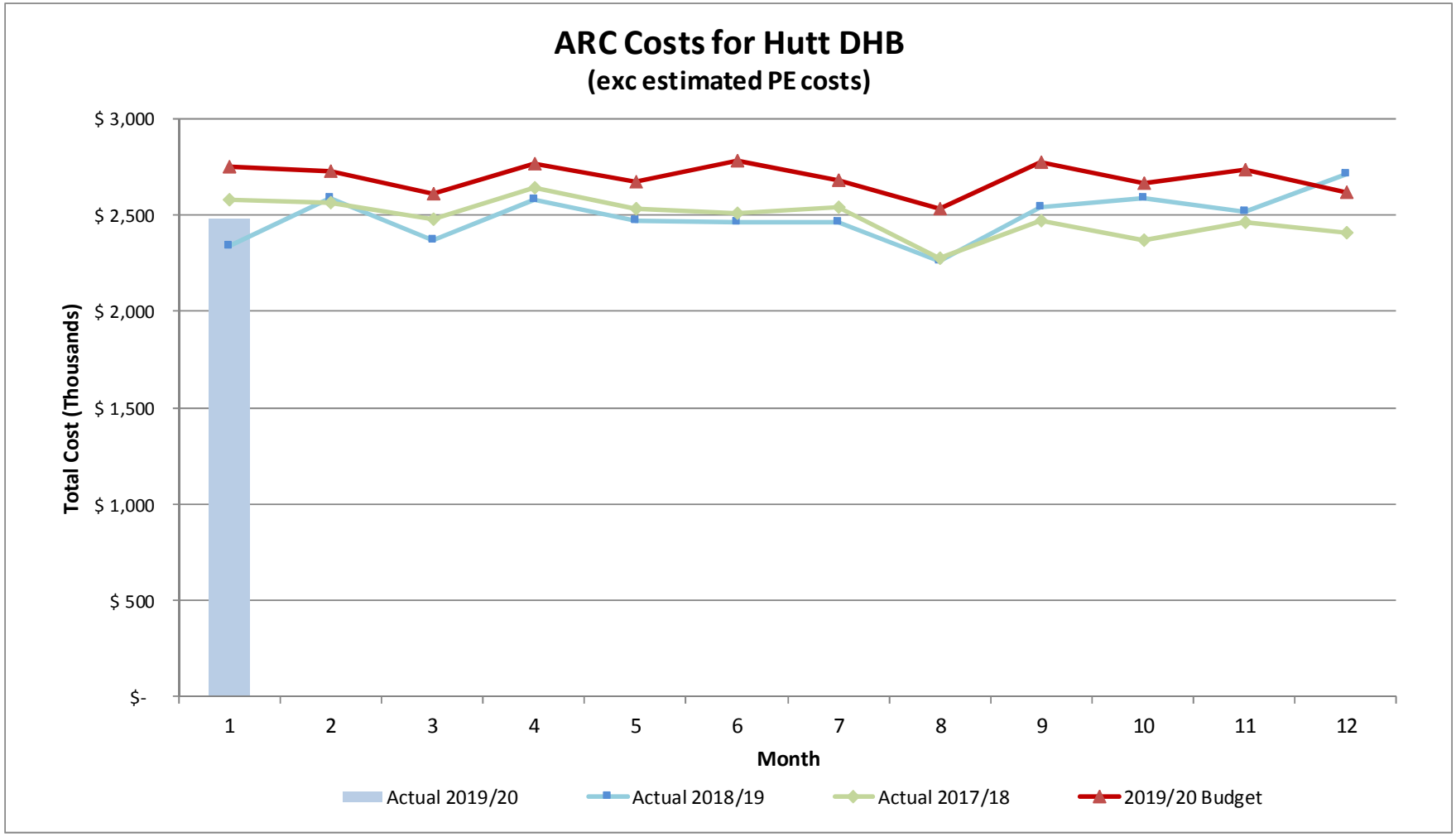
Community Pharmaceuticals accruals are calculated on a consistent methodology, which takes into account the seasonality of the expenditure, and timing delays between the month of service and the month of payment. In the 2018/19 financial year, on average, 31.5% of the costs were paid in the month of service, 66.3% in the month following, and the remaining 2.2% spread across the following months.




The graph above shows the expenditure on community pharmaceutical costs including the actuals for 2017/18 to 2019/20 together with the budget for 2019/20. The budget for 2019/20 has been phased based on trends of expenditure in previous years. The net amount reported as pharmaceutical costs in the accounts includes community pharmaceutical costs, Pharmac rebates, payments for National Haemophilia services and any transactions relating to the Discretionary Pharmaceutical Fund (DPF).

# Aged Residential Care

The following graph shows the expenditure for aged residential care. Note that estimated costs of Pay Equity are excluded.

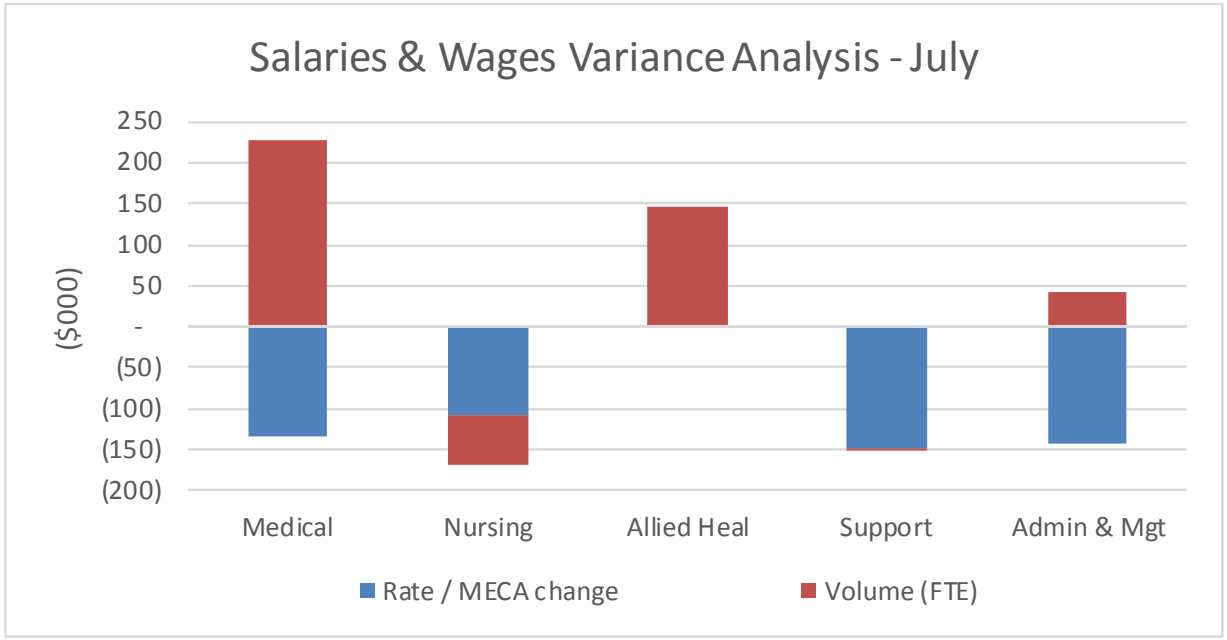


# Personnel & FTE

| Month | | | | | FTE Report | Year To Date | | | | | Annual | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | Budget | Variance | Last Year | Variance | Jul-19 | Actual | Budget | Variance | Last Year | Variance | Budget | Last Year |
| | | | | | ***FTE*** | | | | | | | |
| 267 | 279 | 12 | 266 | (1) | Medical | 267 | 279 | 12 | 266 | (1) | 280 | 273 |
| 800 | 792 | (8) | 752 | (48) | Nursing | 800 | 792 | (8) | 752 | (48) | 792 | 776 |
| 386 | 407 | 21 | 388 | 3 | Allied Health | 386 | 407 | 21 | 388 | 3 | 408 | 387 |
| 135 | 135 | (0) | 135 | 0 | Support | 135 | 135 | (0) | 135 | 0 | 135 | 135 |
| 376 | 383 | 8 | 351 | (24) | Management & Administration | 376 | 383 | 8 | 351 | (24) | 383 | 353 |
| **1,964** | **1,997** | **33** | **1,892** | **(72)** | **Total FTE** | **1,964** | **1,997** | **33** | **1,892** | **(72)** | **1,998** | **1,923** |
| | | | | | ***$ per FTE*** | | | | | | | |
| 19,231 | 18,727 | (504) | 16,848 | (2,382) | Medical | 19,231 | 18,727 | (504) | 16,848 | (2,382) | 213,946 | 219,529 |
| 7,708 | 7,572 | (137) | 7,125 | (583) | Nursing | 7,708 | 7,572 | (137) | 7,125 | (583) | 88,243 | 90,022 |
| 6,738 | 6,745 | 7 | 6,178 | (560) | Allied Health | 6,738 | 6,745 | 7 | 6,178 | (560) | 78,414 | 82,741 |
| 6,020 | 4,911 | (1,109) | 4,475 | (1,545) | Support | 6,020 | 4,911 | (1,109) | 4,475 | (1,545) | 56,575 | 56,760 |
| 7,141 | 6,749 | (392) | 6,458 | (683) | Management & Administration | 7,141 | 6,749 | (392) | 6,458 | (683) | 76,934 | 83,574 |
| **8,861** | **8,626** | **(235)** | **7,984** | **(877)** | **Average Cost per FTE all Staff** | **8,861** | **8,626** | **(235)** | **7,984** | **(877)** | **99,517** | **103,398** |

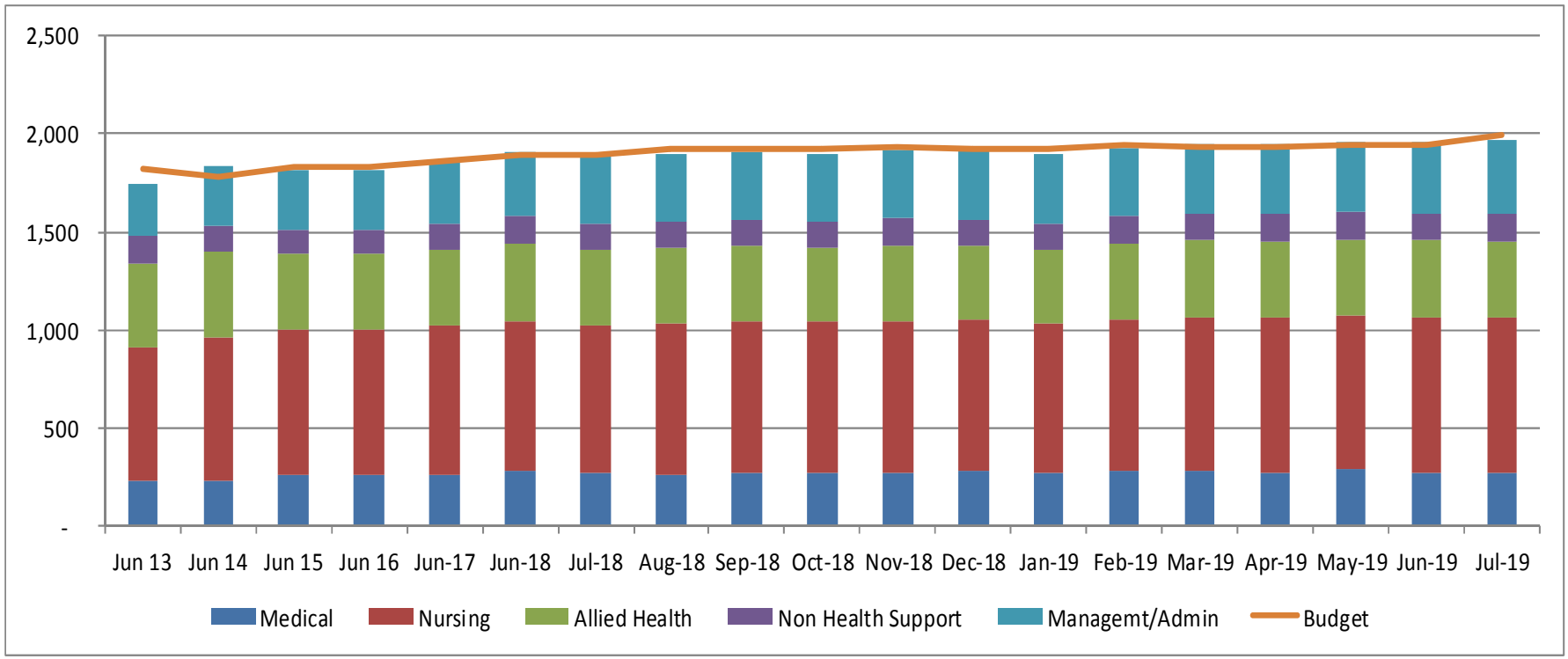
**Personnel & FTE Commentary**

- **Medical** 12 FTE under budget for the month; **SMOs** under budget by 8 FTE, **MOSS** under budget by 3 FTE with other minor variances.
- **Nursing** over by (8) FTEs for the month. **Senior Nurses, Registered Nurses and Midwives** are under budget by 22 FTE. **Registered Midwives** are over budget (1) FTE. **Internal Bureau Nurses** are over by (8). **Health Care Assistants** are (21) FTE over. Personnel cost variance for July ($170k) is the result of a price variance of ($109k) and a volume variance of ($61k).
- **Allied** FTEs are under by 21 FTEs for the month due in the main to; Favourable variances in Health promotion offices & community support workers, Hand therapy, Audiology, social work and psychologists. YTD favourable variance $150k is driven by vacancies.
- **Support** FTEs are on budget. The Cost variance is the result of the Local MECA settlement exceeding the provision provided.
- **Management & Admin** are under budget by 8 FTEs. Driven by administrative support staff vacancies.


Salaries & Wages Variance Analysis - July
250
200
150
100
50
-
(50)
(100)
(150)
(200)
($000)
Medical
Nursing
Allied Heal
Support
Admin & Mgt
Rate / MECA change
Volume (FTE)

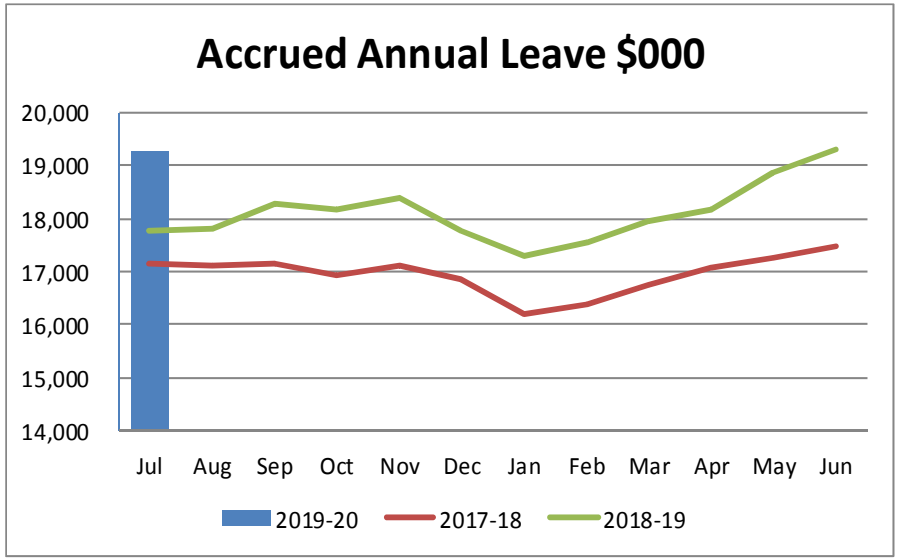
**The following Table and Graph reflect the FTE Trend.**

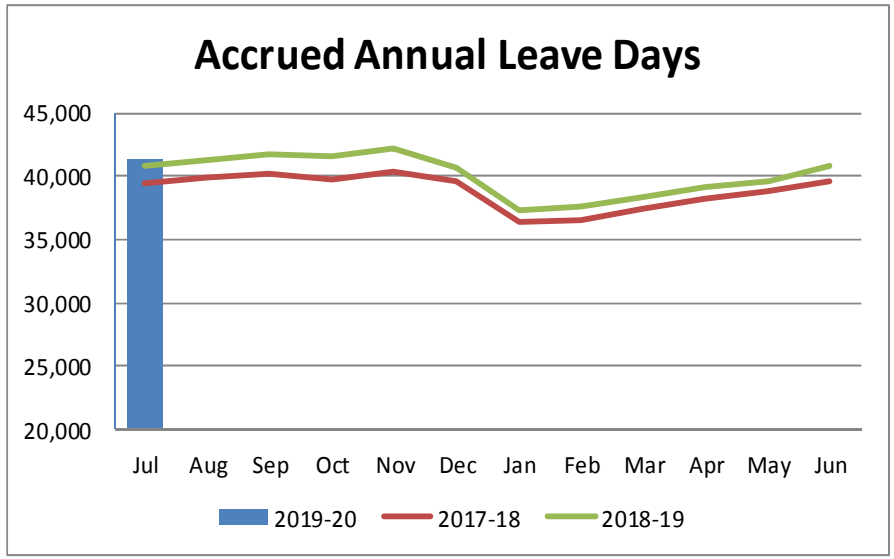
| | | Jun 13 | Jun 14 | Jun 15 | Jun 16 | Jun-17 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | Medical | 224 | 228 | 257 | 257 | 263 | 278 | 266 | 264 | 271 | 268 | 272 | 279 | 272 | 277 | 277 | 269 | 286 | 269 | 267 |
| | Nursing | 690 | 733 | 744 | 744 | 759 | 767 | 752 | 772 | 770 | 773 | 772 | 770 | 761 | 781 | 790 | 791 | 788 | 797 | 800 |
| | Allied Health | 428 | 435 | 385 | 385 | 385 | 396 | 388 | 384 | 387 | 381 | 389 | 383 | 380 | 387 | 389 | 392 | 391 | 392 | 386 |
| | Non Health Support | 133 | 135 | 129 | 129 | 131 | 137 | 135 | 134 | 135 | 132 | 136 | 133 | 132 | 136 | 136 | 136 | 135 | 136 | 135 |
| | Managemt/Admin | 272 | 305 | 302 | 302 | 330 | 330 | 351 | 344 | 343 | 346 | 349 | 352 | 354 | 352 | 358 | 359 | 361 | 364 | 376 |
| Total | **Actual FTE** | **1,748** | **1,836** | **1,817** | **1,817** | **1,869** | **1,908** | **1,892** | **1,898** | **1,905** | **1,900** | **1,918** | **1,916** | **1,899** | **1,932** | **1,950** | **1,948** | **1,961** | **1,958** | **1,964** |
| | Budget | 1,824 | 1,785 | 1,835 | 1,835 | 1,862 | 1,890 | 1,891 | 1,923 | 1,924 | 1,921 | 1,934 | 1,926 | 1,926 | 1,938 | 1,937 | 1,937 | 1,939 | 1,939 | 1,997 |



## Annual Leave

The following graphs show the historical trends in annual leave for the last two years. The cost of annual leave decreased compared to last month by $22k.

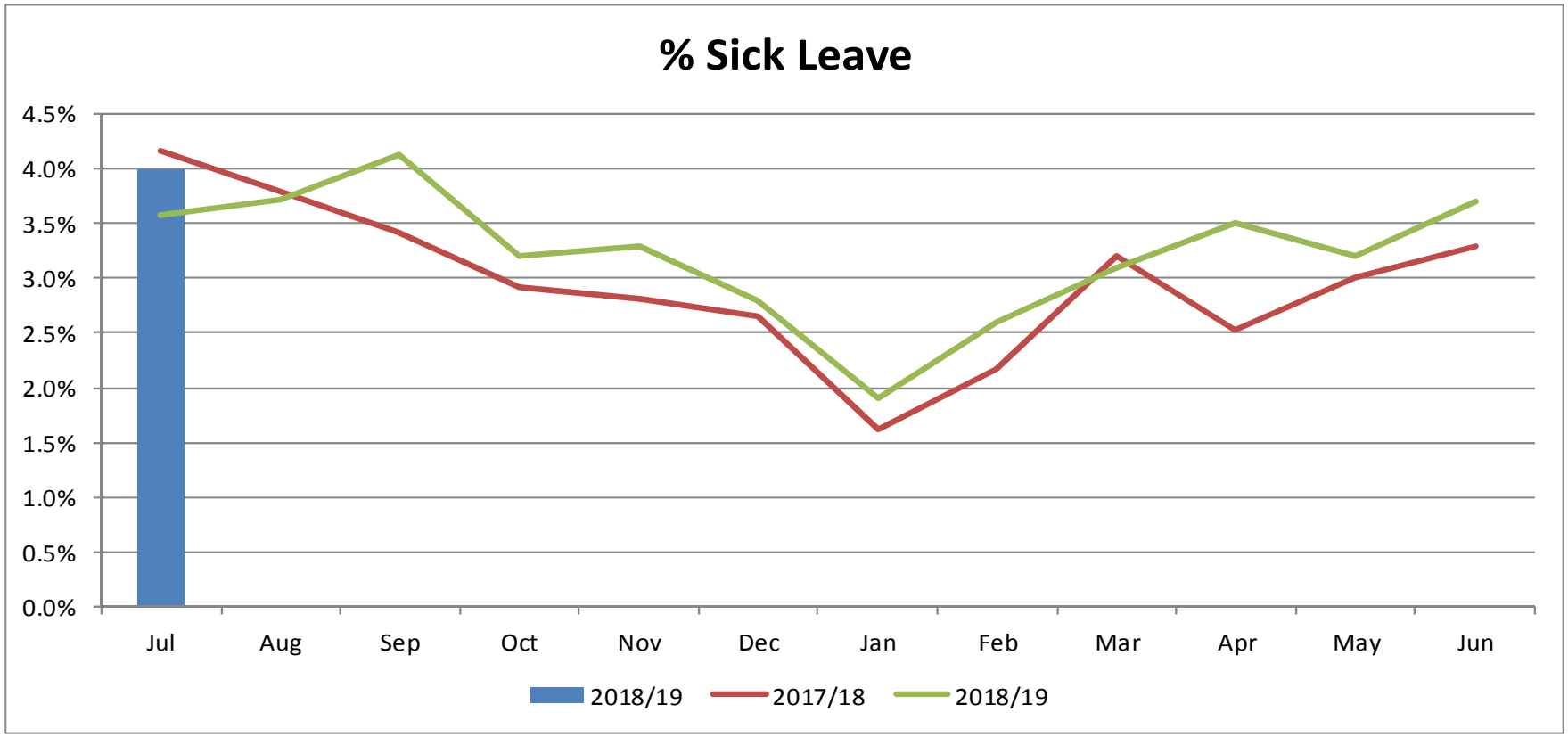



| Category | Total staff with Annual leave days | | | | | | |
|---|---|---|---|---|---|---|---|
| | Less than 20 | 20-30 | 30-40 | Greater than 40 | % of staff >40 | Total Staff | **Total Leave Less LSL $** |
| Medical - Senior | 74 | 28 | 17 | 40 | 25% | 159 | 4,998,040 |
| Medical - Junior | 124 | 21 | 13 | 12 | 7% | 170 | 1,494,340 |
| Nursing | 527 | 177 | 97 | 101 | 11% | 902 | 8,181,461 |
| Allied Health | 372 | 60 | 27 | 14 | 3% | 473 | 1,945,027 |
| Support | 68 | 29 | 19 | 17 | 13% | 133 | 873,589 |
| Mgmt/Admin | 267 | 78 | 35 | 14 | 4% | 394 | 1,788,180 |
| Total* | 1,432 | 393 | 208 | 198 | 9% | 2,231 | 19,280,636 |

## Sick Leave

The following graph shows the historical trends in sick leave for the last two years.




| | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medical | 2.6% | 2.1% | 2.2% | 1.7% | 1.6% | 1.3% | 0.9% | 1.5% | 1.7% | 1.5% | 1.4% | 1.8% | 1.7% |
| Nursing | 4.3% | 4.5% | 4.7% | 3.6% | 3.6% | 3.6% | 2.6% | 3.6% | 3.6% | 4.0% | 3.3% | 4.0% | 4.2% |
| Allied Health | 3.4% | 3.7% | 4.4% | 2.8% | 3.8% | 2.4% | 1.7% | 2.4% | 3.0% | 3.0% | 3.1% | 3.7% | 4.6% |
| Support | 5.4% | 3.5% | 4.0% | 3.1% | 4.6% | 3.5% | 2.4% | 3.9% | 3.2% | 3.8% | 3.9% | 3.9% | 4.3% |
| Admin | 3.2% | 3.9% | 4.1% | 3.6% | 2.8% | 3.0% | 1.3% | 2.4% | 3.0% | 4.3% | 3.8% | 4.6% | 4.5% |
| Total | **3.6%** | **3.7%** | **4.1%** | **3.2%** | **3.3%** | **2.8%** | **1.9%** | **2.6%** | **3.1%** | **3.5%** | **3.2%** | **3.7%** | **4.0%** |

# IDF Analysis

At this stage of the financial year, due to delays in coding there is little volume data available so there is no report on IDF expenditure for this month.

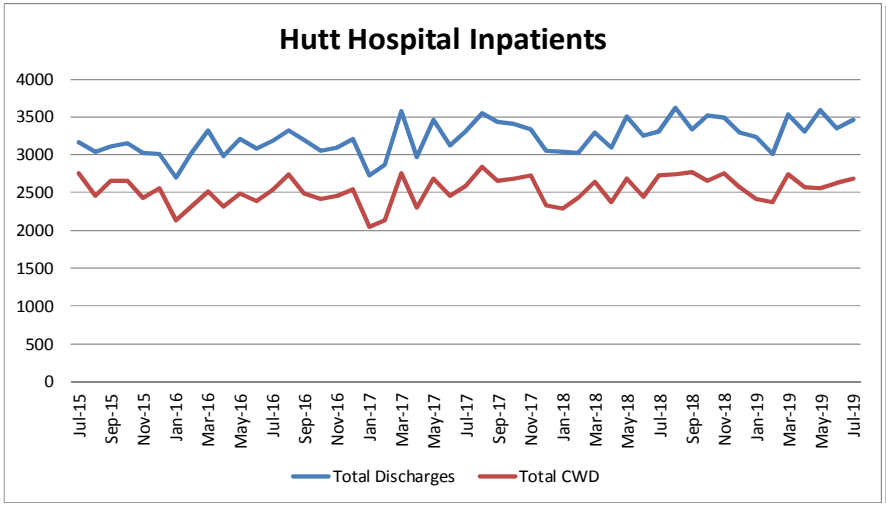
# Hospital throughput

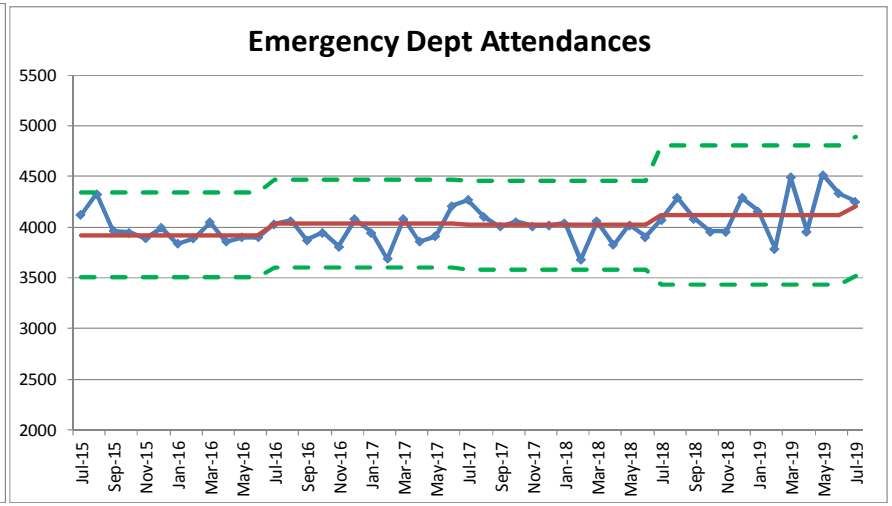
| Month | | | | | **Hutt Valley DHB Hospital Throughput YTD Jul-19** | Year to Date | | | | | Annual | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | Budget | Variance Actual vs Budget | Last year | Variance Actual vs Last year | | Actual | Budget | Variance Actual vs Budget | Last year | Variance Actual vs Last year | Annual Budget | Last year |
| | | | | | *Discharges* | | | | | | | |
| 1,075 | 1,009 | (66) | 1,115 | 40 | Surgical | 1,075 | 1,009 | (66) | 1,115 | 40 | 12,237 | 12,797 |
| 1,954 | 1,695 | (259) | 1,777 | (177) | Medical | 1,954 | 1,695 | (259) | 1,777 | (177) | 20,576 | 19,506 |
| 427 | 423 | (4) | 412 | (15) | Other | 427 | 423 | (4) | 412 | (15) | 5,027 | 5,474 |
| **3,456** | **3,128** | **(328)** | **3,304** | **(152)** | **Total** | **3,456** | **3,128** | **(328)** | **3,304** | **(152)** | **37,840** | **37,777** |
| | | | | | *CWD* | | | | | | | |
| 1,154 | 1,109 | (45) | 1,181 | 27 | Surgical | 1,154 | 1,109 | (45) | 1,181 | 27 | 13,258 | 12,852 |
| 1,143 | 1,066 | (76) | 1,092 | (51) | Medical | 1,143 | 1,066 | (76) | 1,092 | (51) | 12,131 | 11,991 |
| 390 | 425 | 35 | 454 | 64 | Other | 390 | 425 | 35 | 454 | 64 | 5,053 | 4,698 |
| **2,687** | **2,601** | **(86)** | **2,727** | **40** | **Total** | **2,687** | **2,601** | **(86)** | **2,727** | **40** | **30,443** | **29,540** |
| | | | | | | | | | | | | |
| | | | | | *Other* | | | | | | | |
| 4,251 | 4,333 | 82 | 4,075 | (176) | Total ED Attendances | 4,251 | 4,333 | 82 | 4,075 | (176) | 50,937 | 47,491 |
| 1,012 | 1,128 | 116 | 1,049 | 37 | ED Admissions | 1,012 | 1,128 | 116 | 1,049 | 37 | 12,307 | 11,847 |
| 752 | 728 | (24) | 805 | 53 | Theatre Visits | 752 | 728 | (24) | 805 | 53 | 8,911 | 9,271 |
| 147 | 112 | (35) | 124 | (23) | Non- theatre Proc | 147 | 112 | (35) | 124 | (23) | 1,430 | 1,891 |
| 7,674 | 7,084 | (590) | 7,168 | (506) | Bed Days | 7,674 | 7,084 | (590) | 7,168 | (506) | 80,231 | 85,515 |
| 4.48 | 4.30 | (0.18) | 4.20 | (0.28) | ALOS Inpatient | 4.48 | 4.30 | (0.18) | 4.20 | (0.28) | 4.30 | 4.29 |
| 2.24 | 2.03 | (0.21) | 2.20 | (0.04) | ALOS Total | 2.24 | 2.03 | (0.21) | 2.20 | (0.04) | 2.03 | 2.20 |
| 7.68% | 8.02% | 0.34% | 7.57% | -0.11% | Acute Readmission | 7.68% | 8.02% | 0.34% | 7.57% | -0.11% | 7.31% | 7.36% |

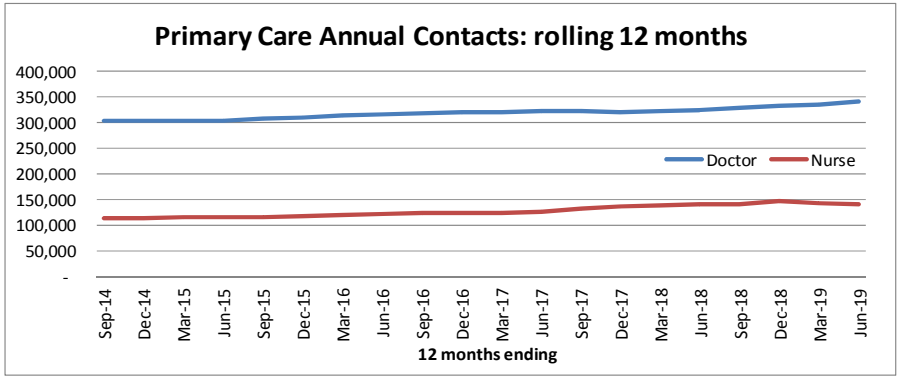
Note: Other inpatient includes mental health and maternity. Activity in this report includes ACC, overseas cases and privately funded cases.

Discharges for medical were higher than budget and 10% higher than July last year. Discharges for surgical were higher than budget but lower than the previous year (mainly Plastics and Orthopaedics), overall caseweights for surgery were higher than budget but less than last July. However, caseweights may increase as the coding is completed.

ED volumes for the month were lower than budget but 4% higher than July last year. A lower proportion of patients were admitted from ED in July compared to last year. Theatre visits for July were higher than budget but lower than July last year. Non-Theatre procedures are higher than budget for the month and last year. Bed days were higher than budget in the month and 7% higher than July last year. ALOS was higher than expected for July for inpatients and slightly higher overall for the year. The acute readmission rate was lower than budget.



# Statement of Financial Position and Cash Flows

## Financial Position as at 31 July 2019

| $000s | Actual | Budget | Variance | Jun 19 | Variance | Explanation of Variances Between Actual and Budget |
|---|---|---|---|---|---|---|
| **Assets** | | | | | | |
| **Current Assets** | | | | | | |
| Bank | 362 | (3,133) | 3,495 | (1,433) | 1,795 | Average bank balance in July-19 was $18.7m |
| Bank - Non DHB Funds * | 1,933 | 7,134 | (5,200) | 5,216 | (3,283) | Payments from NHMG to DHB's paid earlier than budgeted |
| Accounts Receivable | 26,850 | 27,980 | (1,130) | 27,095 | (245) | |
| Stock | 1,424 | 1,484 | (60) | 1,434 | (10) | |
| Prepayments | 922 | 868 | 54 | 727 | 194 | |
| **Total Current Assets** | **31,491** | **34,332** | **(2,841)** | **33,040** | **(1,549)** | |
| **Fixed Assets** | | | | | | |
| Fixed Assets | 209,349 | 220,161 | (10,811) | 210,483 | (1,133) | |
| Work in Progress | 21,534 | 18,048 | 3,486 | 19,710 | 1,824 | |
| **Total Fixed Assets** | **230,883** | **238,209** | **(7,325)** | **230,193** | **690** | |
| **Investments** | | | | | | |
| Investments in Associates | 1,150 | 1,150 | 0 | 1,150 | 0 | Allied Laundry |
| Trust Funds Invested | 1,408 | 1,426 | (17) | 1,409 | (1) | Restricted trusts |
| **Total Investments** | **2,558** | **2,576** | **(17)** | **2,559** | **(1)** | |
| **Total Assets** | **264,932** | **275,116** | **(10,184)** | **265,792** | **(860)** | |
| **Liabilities** | | | | | | |
| **Current Liabilities** | | | | | | |
| Accounts Payable and Accruals | 55,293 | 42,890 | (12,403) | 52,164 | (3,129) | Higher than budgeted accrued expenses |
| Crown Loans and Other Loans | 198 | 23 | (175) | 221 | 23 | |
| Current Employee Provisions | 24,309 | 24,193 | (116) | 24,190 | (119) | |
| **Total Current Liabilities** | **80,860** | **67,093** | **(13,767)** | **76,576** | **(4,284)** | |
| **Non Current Liabilities** | | | | | | |
| Other Loans | 0 | 221 | 221 | 0 | 0 | Finance leases |
| Long Term Employee Provisions | 8,245 | 7,617 | (628) | 8,245 | 0 | |
| Non DHB Liabilities | 1,933 | 7,134 | 5,200 | 5,216 | 3,283 | Payments from NHMG to DHB's paid earlier than budgeted |
| Trust Funds | 1,402 | 1,442 | 40 | 1,409 | 7 | |
| **Total Non Current Liabilities** | **11,580** | **16,414** | **4,834** | **14,870** | **3,290** | |
| **Total Liabilities** | **92,440** | **83,506** | **(8,933)** | **91,446** | **(994)** | |
| **Net Assets** | **172,492** | **191,610** | **(19,118)** | **174,346** | **(1,854)** | |
| **Equity** | | | | | | |
| Crown Equity | 124,123 | 123,916 | 207 | 124,123 | 0 | |
| Revaluation Reserve | 126,422 | 133,597 | (7,175) | 126,422 | 0 | |
| Opening Retained Earnings | (76,199) | (64,289) | (11,909) | (56,323) | (19,876) | |
| Net Surplus / (Deficit) | (1,854) | (1,614) | (240) | (19,876) | 18,022 | |
| **Total Equity** | **172,492** | **191,610** | **(19,118)** | **174,347** | **(1,854)** | |

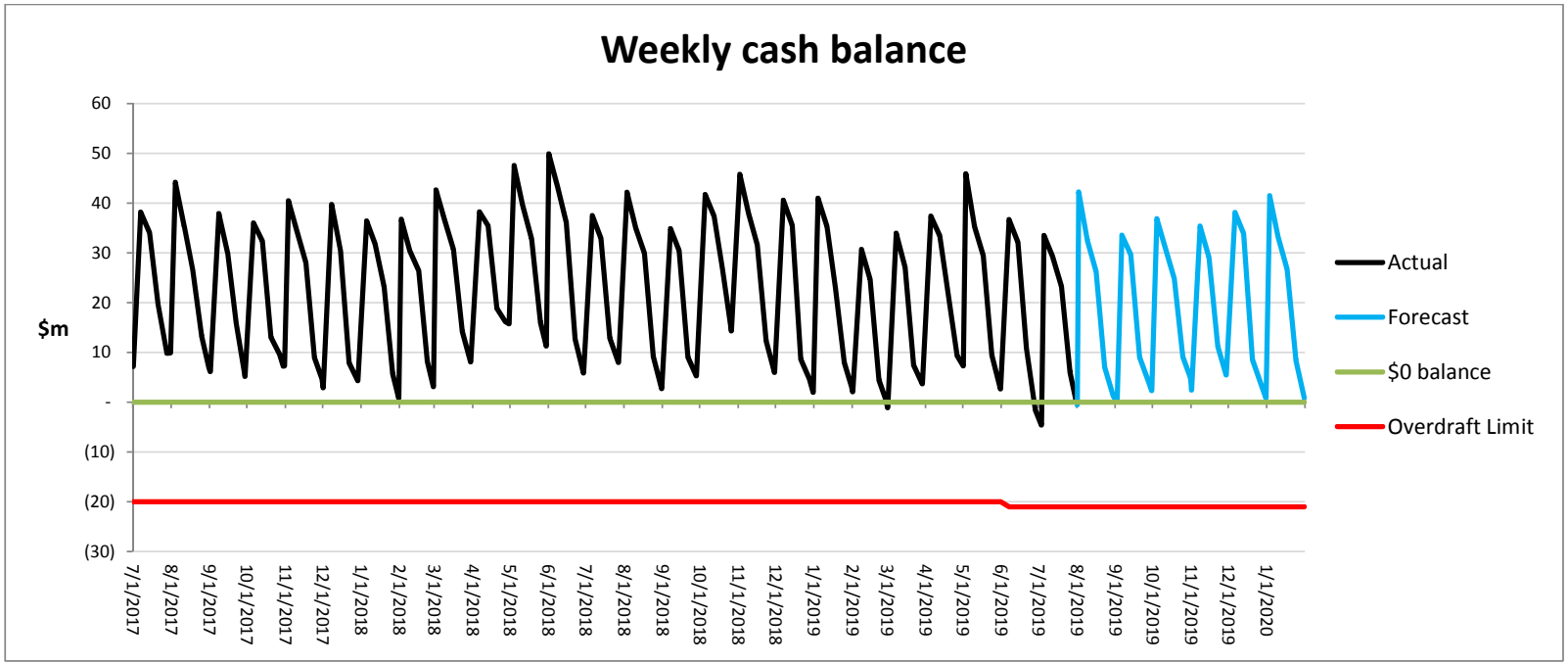
* NHMG - National Haemophilia Management Group

## Statement of Cash Flows to 31 July 2019

| $000s | Jul Actual | Aug Forecast | Sep Forecast | Oct Forecast | Nov Forecast | Dec Forecast | Jan Forecast | Feb Forecast | Mar Forecast | Apr Forecast | May Forecast | Jun Forecast |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Operating Activities** | | | | | | | | | | | | |
| Government & Crown Agency Revenue | 39,286 | 39,318 | 39,225 | 39,180 | 39,208 | 39,549 | 38,877 | 38,378 | 39,364 | 39,009 | 39,607 | 39,443 |
| Receipts from Other DHBs (Including IDF) | 8,191 | 8,928 | 8,928 | 8,928 | 8,928 | 8,927 | 8,928 | 8,928 | 8,928 | 8,928 | 8,928 | 8,928 |
| Receipts from Other Government Sources | 1,100 | 1,117 | 1,098 | 1,149 | 1,100 | 1,092 | 1,130 | 1,061 | 1,063 | 1,121 | 1,035 | 1,064 |
| Other Revenue | 1,472 | 392 | 380 | 418 | 392 | 380 | 380 | 380 | 380 | 380 | 380 | 385 |
| **Total Receipts** | **50,049** | **49,755** | **49,631** | **49,676** | **49,629** | **49,948** | **49,316** | **48,748** | **49,735** | **49,439** | **49,950** | **49,820** |
| Payments for Personnel | (18,535) | (17,026) | (16,295) | (17,815) | (16,356) | (17,124) | (17,893) | (15,611) | (17,155) | (17,156) | (16,402) | (17,167) |
| Payments for Supplies (Excluding Capital Expenditure) | (1,524) | (4,565) | (4,007) | (4,571) | (4,361) | (4,064) | (4,363) | (4,521) | (4,000) | (4,500) | (4,489) | (4,104) |
| Capital Charge Paid | 0 | (1,060) | (1,060) | (1,060) | (1,060) | (1,060) | (1,060) | (1,060) | (1,060) | (1,060) | (1,060) | (1,060) |
| GST Movement | 22 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Payments to Other DHBs (Including IDF) | (8,416) | (8,434) | (8,434) | (8,434) | (8,434) | (8,434) | (8,434) | (8,434) | (8,434) | (8,434) | (8,434) | (8,434) |
| Payments to Providers | (18,044) | (18,372) | (18,089) | (18,261) | (18,270) | (18,525) | (18,026) | (17,489) | (18,225) | (18,118) | (18,646) | (18,319) |
| **Total Payments** | **(46,498)** | **(49,456)** | **(47,884)** | **(50,142)** | **(48,480)** | **(49,208)** | **(49,775)** | **(47,115)** | **(48,873)** | **(49,268)** | **(49,031)** | **(49,083)** |
| **Net Cashflow from Operating Activities** | **3,551** | **299** | **1,747** | **(466)** | **1,148** | **740** | **(459)** | **1,633** | **862** | **170** | **919** | **737** |
| **Investing Activities** | | | | | | | | | | | | |
| Interest Receipts | 26 | 46 | 46 | 46 | 46 | 46 | 46 | 46 | 46 | 46 | 46 | 46 |
| **Total Receipts** | **26** | **46** | **46** | **46** | **46** | **46** | **46** | **46** | **46** | **46** | **46** | **46** |
| Capital Expenditure | (1,708) | (1,120) | (1,120) | (1,120) | (1,120) | (1,120) | (1,120) | (1,120) | (1,120) | (1,120) | (1,120) | (1,108) |
| Increase in Investments and Restricted & Trust Funds Assets | (75) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total Payments** | **(1,782)** | **(1,120)** | **(1,120)** | **(1,120)** | **(1,120)** | **(1,120)** | **(1,120)** | **(1,120)** | **(1,120)** | **(1,120)** | **(1,120)** | **(1,108)** |
| **Net Cashflow from Investing Activities** | **(1,756)** | **(1,074)** | **(1,074)** | **(1,074)** | **(1,074)** | **(1,074)** | **(1,074)** | **(1,074)** | **(1,074)** | **(1,074)** | **(1,074)** | **(1,062)** |
| **Financing Activities** | | | | | | | | | | | | |
| Interest Paid on Finance Leases | (1) | (7) | (7) | (6) | (6) | (6) | (6) | (6) | (6) | (5) | (5) | (5) |
| **Total Payments** | **(1)** | **(7)** | **(7)** | **(6)** | **(6)** | **(6)** | **(6)** | **(6)** | **(6)** | **(5)** | **(5)** | **(5)** |
| **Net Cashflow from Financing Activities** | **(1)** | **(7)** | **(7)** | **(6)** | **(6)** | **(6)** | **(6)** | **(6)** | **(6)** | **(5)** | **(5)** | **(5)** |
| Total Cash In | 50,075 | 49,801 | 49,677 | 49,722 | 49,674 | 49,994 | 49,362 | 48,794 | 49,781 | 49,484 | 49,996 | 49,866 |
| Total Cash Out | (48,280) | (50,583) | (49,010) | (51,268) | (49,607) | (50,334) | (50,901) | (48,240) | (49,999) | (50,394) | (50,156) | (50,197) |
| **Net Cashflow** | | | | | | | | | | | | |
| Opening Cash | (1,433) | 362 | (420) | 246 | (1,300) | (1,232) | (1,572) | (3,112) | (2,558) | (2,776) | (3,685) | (3,846) |
| Net Cash Movements | 1,795 | (782) | 666 | (1,546) | 68 | (340) | (1,539) | 553 | (218) | (909) | (160) | (331) |
| **Closing Cash** | **362** | **(420)** | **246** | **(1,300)** | **(1,232)** | **(1,572)** | **(3,112)** | **(2,558)** | **(2,776)** | **(3,685)** | **(3,846)** | **(4,176)** |

| Non DHB Funds - NHMG | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Opening Balance | 5,216 | | | | | | | | | | | |
| Net Movement | (3,283) | | | | | | | | | | | |
| Closing Balance | 1,933 | | | | | | | | | | | |

## Weekly Cash Flow – Actual to 31 July 2019




Note

- the overdraft facility shown in red is set at $21 million
- the lowest bank balance for the month of July was $1,451k overdrawn

## Summary of Leases – as at 31 July 2019

| | | Original Cost | Monthly Amount | Annual Amount | Total Lease Cost | Start Date | End Date | Lease type |
|---|---|---|---|---|---|---|---|---|
| **Rental Property Leases** | **Occupants** | | | | | | | |
| Wainuiomata Health Centre | District Nurses | | 1,149 | 13,787 | | 1/11/2017 | 31/10/2020 | Operating |
| Public Trust House Lower Hutt | Community Mental Health | | 21,887 | 262,643 | | 1/09/2017 | 1/09/2023 | Operating |
| CREDS - Johnsonville | Eating Disorders | | 5,370 | 64,435 | | 1/01/2015 | Rolling lease | Operating |
| RPH - Porirua Public Health | RPH School Health - Promotional Health | | 9,088 | 109,055 | | 15/03/2015 | 14/03/2021 | Operating |
| Criterion Lane Upper Hutt | Lagans Pharmacy - Physiotherapy | | 2,203 | 26,439 | | 5/01/2019 | 31/12/2020 | Operating |
| CBD Towers Upper Hutt | Community Mental Health | | 9,854 | 118,247 | | 8/06/2015 | 7/06/2021 | Operating |
| Upper Hutt Health Centre | District Nurses | | 974 | 11,688 | | 24/01/2015 | 1/02/2022 | Operating |
| | | | **50,525** | **606,294** | | | | |
| **Car Park Leases** | | | | | | | | |
| CBD Towers Upper Hutt | | | 542 | 6,500 | | 8/06/2015 | 7/06/2021 | Operating |
| Public Trust House Lower Hutt | | | 1,603 | 19,240 | | 1/09/2017 | 1/09/2023 | Operating |
| St Peters (SPO) | | | 270 | 3,240 | | Ongoing | Ongoing | Operating |
| | | | **2,415** | **28,980** | | | | |
| **Motor Vehicle Leases** | | | | | | | | |
| Motor Vehicle Lease plus Management Fees (115 Vehicles) | | | 31,959 | 383,509 | | Ongoing | Ongoing | Operating |
| | | | **31,959** | **383,509** | | | | |
| **Equipment Leases** | **Supplier** | | | | | | | |
| MRI ingenia 1.5T | | - | 38,934 | 467,203 | 1,401,609 | 26/09/2016 | 26/09/2019 | Operating |
| Theatre Equipment (FAR0135107) | All Leasing | 710,858 | 21,009 | 252,103 | 756,309 | 1/04/2017 | 1/01/2020 | Finance |
| Theatre Equipment (FAR0135105) | All Leasing | 98,266 | 2,904 | 34,850 | 104,550 | 1/07/2017 | 1/04/2020 | Finance |
| Stryker Orthopaedic Tools | | - | 9,024 | 108,292 | 758,044 | 1/09/2016 | 31/08/2023 | Operating |
| 3 x Ultrasounds (Equigroup) | GE Healthcare Limited | - | 7,303 | 87,641 | 438,205 | 28/06/2017 | 28/06/2022 | Operating |
| 1 x Ultrasound (Equigroup) | Philips NZ Commercial Ltd | - | 1,761 | 21,129 | 105,645 | 28/08/2017 | 28/07/2022 | Operating |
| CT Scanner (Equigroup) | Toshiba Medical Systems | - | 24,976 | 299,711 | 1,498,555 | 28/05/2017 | 28/05/2022 | Operating |
| | | **809,124** | **105,911** | **1,270,929** | **5,062,917** | | | |
| **Total Leases** | | | **190,810** | **2,289,712** | | | | |

# Treasury - as at 31 July 2019

**1) Short term funds / investment ($000)**

| NZHP banking activities for the month | Current month ($000) | Last month ($000) |
|---|---|---|
| Average balance for the month | $18,737 | $21,124 |
| Lowest balance for the month | ($4,617) | ($1,451) |
| Average interest rate | 1.66% | 1.83% |
| Net interest earned for the month | $26 | $32 |

**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 | | 8 |
| Total value of transactions | | $69,726 NZD |
| Largest transaction | | $31,760 NZD |

| | No. of transactions | Equivalent NZD |
|---|---|---|
| AUD | 6 | $12,579 |
| GBP | 0 | $0 |
| USD | 2 | $57,147 |
| **Total** | **8** | $69,726 |

**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 | $1,892 | $131 | $383 | $40 | $22 | $91 | $19 | $1,205 |
| Wairarapa District Health Board | $1,011 | $507 | $84 | $0 | $0 | $170 | $0 | $251 |
| Accident Compensation Corporation | $660 | $590 | $34 | ($8) | ($133) | $17 | $46 | $114 |
| Ministry of Health | $213 | $128 | $28 | ($132) | $0 | $2 | ($12) | $199 |
| University of Otago | $66 | $66 | $8 | $1 | $0 | $0 | $0 | ($9) |
| Ministry for Vulnerable Children, Oranga | $55 | $0 | $0 | $0 | $42 | $0 | $0 | $13 |
| Non Resident | $54 | $0 | $9 | $0 | $0 | $0 | $0 | $45 |
| ESR Limited | $40 | $40 | $0 | $0 | $0 | $0 | $0 | $0 |
| Hawkes Bay District Health Board | $35 | $9 | $9 | $4 | $0 | $0 | $0 | $14 |
| Southern Cochlear Implant Programme | $33 | $33 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Total Top 10 Debtors** | **$4,060** | **$1,503** | **$555** | **($95)** | **($68)** | **$280** | **$54** | **$1,831** |

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| | |
|---|---|
| **Date:** 17 September 2019 | **BOARD INFORMATION** |
| **Author** | Interim Chief Operating Officer - Melissa Brown |
| **Endorsed by** | Chief Executive Capital & Coast and Hutt Valley DHBs – Fionnagh Dougan |
| **Subject** | **HVDHB OPERATIONAL PERFORMANCE REPORT** |

**RECOMMENDATIONS**

It is recommended that the Board:

(a) **NOTES** that Hutt Valley DHB's performance against the *Improved Access to Elective Surgery* health target as of September 2019 was 96.7% for discharges;

(b) **NOTES** that Hutt Valley DHB's performance against the *Faster Cancer Treatment* target for August 2019 was 100% percent for the 60 day target, meeting the Ministry of Health target;

(c) **NOTES** that for the first quarter of 2019-2020 FY so far, Hutt Valley DHB achieved only 84% percent against the *Shorter Stays in ED* health target;

(d) **NOTES** that Hutt Valley DHB's performance against the radiology targets for August/September 2049 was 94% for ultrasound, 76% for MRI, and 91% for CT;

(e) **NOTES** that for the first quarter of 2019-2020 FY so far, Hutt Valley DHB achieved 95%, meeting the Ministry of Health target of offering smokers information and advice to quit.

## 1. INTRODUCTION

### 1.1 Purpose

The purpose of this paper is to provide the Board with an update on Hutt Valley DHB's operational performance against key system and target measures; and specific actions to mitigate the identified issues.

## 2. SHORTER STAYS IN ED TARGET

After a disappointing start to the first quarter 2019/20 (as seen in Table 1 below), Hutt Valley DHB has seen a favourable increase to the shorter stays in ED target (SSIED). HVDHB finished Quarter 4 (2018/19) on 88.6% for the Shorter Stays in ED performance target. Although this was significantly under the Ministry of Health target of 95%, it was 1.1% higher than the national average of 87.5%. After a busy start to winter, which saw the SSIED target drop to a low of 80%, the current quarter is seeing a positive trend with September 2019 indicating a reduction in flu like presentations.

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**Table 1: Emergency shorter stays by quarter 2017/18 to 2019/20, admitted, treated and discharged, total under 6 hour target and total ED presentations.**

## Shorter Stays in Emergency Departments

Excludes "Did Not Wait" Patients

Discharge MOH (All) < Excludes Did Not Wait

| | | | Data | | |
|---|---|---|---|---|---|
| Arrival FinYear | Arrival Quarter | Arrival Month | Percentage Under 6 Hours | Discharged Within 6 Hours | Total Patient Presentations |
| 2019/2020 | Quarter 1 | September 19 | 91% | 902 | 993 |
| | | August 19 | 84% | 3322 | 3934 |
| | | July 19 | 81% | 3061 | 3771 |
| | Quarter 1 Total | | 84% | 7285 | 8698 |
| 2019/2020 Total | | | 84% | 7285 | 8698 |
| 2018/2019 | Quarter 4 | June 19 | 85% | 3296 | 3873 |
| | | May 19 | 90% | 3691 | 4088 |
| | | April 19 | 91% | 3314 | 3660 |
| | Quarter 4 Total | | 89% | 10301 | 11621 |
| | Quarter 3 | March 19 | 88% | 3558 | 4040 |
| | | February 19 | 90% | 3138 | 3494 |
| | | January 19 | 89% | 3408 | 3844 |
| | Quarter 3 Total | | 89% | 10104 | 11378 |
| | Quarter 2 | December 18 | 89% | 3462 | 3901 |
| | | November 18 | 89% | 3309 | 3704 |
| | | October 18 | 90% | 3326 | 3688 |
| | Quarter 2 Total | | 89% | 10097 | 11293 |
| | Quarter 1 | September 18 | 89% | 3309 | 3727 |
| | | August 18 | 89% | 3499 | 3939 |
| | | July 18 | 92% | 1847 | 2014 |
| | Quarter 1 Total | | 89% | 8655 | 9680 |
| 2018/2019 Total | | | 89% | 39157 | 43972 |

In August there was an increase of presentations, up from July 2019, however the admission rate has held steady at 24% (See Table 2 below).

**Table 2: Presentation and admission rates June 2019 to August 2019**

| | 03-Jun | 10-Jun | 17-Jun | 24-Jun | 01-Jul | 08-Jul | 15-Jul | 22-Jul | 29-Jul | 05-Aug | 12-Aug | 19-Aug | 26-Aug |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Admitted | 224 | 255 | 227 | 255 | 245 | 232 | 193 | 232 | 237 | 238 | 244 | 251 | 226 |
| Treated & Discharged | 662 | 662 | 674 | 664 | 639 | 623 | 632 | 606 | 613 | 651 | 638 | 658 | 663 |
| Did Not Wait | 130 | 126 | 82 | 112 | 146 | 127 | 85 | 98 | 67 | 96 | 87 | 111 | 86 |
| **Presentations** | **1016** | **1043** | **983** | **1031** | **1030** | **982** | **910** | **936** | **917** | **985** | **969** | **1020** | **975** |
| *Budget Attends* | *879* | *879* | *879* | *879* | | | | | | | | | |
| **Under 6 Hours (%)** | **85.44%** | **81.68%** | **88.35%** | **83.13%** | **78.62%** | **76.14%** | **85.58%** | **81.38%** | **86.94%** | **83.69%** | **86.28%** | **81.19%** | **86.28%** |
| *Target (%under 6 hours)* | *95%* | *95%* | *95%* | *95%* | *95%* | *95%* | *95%* | *95%* | *95%* | *95%* | *95%* | *95%* | *95%* |
| **Admitted (%)** | **22%** | **24%** | **23%** | **25%** | **24%** | **24%** | **21%** | **25%** | **26%** | **24%** | **25%** | **25%** | **23%** |

HUTT VALLEY DHB

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Table 3 outlines the specialty areas into which patients were admitted for the week commencing 26 August 2019. General Medicine has the largest numbers of admissions generally.

**Table 3: Shorter Stays in ED target Admissions by Services**

## Volumes by Discharge Type (excl DNW)

| ArrivalWeek | Mon 26 Aug |
|---|---|

| Row Labels | Visits | Under 6 Hrs |
|---|---|---|
| **Admitted** | | |
| General Medical | 94 | 69% |
| Paediatric | 33 | 67% |
| General Surgery | 31 | 61% |
| Plastics | 25 | 92% |
| Cardiology | 15 | 73% |
| Orthopaedics | 13 | 77% |
| Gynaecology | 7 | 86% |
| Mental Health Inpatient | 5 | 60% |
| Dental Surgery | 1 | |
| Obstetric Women | 1 | 100% |
| Mental Health Intensive | 1 | |
| **Admitted Total** | **226** | 71% |
| **Treated & Discharged** | **663** | 92% |
| **Grand Total** | **889** | 86% |

Table 4 outlines both the ED presentation numbers and admission rates by triage categories and ethnicity for August 2019. Pacific presentations made up 10% of all presentations, and but made up 31% of total admissions. Maori presentations made up 22.7% of all presentations, and made up 21% of admissions. NZ European presentations made up just over 50% of total presentations, however, only 27% of admissions.

**Table 4: Admission rates by triage categories and ethnicity for August**

| Triage | Data | NZ European | NZ Maori | Pacific | Grand Total |
|---|---|---|---|---|---|
| 1 | **Presentations** | **16** | **10** | | **33** |
| | Sum of Admit Rate % | 69% | 70% | | 67% |
| 2 | **Presentations** | **384** | **186** | **88** | **762** |
| | Sum of Admit Rate % | 49% | 51% | 71% | 50% |
| 3 | **Presentations** | **839** | **349** | **139** | **1583** |
| | Sum of Admit Rate % | 34% | 22% | 24% | 29% |
| 4 | **Presentations** | **705** | **312** | **150** | **1416** |
| | Sum of Admit Rate % | 14% | 10% | 9% | 12% |
| 5 | **Presentations** | **262** | **132** | **63** | **554** |
| | Sum of Admit Rate % | 5% | 2% | 0% | 4% |
| **Total Presentations** | | **2206** | **989** | **440** | **4348** |
| **Admit Rate %** | | **27%** | **21%** | **31%** | **24%** |
| Percentage of Total Presentation | | 51% | 23% | 10% | |

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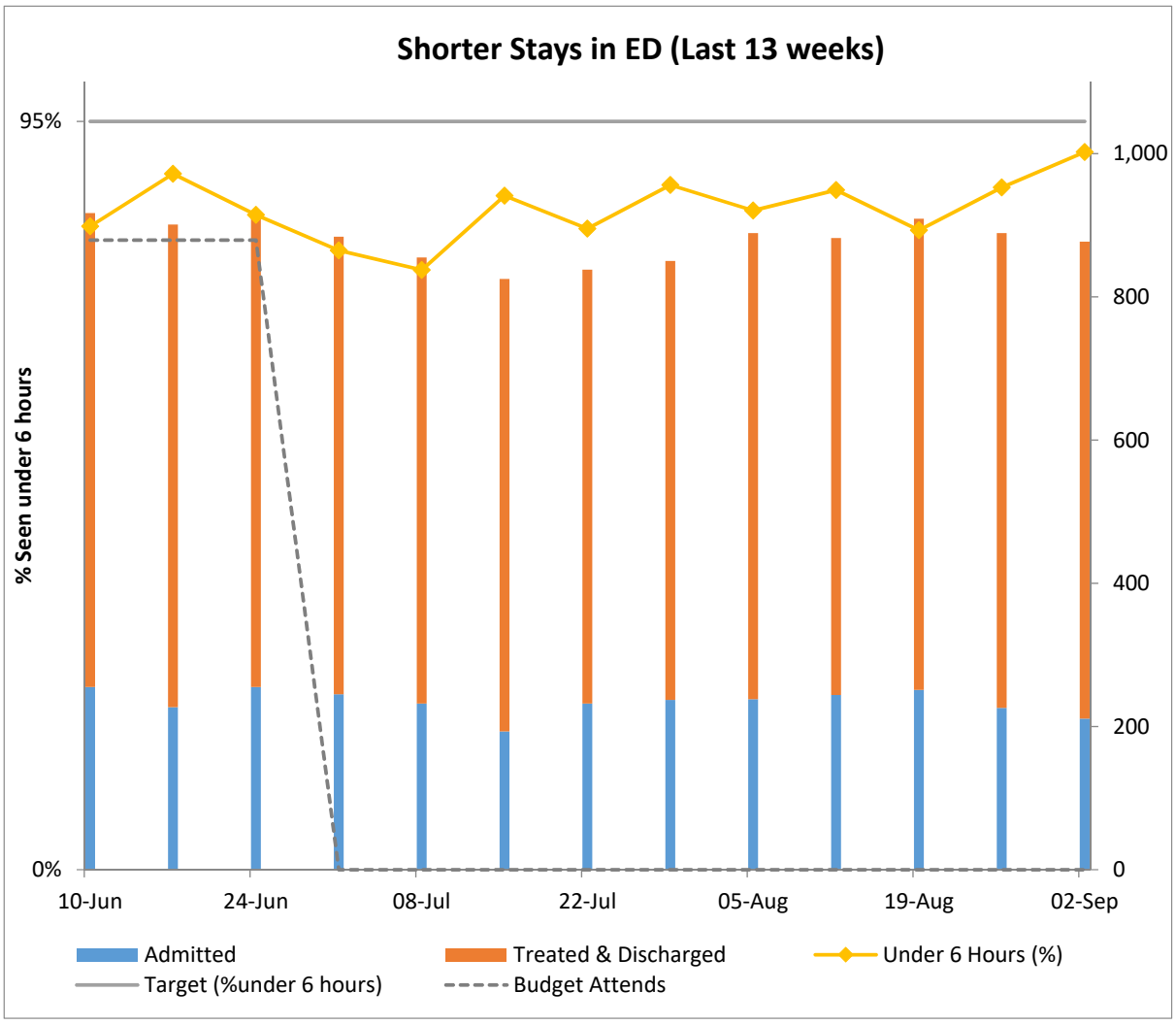
Table 5 provides an overview of the Emergency Department performance against the target of 95% of patients being treated and either admitted or discharged within 6 hours. Performance is now trending upwards. In early September 2019 the Emergency Department performance improved markedly, at one point, reaching a high of 99%. The collaborative efforts of services across the DHB to have patients seen, referred, treated and discharged/admitted in a timely manner has been outstanding and supports the provision of a safe, quality and timely service. Work aimed at improving ED performance is also underway. The Interim Chief Operating Officer and the Business Development Manager met with individual CHODs to discuss key issues and solutions around access and flows for individual specialty areas. Key actions around improvements will be developed with key accountabilities and timeframes for completion to be determined.

**Table 5: Shorter stays in ED last 13 weeks June to September 2019**



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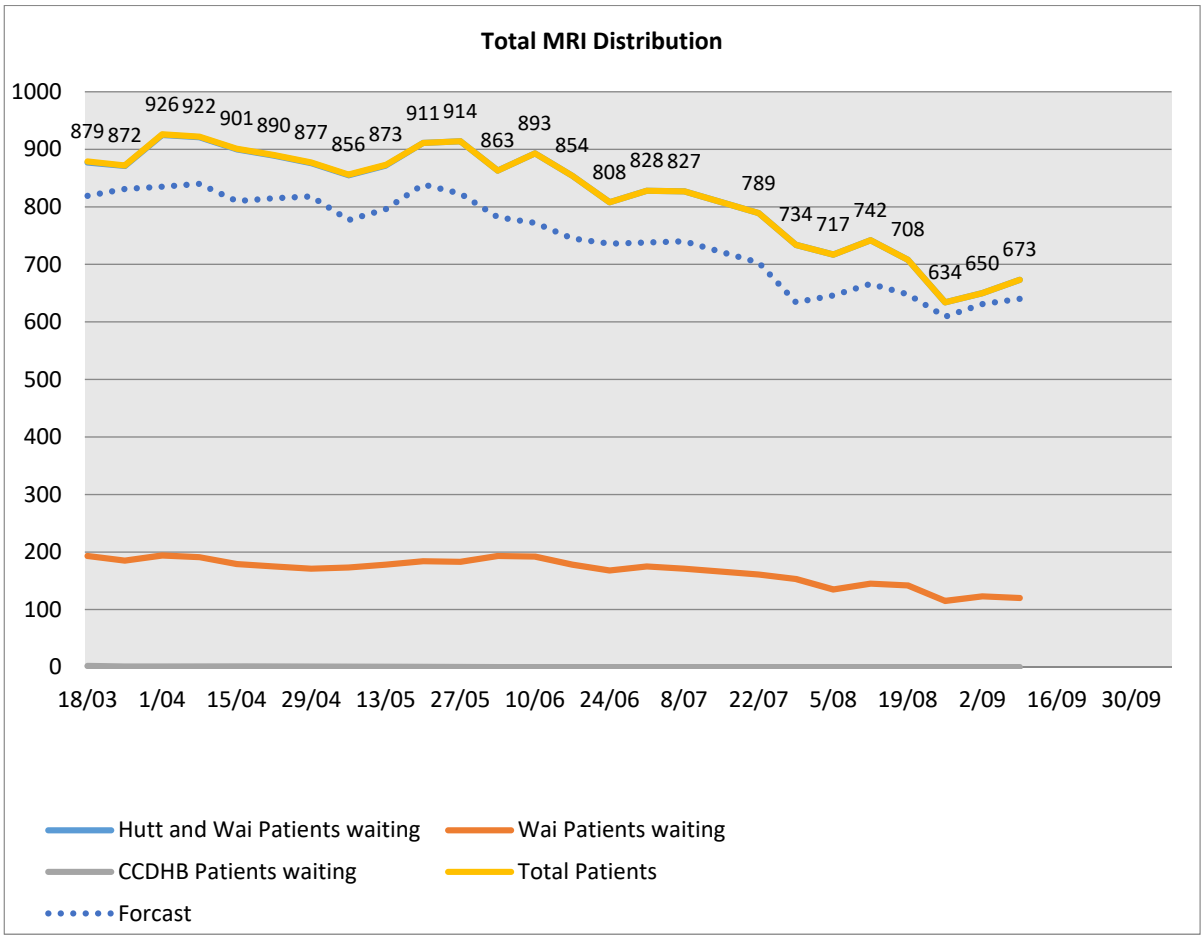
## 3. RADIOLOGY

Ultrasound waiting time is currently at 94%, an excellent position and meeting the Ministry of Health target.

MRI waiting times are longer than the Ministry's target of 85% of patients scanned within 6 weeks. However MRI elective waiting times have improved significantly over the last 6 months as can be seen in the Figure 1, with current performance at 76% for Hutt and 77% for Wairarapa. Performance improvements are the result of:

- Staff working extended shifts and one weekend a month;
- Use of locum staff to cover while recruitment for permanent positions progresses;
- Outsourcing of MRIs.

**Figure 1: Current MRI waiting status, Wairarapa and Hutt volumes**



HUTT VALLEY DHB

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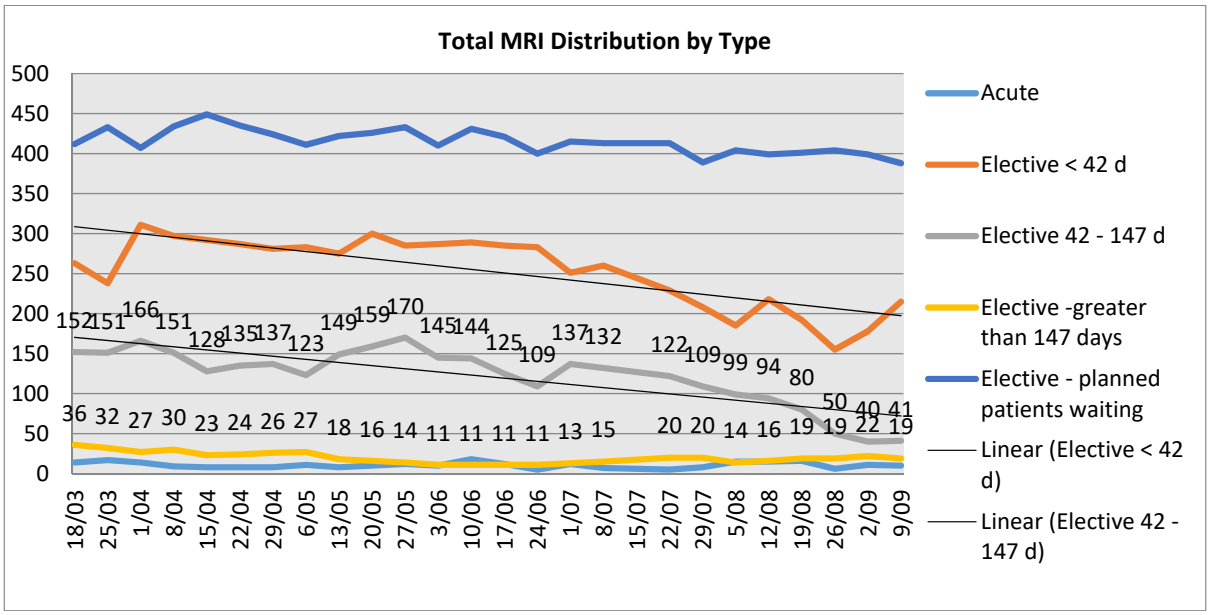
**Figure 2: Current MRI waiting status - total elective and acute patients waiting**




## 3.1 Computerised Tomography (CT)

The current CT wait time is currently at 91%, currently below the Ministry of Health target of 95%.

**Figure 3: CT wait times by type, total distribution and elective status**

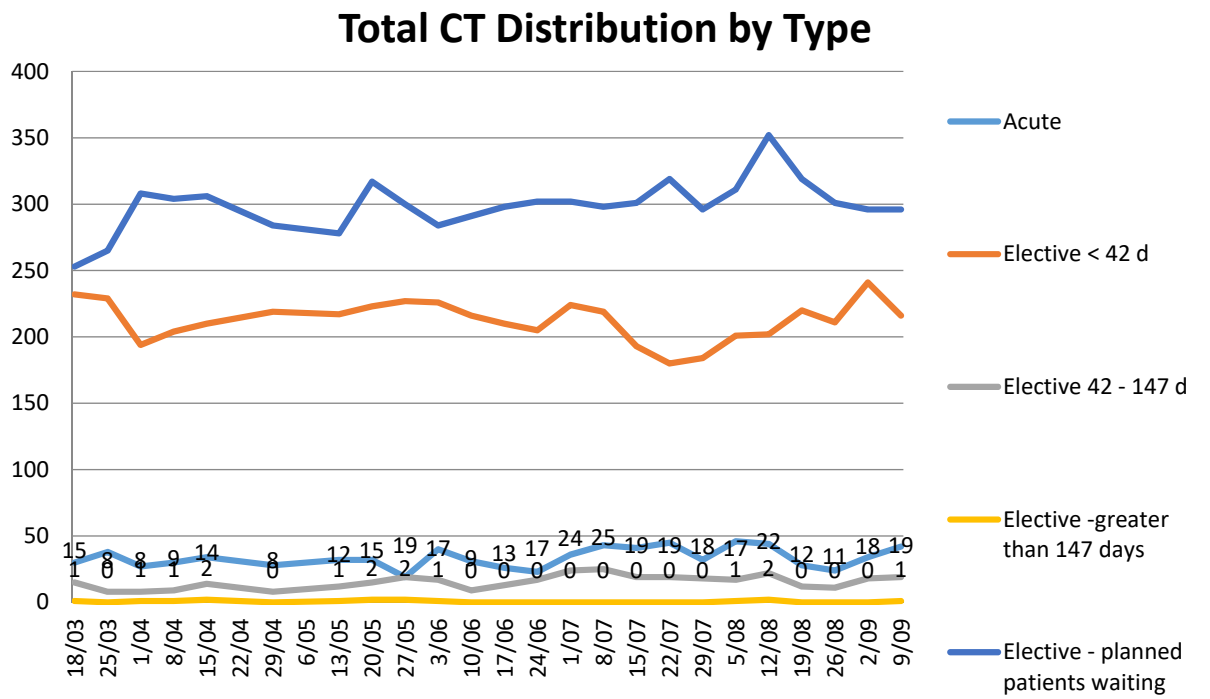
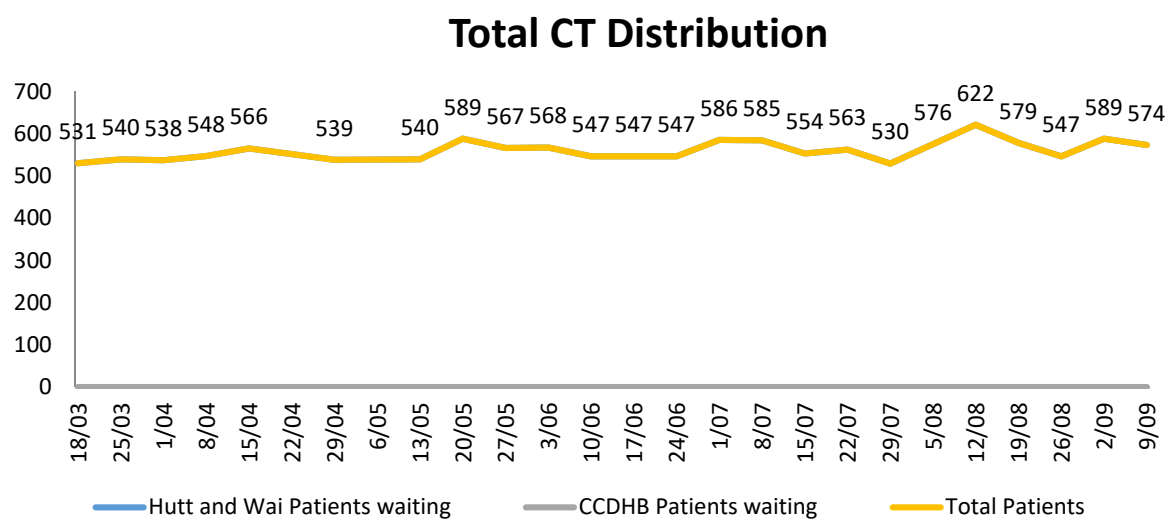


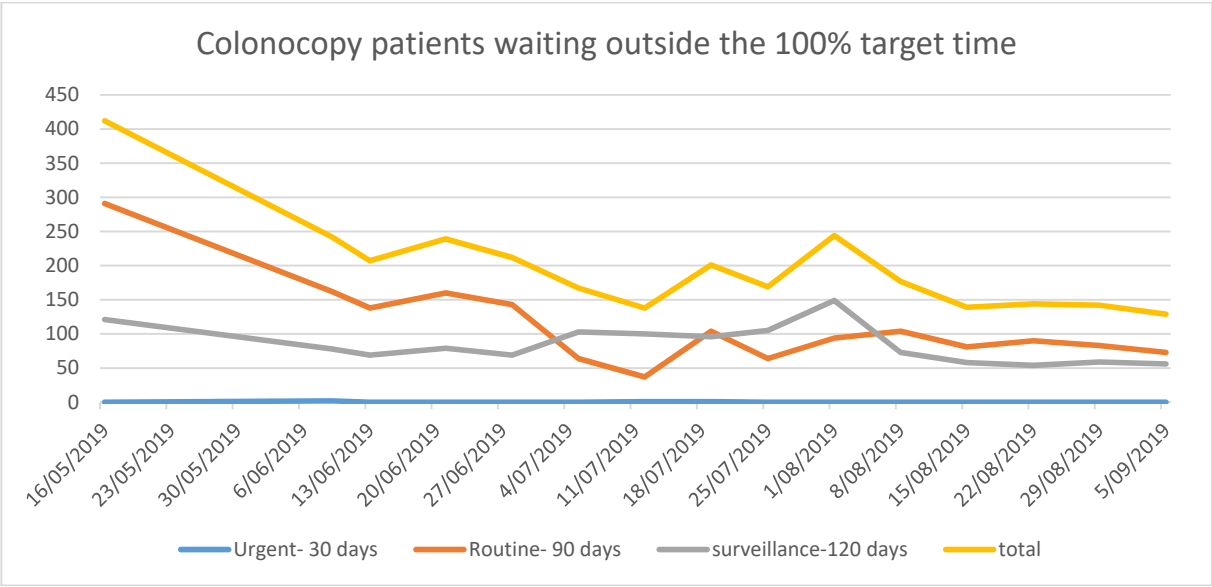
**Figure 4: Total CT numbers waiting by date**




## 4. COLONOSCOPY UPDATE

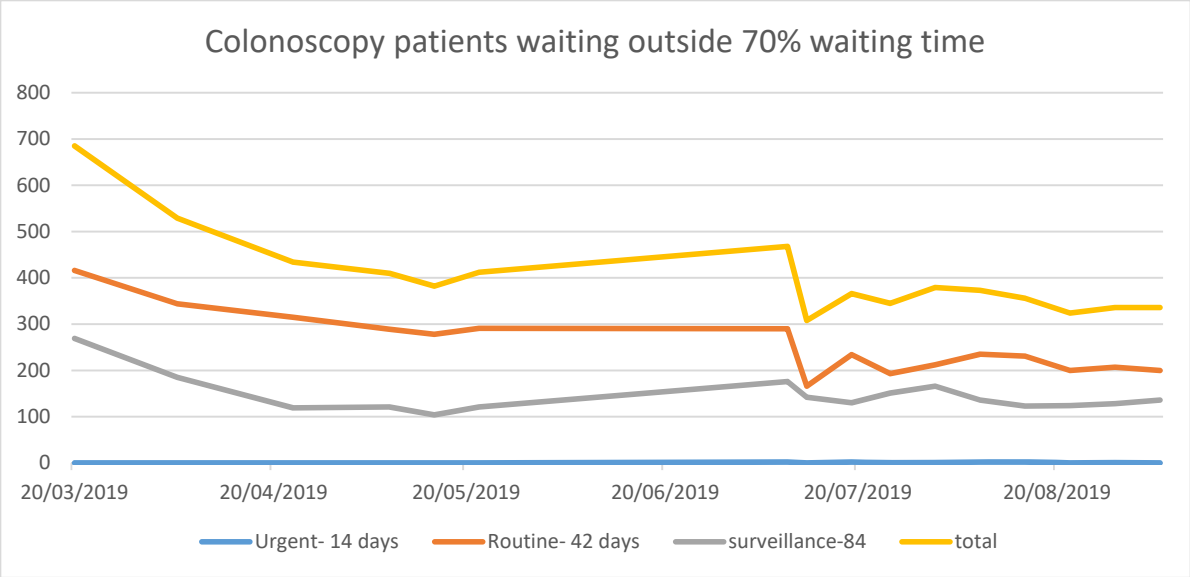
Colonoscopy wait times have plateaued over recent weeks due to holidays, resignation and staff injury. Outsourcing has helped and there is locum support from mid-September as well as a new SMO to follow, who commences in December 2019. Recruitment for the last gastroenterologist vacancy is ongoing. Filling this position will see the senior medical officer resources matching demand.

**Figure 5: Colonoscopy patients outside 100% recommended wait times June to August 2019**



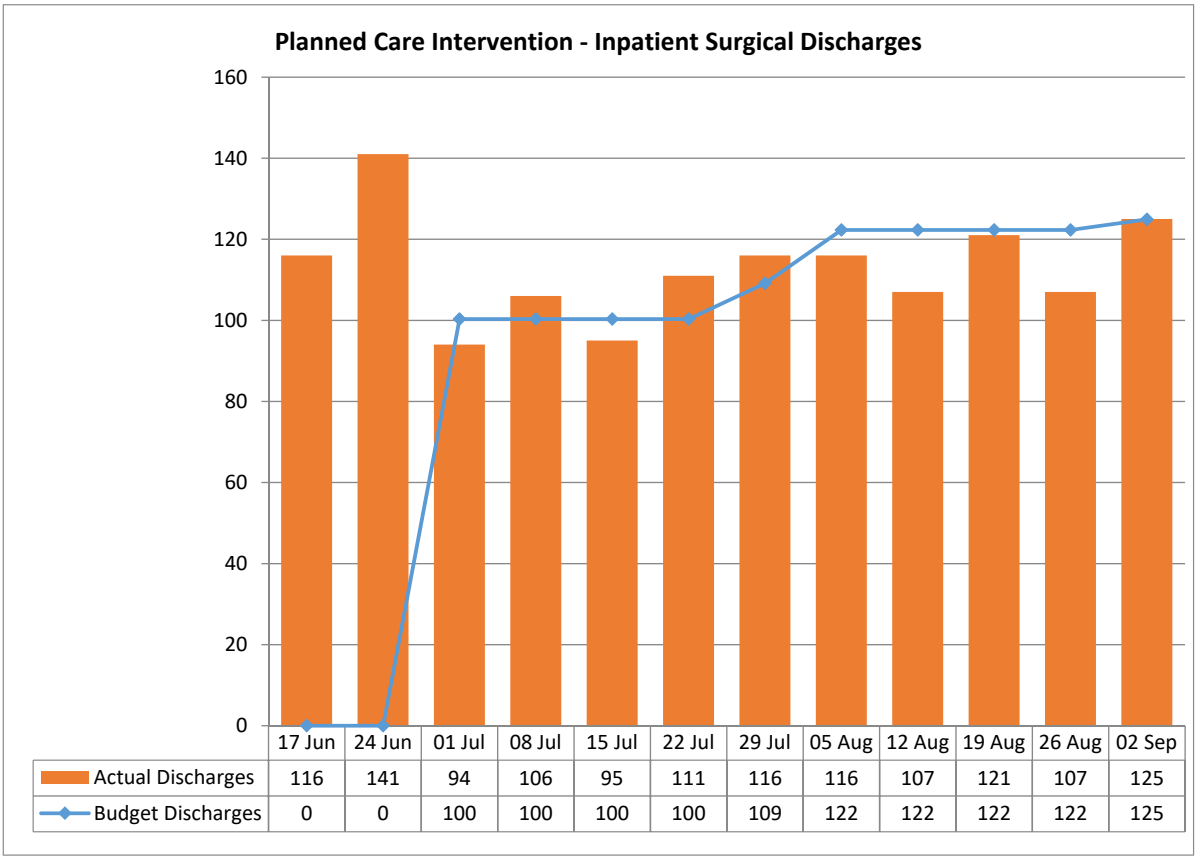

The current waiting list against the 100% target at the Ministry of Health's request and the above graph shows how the numbers of patients waiting are tracking against the 3 triage categories of urgent (30 days), routine (90 days) and surveillance (120 days). Note that Hutt Valley DHB usually works to the 70% target but is measured against the 100% target at the request of the Ministry of Health.

**Figure 6: Colonoscopy patients outside 70% recommended wait times June to August 2019**




## 5. IMPROVED ACCESS TO ELECTIVE SURGERY

**Table 6: Overall planned care surgical interventions June to September 2019 budgeted versus actual activity**




| | 17 Jun | 24 Jun | 01 Jul | 08 Jul | 15 Jul | 22 Jul | 29 Jul | 05 Aug | 12 Aug | 19 Aug | 26 Aug | 02 Sep |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual Discharges | 116 | 141 | 94 | 106 | 95 | 111 | 116 | 116 | 107 | 121 | 107 | 125 |
| Budget Discharges | 0 | 0 | 100 | 100 | 100 | 100 | 109 | 122 | 122 | 122 | 122 | 125 |

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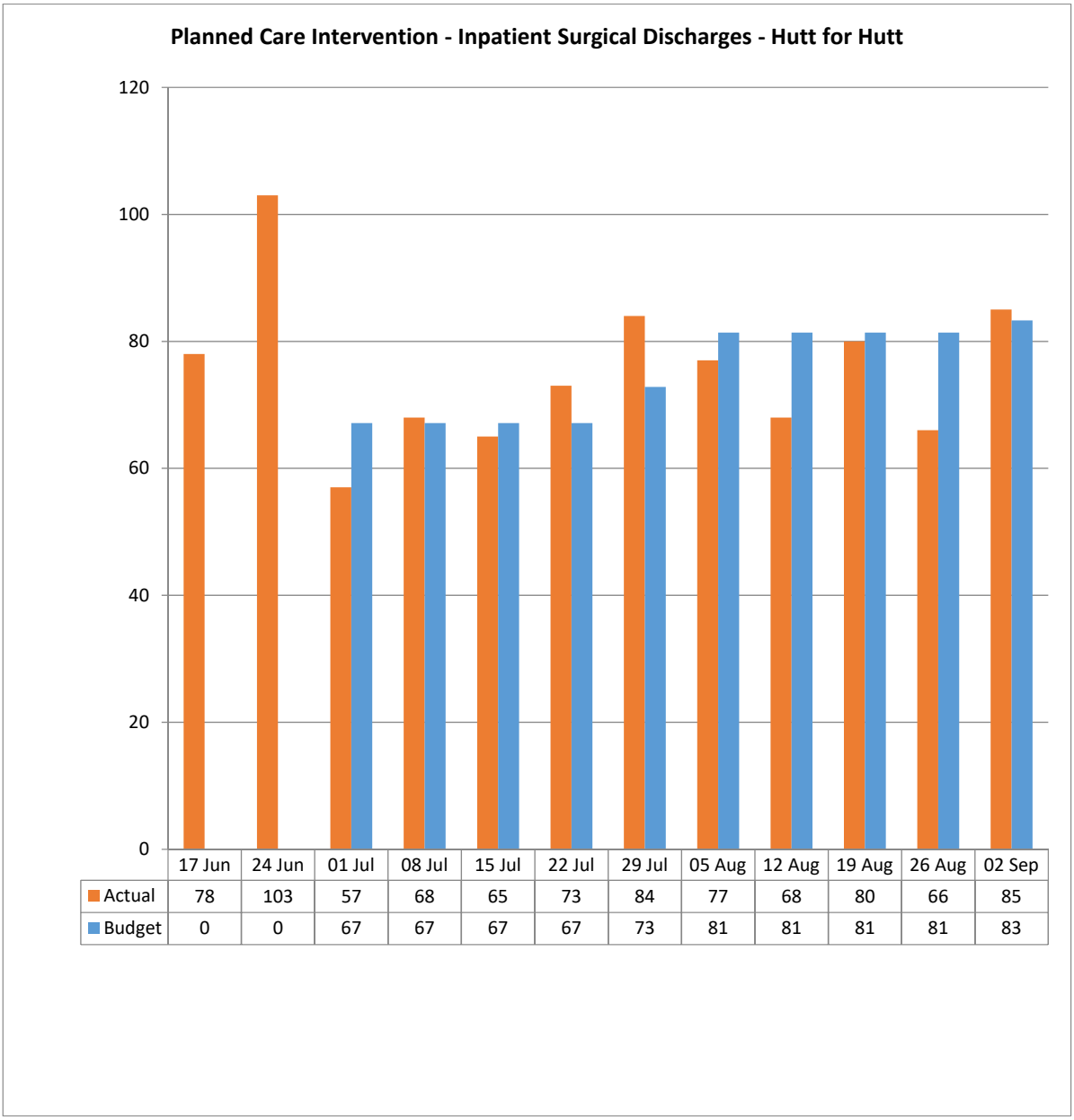
There has been a reduction in surgical activity across July and August 2019 (see Table 6), related mainly to surgeon and anaesthetist leave - more than can be accommodated to maintain the required level of elective activity, increasing the number of vacant theatre sessions. There was also MIT strike action planned for, which was withdrawn without enough time to reinstate surgical lists. Whilst discharges are at 96.7% of the target, case weights (or level of complexity) is significantly below target. Further work is required to improve production planning, scheduling and rostering across surgical and anaesthetic services. In four of the past five weeks actual surgical activity for Hutt was down, as were inter-district in flows to Hutt in three of the past five weeks (see tables 7 & 8 following).

**Table 7: Planned care surgical interventions – Hutt surgical activity for Hutt community June to September 2019 - budgeted versus actual activity**




| | 17 Jun | 24 Jun | 01 Jul | 08 Jul | 15 Jul | 22 Jul | 29 Jul | 05 Aug | 12 Aug | 19 Aug | 26 Aug | 02 Sep |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | 78 | 103 | 57 | 68 | 65 | 73 | 84 | 77 | 68 | 80 | 66 | 85 |
| Budget | 0 | 0 | 67 | 67 | 67 | 67 | 73 | 81 | 81 | 81 | 81 | 83 |

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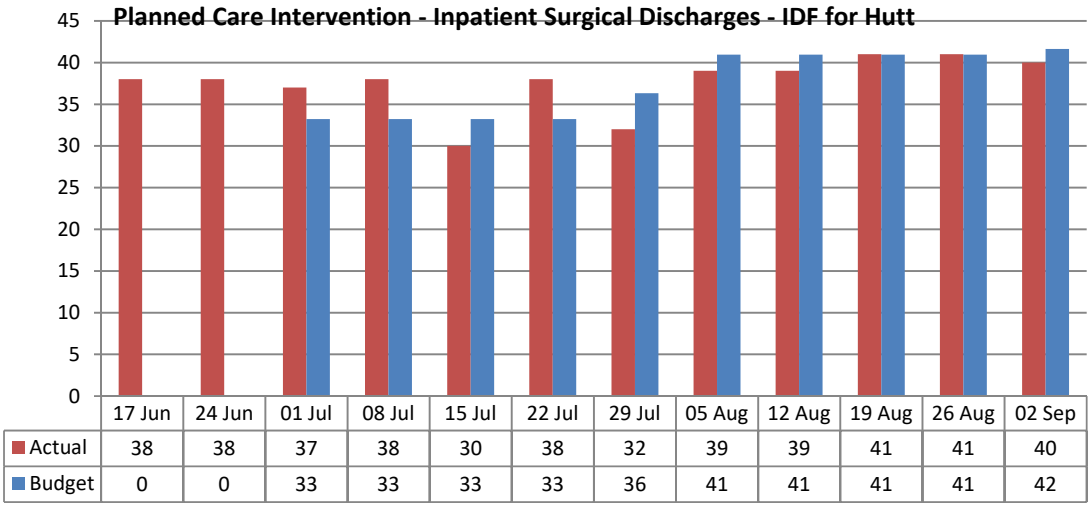
**Table 8: Planned care surgical interventions – inter-district flows for Hutt community June to September 2019 budgeted versus actual activity**




| | 17 Jun | 24 Jun | 01 Jul | 08 Jul | 15 Jul | 22 Jul | 29 Jul | 05 Aug | 12 Aug | 19 Aug | 26 Aug | 02 Sep |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | 38 | 38 | 37 | 38 | 30 | 38 | 32 | 39 | 39 | 41 | 41 | 40 |
| Budget | 0 | 0 | 33 | 33 | 33 | 33 | 36 | 41 | 41 | 41 | 41 | 42 |

**Table 9: Elective Service Performance Indicators – Compliance May to August 2019**

| | May | June | July | August |
|---|---|---|---|---|
| | | | | |
| **ESPI 2 – First Specialist Appointment** | 5.3% | 5.1% | 7.7% | No totals as yet |
| **ESPI 5 - Surgery** | 9.1% | 16.6% | 12% | No totals as yet |

ESPI 2 and ESPI 5 compliance continues to be challenging for Hutt Valley DHB, mostly as a result of industrial activity earlier in the year and production planning, scheduling and rostering issues.

Recovery plans for ESPI 2 and ESPI 5 are updated across all specialities on a monthly basis and submitted to the Ministry of Health. Compliance for ESPI 2 and ESPI 5 should occur by early 2020 for most specialties, with improved attention to rostering, scheduling and production planning. A risk is that we remain non-compliant for plastics beyond these timeframes, unless thresholds are reviewed.

Recovery planning for both ESPI 2 and 5 includes appropriate outsourcing (mainly ophthalmology), reviewed threshold criteria for gynaecology, reducing acute interruptions to elective activity wherever possible and appropriate use of locums. Further work is required as part of the theatre optimisation project to improve theatre capacity across the short, medium and longer term, including implementing efficiencies where there are currently gaps e.g. full day theatre lists, scheduling, production plans, rostering and thresholds; and longer term investment planning with CCDHB to meet future demand.

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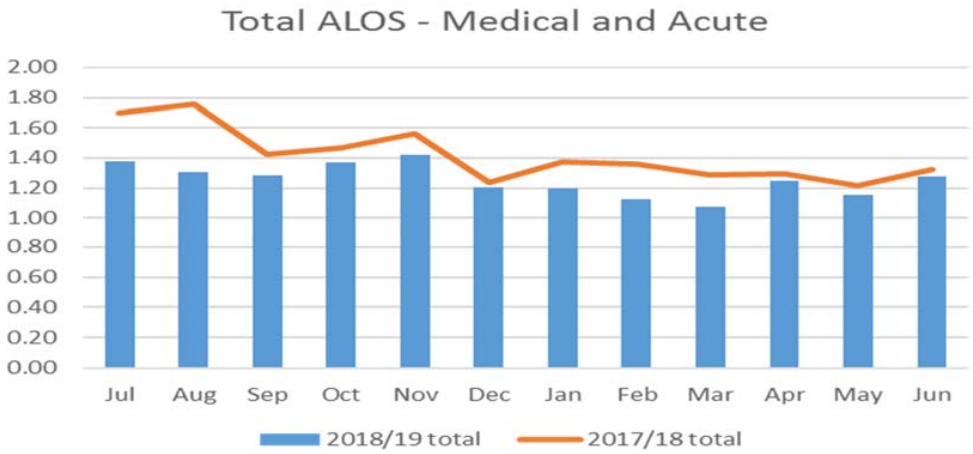
## 6. SHORTER, SAFER, SMOOTHER CARE

### 6.1 Total Average length of stay (ALOS)

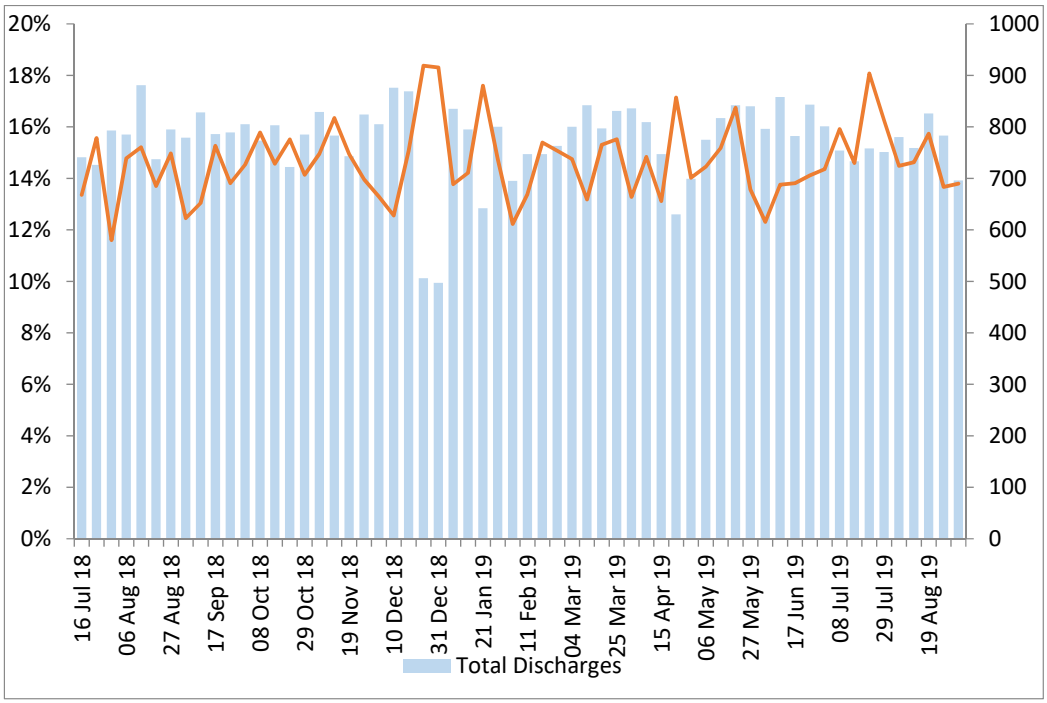
The total ALOS for the 2018/19 Financial Year has reduced overall. This was increased for the last month of the year due to the winter surge (see table 10 following).

**Table 10: Average length of stay July to June 2017 to 2019**




## 7. DISCHARGES BEFORE 11AM

**Table 11: Discharges before 11am July 2018 to August 2019**




The number of discharges before 11am continues to remain significantly below the expected level (see table 11 above). Considerable work is required to identify root causes and possible solutions. Development of specific care pathways for patient groups, better communication with patients and families and improved planning for discharge will result in improved performance.

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## 8. FASTER CANCER TREATMENT

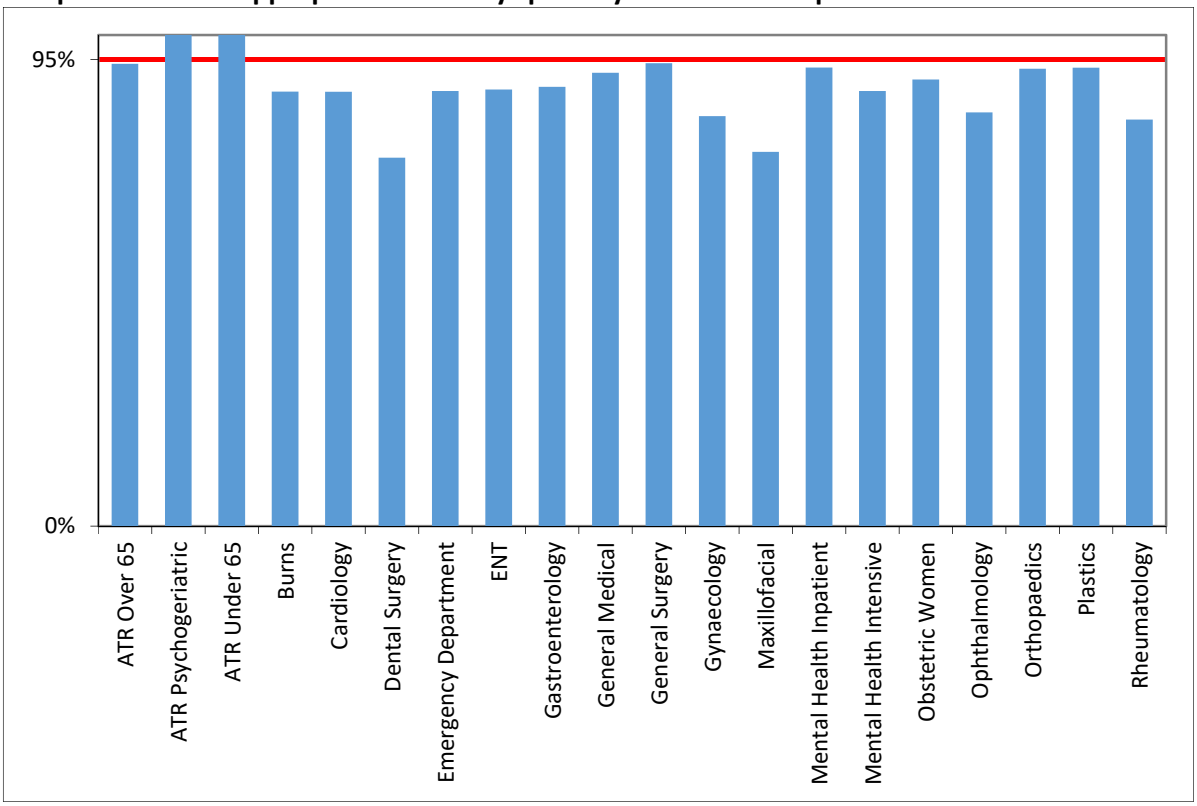
For August, Hutt Valley DHB achieved 100% of the target for 62 days and 82.6% for 31 days (eight patients waited longer than expected). Delays related to radiation and surgical capacity. Work with the Central Cancer Network programme continues to progress, and the Ministry of Health have released the 2019-2029 Cancer Action Plan, which outlines the future proposals for Cancer services nationwide. Hutt Valley will work alongside the Ministry of Health to implement plans as required.

**Table 12: Faster Cancer Treatment 2019/20 monthly performance**

| Fin Year | Month | 62 Day Total | Patient Breech | Clinical Breech | Capacity Breech | 62 Day Patients | 62 Day Target Met | 62 Day Target (%) | 31 Day Patients | 31 Day Target Met | 31 Day Target (%) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Aug 19 | 11 | 0 | 3 | 0 | 8 | 8 | 100.0% | 46 | 38 | 82.6% |
| | Jul 19 | 14 | 0 | 0 | 1 | 14 | 13 | 92.9% | 65 | 56 | 86.2% |

## 9. SMOKING CESSATION

**Table 13: Better help for smokers to quit – percentage of patients offered counselling to quit and provided with appropriate advice by specialty – Week of 9 September 2019**




Overall the 95% target of offering counselling to quit and providing appropriate advice to smokers was achieved in August 2019 (128 out of 135 patients). Individual results for specialty areas are outlined in table 13 above for the week commencing 9 September 2019.

## 10. WOMEN'S AND CHILDREN'S HEALTH

### Maternity

Birth numbers continue to trend down over time at Hutt Valley, with a 3.4% reduction in the number of births for quarter 4, compared to the same time last year (Table 14). However, rates of intervention continue to rise, with increasing rates of caesarean section and instrumental births and a reduction in rates of normal birth (Table 15). The Women's Health Review governance group and key stakeholders met on 22 August to prioritise work streams and recommendations arising from the Women's Health external review report.

Maternity refurbishment work continues.

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**Table 14: Hutt Valley DHB birth numbers by month January 2018 to July 2019**

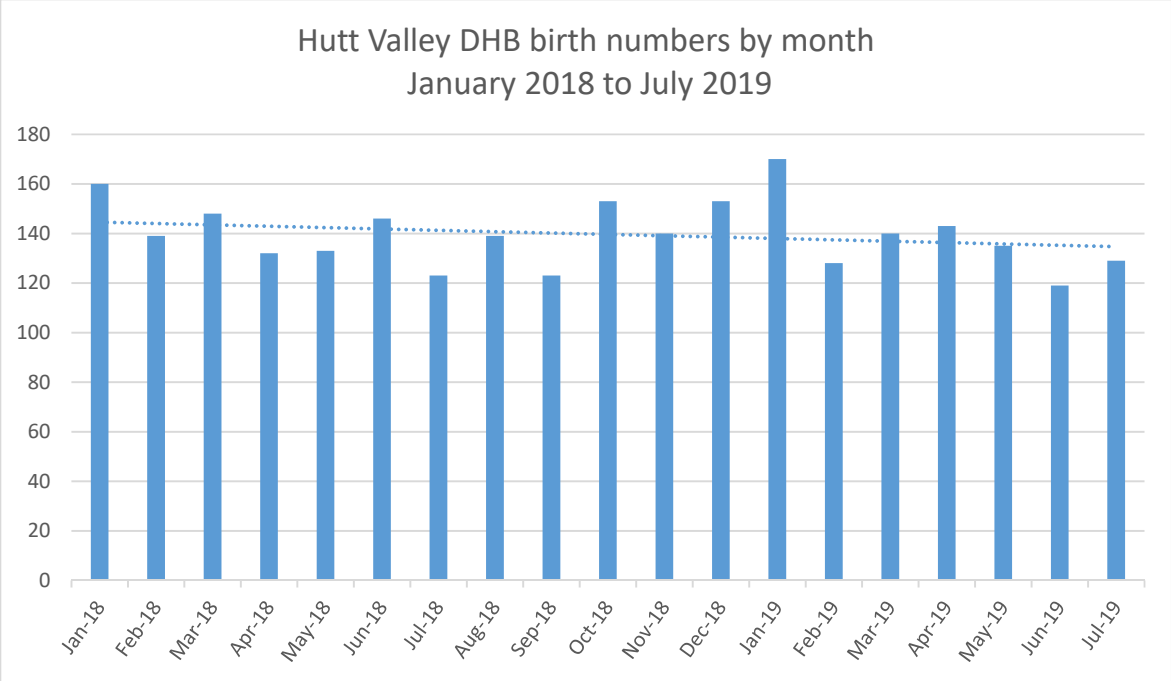
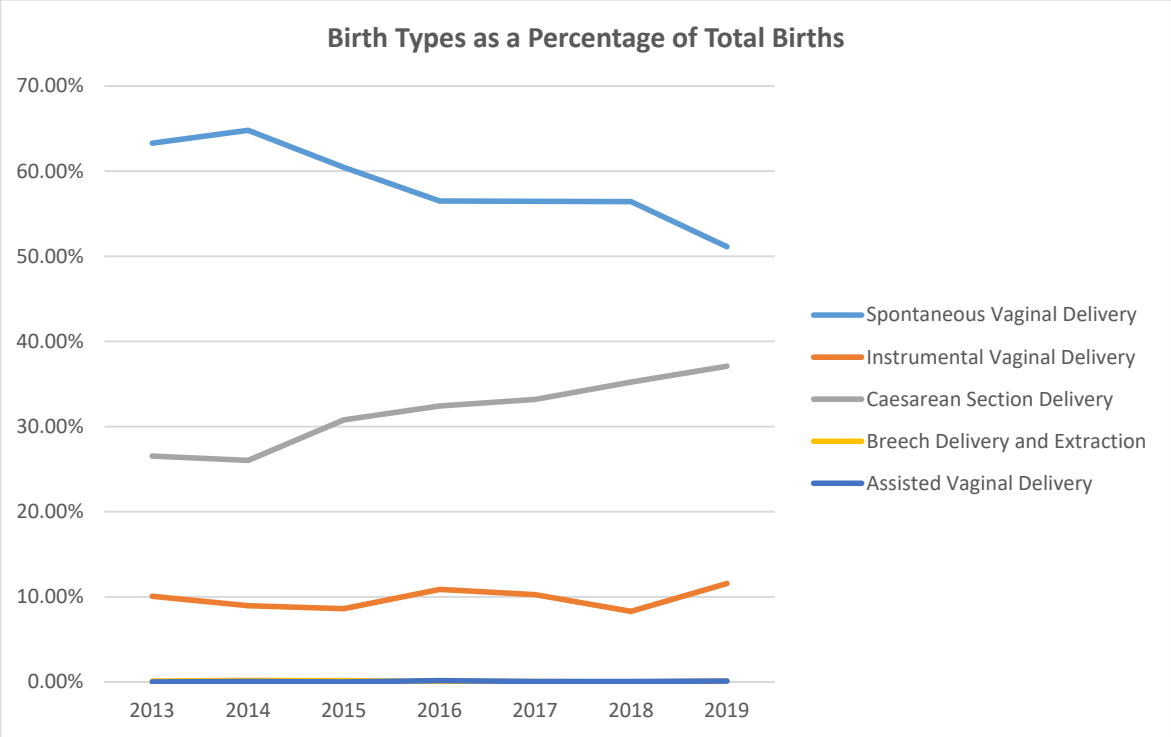



**Table 15: Hutt Valley DHB birth types as a percentage of total births 2013 to 2019**



## 11. COMMUNITY HEALTH

### Community integration / one team

The Community Health leadership team is developing a plan to integrate DHB and Community services.

Key stakeholder discussion and workshops have enabled engagement. A proposal of first step actions and structural change to the community teams is currently being drafted for consideration by the ELT.

### 11.1 Rheumatology

The Wellington Regional Rheumatology Service and Medical Day Stay Interaction Optimisation project is in progress. This project aims to improve the patient journey by improving referral management processes and tools to support safe prescribing as well as improving patient information and education prior to infusions.

### 11.2 Diabetes

Training by community health specialties for the Upper Hutt health care home group staff will commence on September 19th 2019, with the aim of improving knowledge and skills, communication and enhancing relationships to provide more patient centred care. Sessions will alternate between the following specialty groups - Diabetes, Cardiology, Rheumatology, Respiratory, and District Nursing.

### 11.3 Geriatric Advanced Trainee at hospital front door 6 month pilot

A 6 month RMO position commencing December 2019, incorporates community geriatrics and front door liaison with ED for frail patients, aligning with early supported discharge work that is progressing within the community integration/one team project. It will include geriatric home visits for patients who are medically fit for discharge from ED, but perceived as "risky discharges" due to frailty. Geriatric input will involve Cognitive Global Assessment, liaison with community services as needed and advance care planning input as required, linking with the current frailty screening in ED.

### 11.4 Respiratory

An additional 0.3 FTE of SMO time has been allocated to the Respiratory Service as part of the Medical Services Improvement Programme, commencing in March 2020. This role will allow for improved capacity to help reduce wait times for semi urgent referrals currently highlighted as a clinical risk.

A review of clinical outcomes of semi urgent patients waiting longer than desired time frames will be undertaken over the next few weeks as part of the quality assurance initiative requested by the Morbidity and Mortality Committee.

Note: Urgent referrals have been compliant with ESPI targets over recent months.

### 11.5 Strategies being implemented to reduce the use of minders

"Minders" is a term used for staff that provide patient observation and engagement as one option to support patient safety and manage risk to patients, staff and the environment. The need for patient observation should be determined through patient assessment and review of the care plan with appropriate first line intervention put in place, in the first instance.

First line interventions include intentional rounding (frequent review of the patient), use of low beds to minimise falls risk, medication review completed and actions in place, and engagement actions such as distraction, music, conversation, or diversion.

The perception is that "Minder" use is high at Hutt Valley DHB, however this is problematic in all DHBs who face:

- Increasing patient complexity.
- An ageing population - those admitted are more prone to falls.
- An increasing number of presentations to hospital with mental health issues where self-harm or harm to others is a risk. This crosses all ages - children with eating disorders and associated self-harm risk through to older persons with psychogeriatric issues.
- Ongoing patient flow issues – where bed blockage is a problem and patients cannot promptly be moved to the right place in a timely manner – i.e. patient requires "Minding" in ED or MAPU until a bed is available within mental health services.
- Assessment delays – where patients presenting to ED require a mental health assessment. The 'at risk' people are "Minded" until assessed. Frequently there are delays in this process, keeping patients in ED or MAPU overnight or longer until a team can assess them during the day.
- Ongoing staff and skill mix shortages.

While some of the "Minder" use is budgeted at ward level, the ongoing and increasing cost is related to outsourcing nursing costs (incorporating a portion of the "Minders" cost), which is unbudgeted.

Strategies in place to address "Minder" use include:

- Implementation of the recent TAS Minder Audit recommendations.
- Collaborative work with CCDHB re Patient Observation and Engagement policy and process. This includes building on the TAS audit recommendations – auditing of process against policy, reviewing the policy and assessment process, implementing observation and engagement training for staff that "Mind".
- Implementing strategies within the 'Whanau as Partners in Care' programme so that having whanau assist with their loved ones care is the norm, not an exception.
- Implementing CCDM recommendations for appropriate FTE levels so that safe staffing is in place and safe care is delivered. CCDM FTE calculations take "Minding" needs into account and allows budget to be applied for unplanned care (most "Minding" falls into this category as it is not predictable care other than taking historical need into account).
- Daily review of "Minder" requests, including cohorting of patients (room sharing), where appropriate, as this reduces the 1:1 care needs.

With regard to outsourced nursing costs – this relates to agency use where additional staff are required to be rostered on for a shift so that demand can be met. Implementing CCDM FTE recommendations for all areas will address this as adequate resource will be applied to meet demand. Once in place a zero agency use policy could be put in place.

# Our Vision for Change - Update

**Reporting Period: Jun-19**

## Support People Living Well

**Immunisations age 2 yrs: Target 95%**
Quarterly since Sep 14

| | |
|---|---|
| Total | 92.7% |
| Māori | 91.5% |
| Pacific | 93.8% |
| Dep Q5 | 91.4% |

**Primary care Smoking advice: Target 90%**
Quarterly since June 16

| | |
|---|---|
| Māori | 89.7% |
| Pacific | 88.5% |
| Total | 92.0% |

**Hospital Smoking advice: Target 95%**
Monthly since Oct 17

| | |
|---|---|
| Māori | 95.5% |
| Pacific | 92.3% |
| Total | 95.4% |

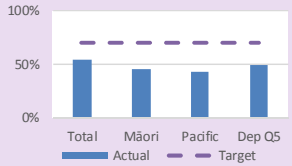
**Breast Screening: Target 70%**
Quarterly since June 15

| | |
|---|---|
| Māori | 69.2% |
| Pacific | 69.0% |
| Total | 75.6% |

**Cervical Screening: Target 80%**
Quarterly since June 13

| | |
|---|---|
| Māori | 67.9% |
| Pacific | 67.6% |
| Total | 73.0% |

Babies Breastfed at 3 mths Jul-Dec 18




**Living Well**

- Wellbeing Plan, supporting the DHB's Mauri Ora staff wellbeing plan.
- Completion of collaborative Hutt Valley Tobacco Control Action Plan, with support of Hutt City Council's Smokefree Policy Review (approved) recommendations, including 'vapefree in smokefree environments'
- Consultation with local Māori and Pacific people on a Vaping Position Statement and re-establishment of a Water in Schools programme across the Hutt Valley.

## Shift Care Closer to Home

**PHO Enrolment**
Quarterly since Jan 17

| | |
|---|---|
| Total | 98.0% |
| Māori | 91.2% |
| Pacific | 98.0% |
| Dep Q5 | 96.1% |

**GP & Nurse visits per person**
Annual since 2011/12

| | |
|---|---|
| Māori | 3.60 |
| Pacific | 3.50 |
| Other | 4.23 |

**ARC Average Subsidised beds**
Monthly since Jul 16

| | |
|---|---|
| Resthome | 252 |
| Dementia | 134 |
| Hospital | 340 |
| Psychoger | 40 |
| Total | 766 |

**Self Ref Non-Admit ED per 1000 pop**
Monthly since July 17

| | |
|---|---|
| Māori | 24.74 |
| Pacific | 28.52 |
| Total | 14.66 |

**Acute Bed days per 1000 pop**
Annual Since Mar 17

| | |
|---|---|
| Total | 360 |
| Māori | 335 |
| Pacific | 408 |
| Dep Q5 | 371 |

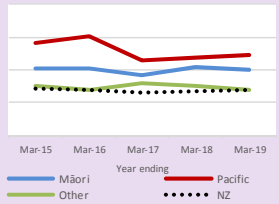
**Acute readmission Age 0-4**
Annual Since Mar 17

| | |
|---|---|
| Māori | 12.2% |
| Pacific | 14.7% |
| Other | 14.3% |

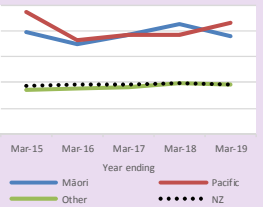
**Acute readmission Age 75+**
Annual Since Mar 17

| | |
|---|---|
| Māori | 13.6% |
| Pacific | 13.9% |
| Other | 12.0% |

Ambulatory Sensitve Hospitalisation Rate - Age 0-4




Ambulatory Sensitive Hospitalisation Age 45-64




**Shift Care Closer to Home**

- 2nd group of GP practices have gone live as Health Care Homes – HCH now covers 54% .
- Iron infusions in primary care and free Long Acting Reversible Contraceptives to CSC holders are operational.
- Specialist community services exploring training (Resp, Diabetes, Rheum & Card) for primary care nurses in Upper Hutt
- Acute phone consult liaison model continues in Geriatrics, Paediatrics, Cardiology and Mental Health.
- 3 staff workshops held with community service allied health staff on 'one DHB community team'
- A repeat 'Day of Care' audit Q2, 2019/20 to identify gaps to enhance supported discharge / rapid response function.
- Specialist Palliative Care (Te Omanga Hospice) integrated model of nursing care coordinated and seamless care to patients and their family/whanau.

## Deliver Shorter, Safer, Smoother Care

**Shorter Stays in ED: Target 95%**
Monthly since Jul 17

| | |
|---|---|
| Admitted | 69% |
| Not Admit | 91% |
| Total | 85% |

**Mental Health Waiting times age 0-19:**
Quarterly since Sep 16
Targets 80% < 3wks; 95%<8 wks

**Mental Health provider arm**

| | |
|---|---|
| Under 3 weeks | 63.90% |
| Under 8 weeks | 89.27% |

**Addictions Provider & NGO**

| | |
|---|---|
| Under 3 weeks | 75.86% |
| Under 8 weeks | 93.10% |

**Electives waiting > 4 months: Target 0**
Monthly since July 17

| | |
|---|---|
| Outpatient (ESPI2) | 325 |
| Inpatient (ESPI5) | 158 |

**Average Length of Stay (ALOS) internal data**
Monthly since July 16

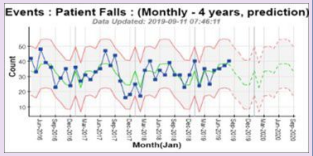
| | |
|---|---|
| Acute | 2.11 |
| Elective | 1.16 |

**Caesarian section rate**
Monthly since July 16

| | |
|---|---|
| Caesar rate | 38% |

**% Complaints not responded in 20 days**
At 11 Sept 19

25% 7 of 28




**Deliver Shorter, Safer, Smother Care**

- The Steering Group is in place to oversee implementation of the recommendations of the Women's Health review. A workshop was held to agree the work breakdown structure and key principles. Next steps include setting up workstream groups and the project team. In parallel to project planning, a number of urgent actions are being addressed relating to recruitment, refurbishment and purchase of essential equipment.

## Adaptable Workforce

**% Sick Leave**
Monthly since Jan 17

| | |
|---|---|
| Medical | 1.8% |
| Nursing | 4.0% |
| Allied | 3.7% |
| Support | 3.9% |
| Admin | 4.6% |

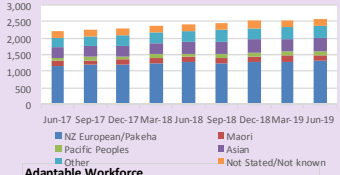
**Staff Turnover**
Monthly since Jul 16

| | |
|---|---|
| Medical | 0.7% |
| Nursing | 0.6% |
| Allied | 0.9% |
| Support | 0.0% |
| Admin | 0.8% |

**%Staff with> 2yrs AL**
Monthly since Jul 17

| | |
|---|---|
| Snr Medical | 20.8% |
| Jnr Medical | 5.1% |
| Nursing | 13.8% |
| Allied | 3.4% |
| Support | 6.1% |
| Admin | 3.3% |
| Mgmnt | 2.4% |

Staff Ethnicity & Head Count




**Adaptable Workforce**

"Nursing at its Best" our 5-year nursing workforce strategy launched 1st Feb. Implementation under the 4 nursing strategic priorities: Nursing workforce; Clinical leadership; Education & professional practice; Quality, patient safety & innovation.

**CCDM Implementation**

- Delivery of CCDM/CaaG screens with accompanying Variance mobile app to meet nursing MECA.
- CCDM FTE calculations approved and almost fully implemented for GSG, Ortho, MAPU and Medical. The remaining wards FTE calculations completed and being reviewed by CCDM Council.
- All other components of CCDM are underway and on track as per the CCDM work programme.

## Smart Infrastructure

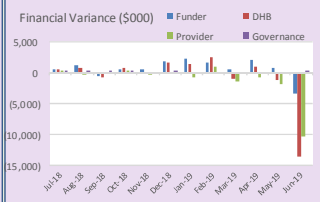
- Data reporting tool, for Smooth Sailing, designed, built and implemented. Measures real time delays in patient flow in ED, in to MAPU and Medical Ward.
- Frequent Attendee electronic whiteboard built, undergoing testing. To identify patients for joint planning across the continuum.
- The ScOPe software to improve theatre scheduling, implementation is underway. plastics is anticipating a soft go-live end Sept. Full rollout by mid-November 2019.
- Rollout of whiteboards for SCBU, Community Health Personal Care, ED Allied Health, Delivery Suite
- Allied Health Activity Capture (AHAC) to capture their activities to meet HISO requirements and has seen significant productivity gains (30 min per day)
- RFP process completed for electronic patient observations – successful vendor still to be notified
- Digital Dental project – replacing x-ray imaging in dental hubs and vans.

## Effective Commissioning

- Enhanced governance and membership of the Alliance Leadership Team was supported by ELT in August - Revised ToR and membership due to go to Hutt INC in September
- A 2DHB Joint Governance structure is being developed to progress the Hospital Services Network, the Joint DHB Long Term Investment Plan, the Mental Health Improvement Plan, and the Information Management Alliance. Feedback is being sought from ELTs on the proposed structure.
- CCDHB Operational team has been evaluating the community options for a Renal satellite clinic in the Hutt Valley. A business case including financials will be submitted to September Board to progress.
- New Executive Director, Oncology at CCDHB has met with Clinical leaders at Hutt Valley DHB to build closer connections. Initial discussions focused on improving inpatient pathways.
- Joint planning workshop for Cardiology and ENT leaders, across both sites is planned for October 2019.

## Financial Result

| YTD Jun-19 | Actual | Budget | Variance |
|---|---|---|---|
| Funder | 4,534 | (159) | 4,694 |
| Governance | (134) | 4 | (138) |
| Provider | (24,276) | (7,893) | (16,383) |
| **Net Result** | **(19,876)** | **(8,049)** | **(11,827)** |




**Financial performance**

The overall deficit of ($19,876k) includes 'One Off' impairment of FPIM ($2,216k) and provision to settle claims under the Holidays act ($9,321k). Excluded these two items, the unaudited deficit would be ($8,339k), which is ($290k) unfavourable against a budget deficit of ($8,049k).
Personnel and outsourced Personnel unfavourable ($9,398k),Medical unfavourable ($2,779k); Outsourced medical is ($1,341k) unfavourable, internal staff ($1,437k) unfavourable. Nursing unfavourable ($5,223k)
Allied Health unfavourable ($583k); driven by the MECA settlement.
Outsourced other expenses unfavourable ($996k) with overspends in clinical services of ($1,375k).

| Key | |
|---|---|
| | On track no issues |
| | Some issues watch |
| | Off track action needed |

**PUBLIC**

| | |
|---|---|
| **Date:** 17 Sept 2019 | **BOARD INFORMATION** |
| **Author** | General Manager – Quality, Service Improvement and Innovation – Debbie Gell |
| **Endorsed by** | Chief Executive Hutt Valley DHB - Fionnagh Dougan |
| **Subject** | **HUTT VALLEY DHB HEALTH AND SAFETY UPDATE** |

**RECOMMENDATIONS**

It is **recommended** that the Board:

(a) **NOTE** the report for September 2019;

(b) **Note** the implementation of a Serious Adverse Events Committee;

(c) **NOTE** the final Certification Audit has been received.

**APPENDICIES**

1. Infection Control Policy

## 1. INTRODUCTION

### 1.1 Purpose

The purpose of this paper is to inform the Board of key Quality, Health and Safety activities at Hutt Valley DHB.

### 1.2 Previous Board Discussions/Decisions

The paper responds to the request for confirmation that Hutt Valley DHB has current policies/procedures, including the testing of staff members, in the event of an infectious outbreak. This information was requested by the Combined Board on 29 August 2019. It should be noted that Capital and Coast DHB, Hutt Valley DHB and Wairarapa DHB have a combined Infection Control Policy. The Infection Control Policy defines the approach to the management of outbreaks which is inclusive of how staff are supported. The screening and support for staff is dependent on the type of outbreak. The Infection Control Policy is attached (see Appendix 1) as requested**.**

## 2. A COMMITMENT TO WORKING ON QUALITY AND SAFETY

A Hutt Valley DHB value is *Being Our Best*: one of the ways staff model this is by looking for and acting on opportunities for improvement and innovation.

### 2.1 Quality and Patient Safety Committee – August 2019

The Quality and Patient Safety Committee (QPSC) is the key committee for enabling clinical governance, ensuring the organisation has appropriate systems and processes for patient safety, and learning from our events. The committee meets monthly. At the August 2019 meeting, the committee heard from Sarah

Mills, Clinical Head of Department for Paediatrics, the leaders of the Plastics and Burns Service and considered a number of serious adverse event reviews.

In 2018, QPSC asked for an annual review and discussion of the number of newborns being sent to CCDHB neonatal intensive care for management of suspected hypoxic ischaemic encephalopathy (HIE). This is a condition with multiple causes, where there is obstruction of prenatal blood supply causing cerebral ischaemia. Sarah Mills provided a summary of the recent changes in management, whereby CCDHB has encouraged early discussion and transfer of mild cases. There has been a clear increase in the number of babies transferred, a clinical reason why this has occurred. When Hutt Valley is compared to the national average using the Perinatal and Maternal Mortality Review Committee (PMMRC) data for high grade cases, Hutt Valley is close to the national average. The Paediatric department will continue to review this data on a regular basis.

QPSC has broadened its scope to facilitate the presentation and discussion of clinical risks across the organisation. Marcus Bisson, Clinical Head of Department for Plastics and Burns and Carolyn Braddock, Service Manager discussed two topics: the management of skin lesions and breast reconstruction services. For each of these, despite efficiency and improved processes, the service is not able to meet the volume of demand due to staffing and infrastructure constraints. These concerns were noted by the committee, and will be incorporated into the clinical governance and risk management work already underway.

The reviews of three serious adverse events were considered and the recommendations accepted, additionally seven always report and review events were included in a group review which was accepted. Four new events were notified to the committee and reviews are proceeding. A revised process for serious adverse events is being implemented, including the introduction of a serious event review committee (SERC) to improve the timeliness, quality and oversight of serious adverse events prior to consideration by QPSC.

## 2.2 Quality and Patient Safety Dashboard – August 2019

The Hutt Valley DHB Quality and Patient Safety dashboard reports a small set of internationally recognised patient safety indicators:

- the number of reported events;
- the number of complaints by service and theme;
- reportable events by service and category;
- open complaints by service;
- key safety event types: falls, medication errors, skin/tissue and staffing.

The data is drawn from the Safety, Quality and Reportable Events (SQuARE) database, on the first available working day of the month. It is presented in Statistical Process Control (SPC) charts produced with the Lightfoot 'Signal for Noise' tool.

The SPC charts show a mean (in green), Upper and Lower Control Limits (in red) and the data for the month in blue. The dotted lines are predicted based on the previous three years data, allowing for seasonal variation. Presenting the data in this way enables staff to identify and respond to special cause variation (those causes not part of the system all the time or that do not affect everyone but arise because of specific circumstances) – this is shown by red dots or crosses. Common cause variation is due to causes inherent in the system over time.

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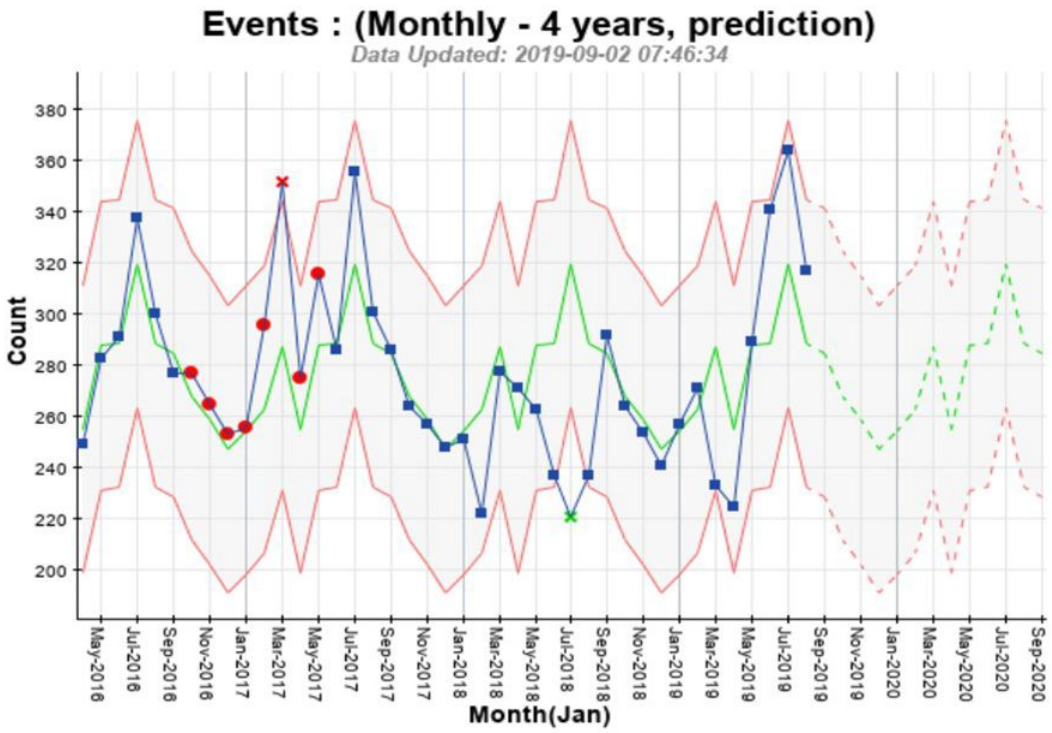
## Reportable Events




| Commentary | Suggested Action |
|---|---|
| There has been a decrease in reported events in August following a peak in reportable events for July 2019 – that peak was similar to the winter months in 2016 and 2017. The number of Reportable Events received this month is consistent with what would be expected through common cause variation. | Continue monitoring. |

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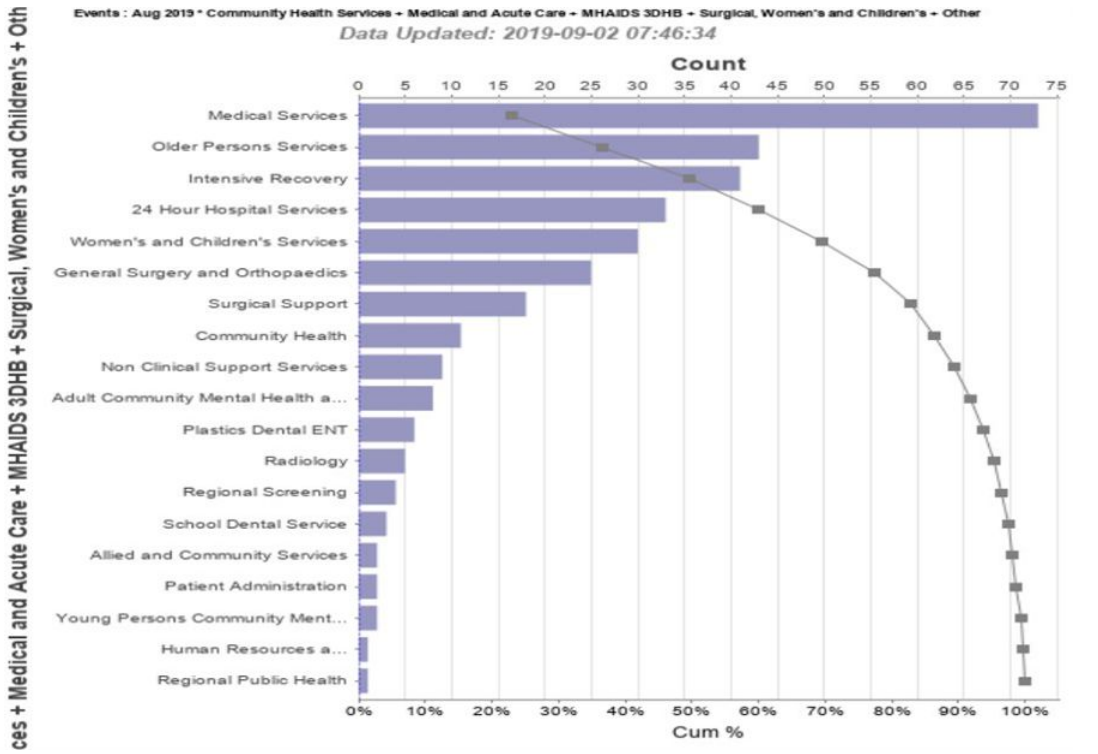
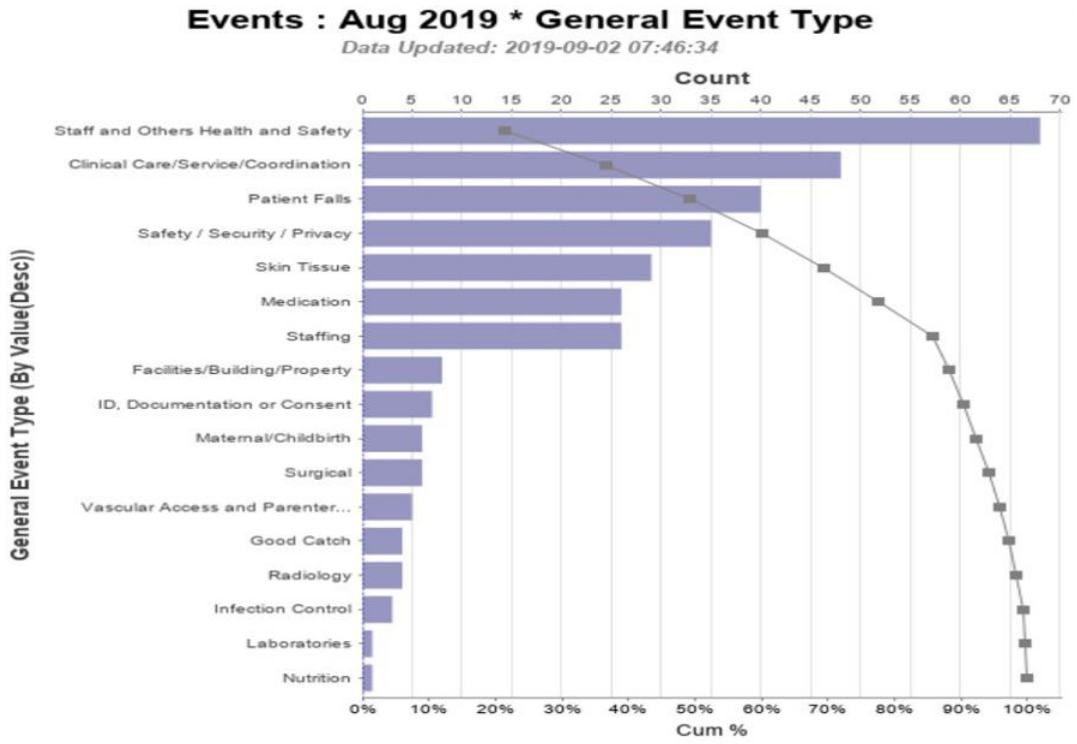



| Commentary | Suggested Action |
|---|---|
| Of the events reported this month, 23% (n=73) of the total number reported originate from Medical Services, 9.5% (n=30) in Women's and Children's Services and 10.4% (n=33) in 24 Hour Hospital Services. This accounts for 42.9% of all events reported.<br>The six largest service groups, as expected, have the greatest number of events. While numbers and proportions change each month, the pattern of events for these six services is similar this month to that seen previously. | Continue monitoring and oversight by service groups. |

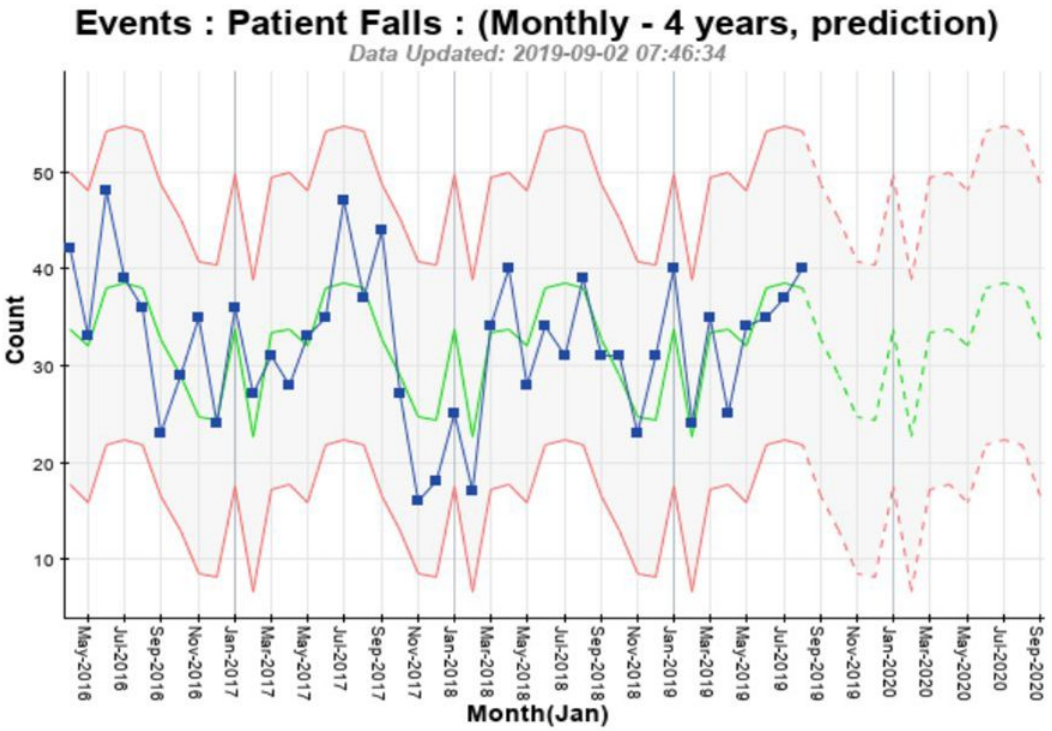
**PUBLIC**




| Commentary | Suggested Action |
|---|---|
| For the events reported this month, 21.5% (n=68) of all events occurred in Staff and other H&S, 15.1% (n=48) occurred in Clinical Care/Service/Coordination, 11.0% (n=35) occurred in Safety/Security/Privacy, 8.2% (n=26) occurred in Medication, 12.6% (n=40) occurred in Patient Falls – these account for 68.4% of all reportable events logged.<br>Overall the pattern of categories is consistent with previous months with Staff and Others Health and Safety and Clinical Care/Service/Co-ordination being key contributors. In looking closer at the events, many are related to the busy winter period. Work is continuing to encourage event reporting and correct classification. | Continue monitoring by the Quality and Patient Safety Committee, and Health and Safety. |

**PUBLIC**

## Reportable Events Key Clinical Indicators




| Commentary | Suggested Action |
|---|---|
| The number of patient fall events is consistent with what would be expected through common cause variation. No special cause variation is identified. | Continue monitoring by the Falls Committee with active implementation of falls minimisation strategies on wards. |

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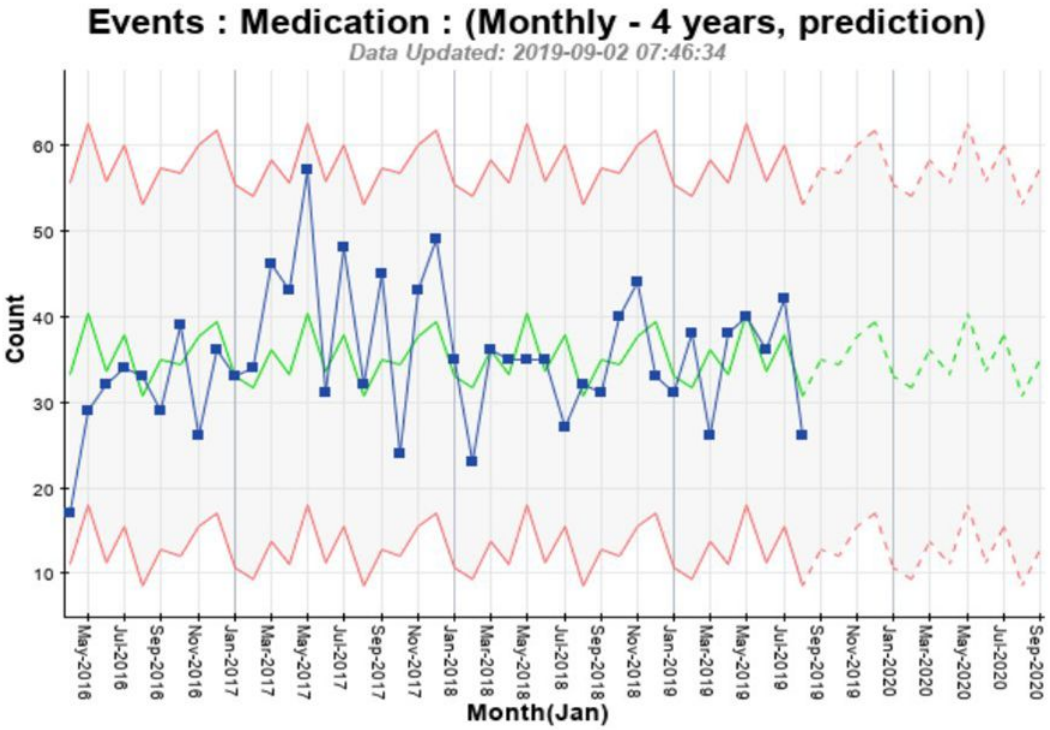
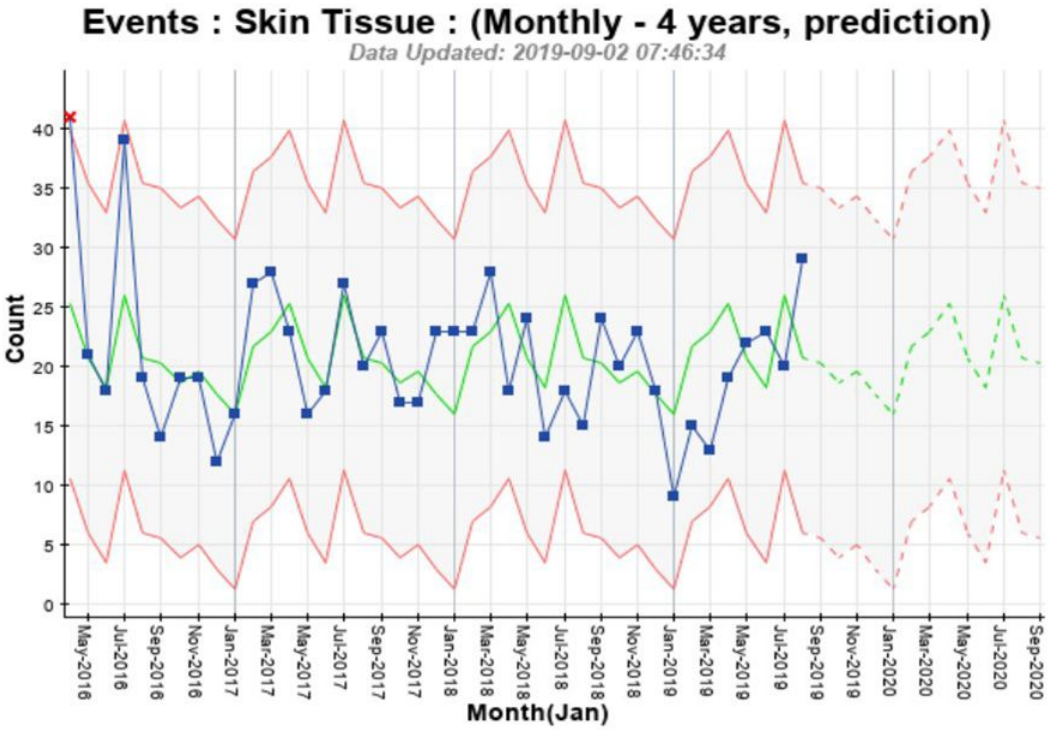



| Commentary | Suggested Action |
|---|---|
| Number of medication events logged on SQuARE for this month is consistent with what would be expected through common cause variation. No special cause variation is identified. | Continue monitoring and analysis by ward medication groups and the Medicines Committee. |



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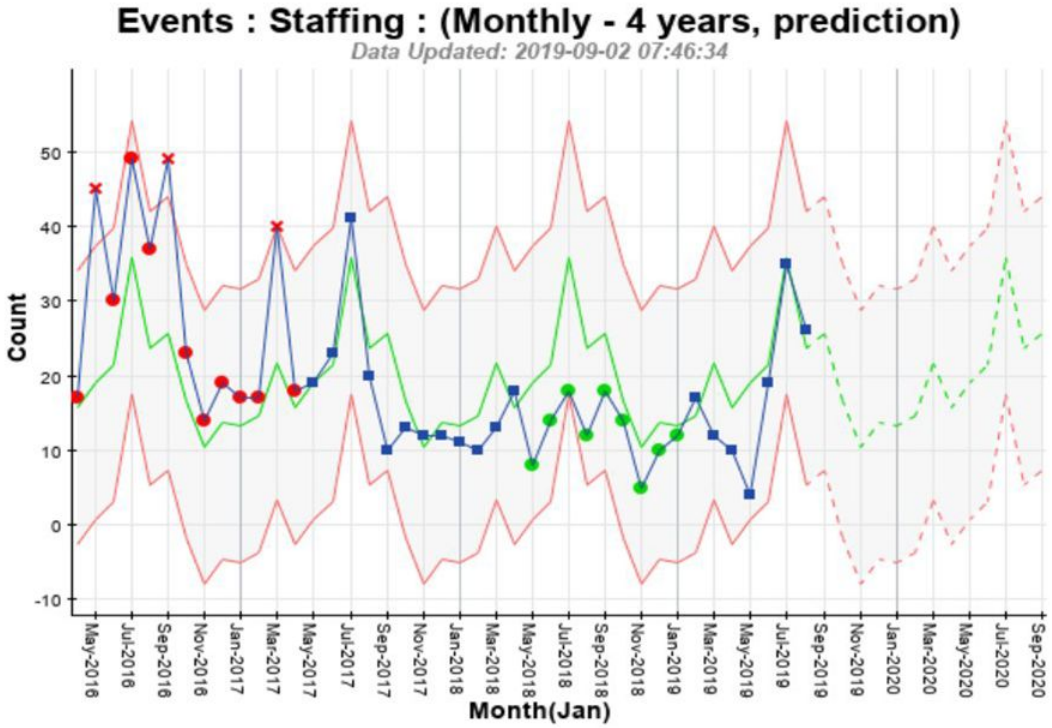
| Commentary | Suggested Action |
|---|---|
| Number of skin/tissue events logged on SQuARE for this month is consistent with what would be expected through common cause variation. No special cause variation is identified, however there has been several months of increased reporting. This is likely related to the introduction of the Nurse Coordinator for Pressure Injury Prevention and Management – this work is increasing reporting, as well as improving management of skin events, particularly in the Medical Services who have seen a notable increase this month. | Continue monitoring and analysis by the Pressure Injury Steering Group. |




| Commentary | Suggested Action |
|---|---|
| The number of staffing events logged on SQuARE for this month is consistent with what would be expected through common cause variation. | Continue monitoring within services. |

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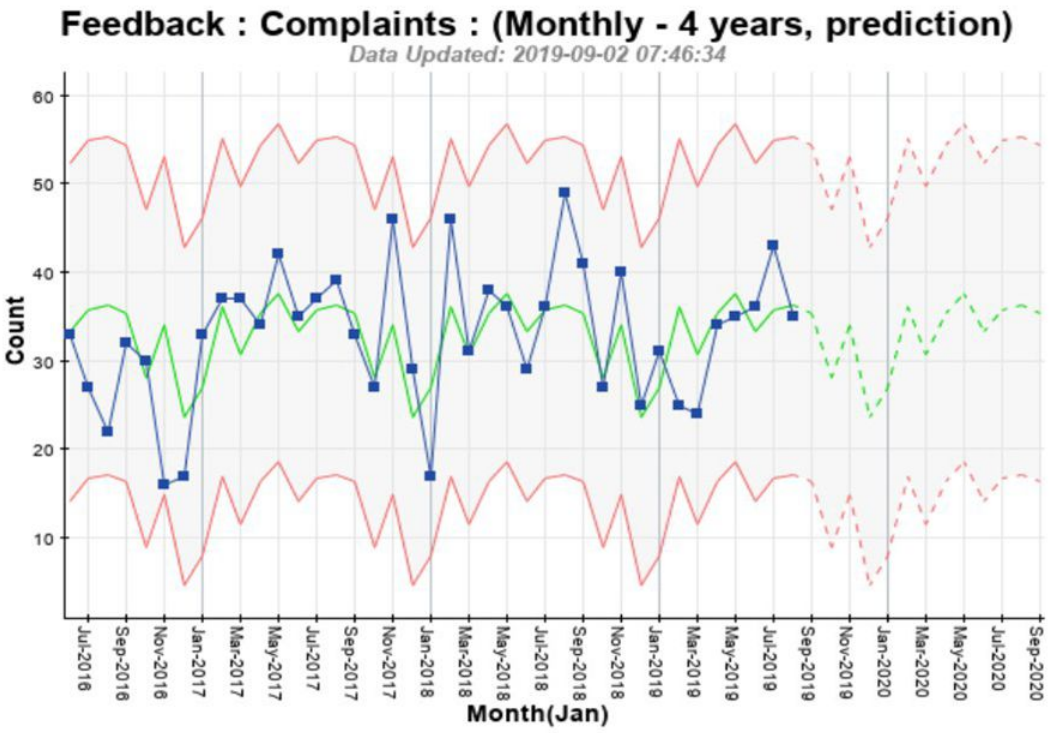
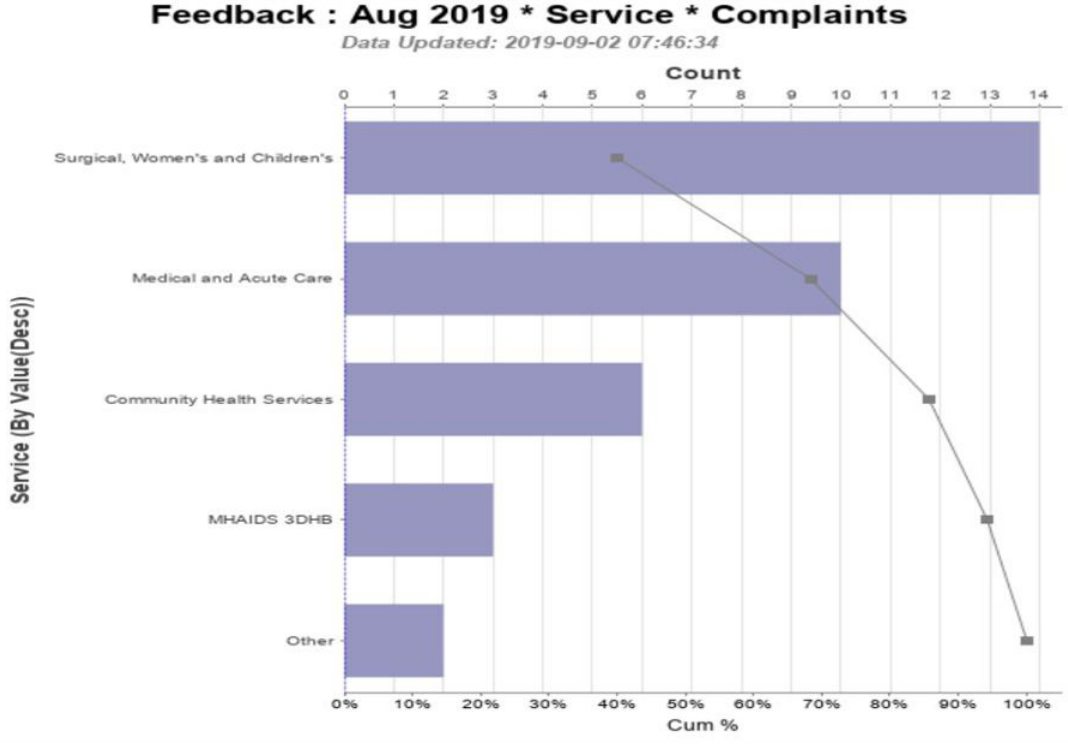
## Feedback




| Commentary | Suggested Action |
|---|---|
| The number of complaints logged on SQuARE for this month (n=35) is consistent with what would be expected through common cause variation | Continue monitoring within services. |



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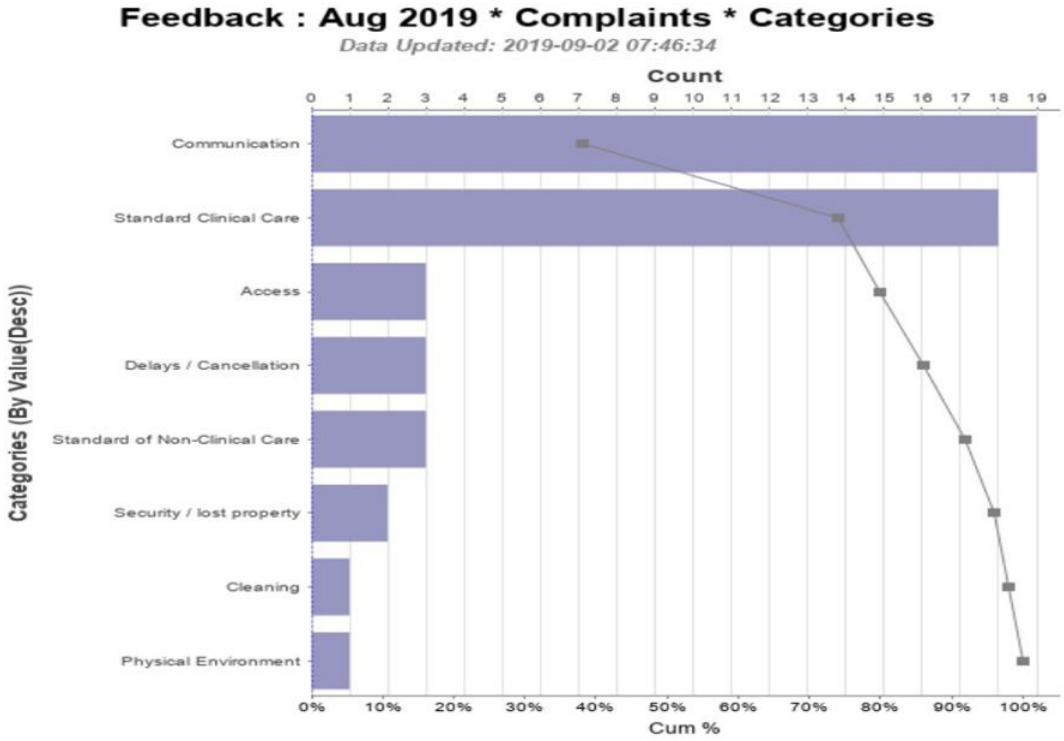
| Commentary | Suggested Action |
|---|---|
| Complaints received (including HDC complaints) for this month were predominately in the Surgical, Women's and Children's Service Group (n=14) followed by Medical and Acute Care (n=10). This is a similar pattern to previous months. | Services continue to respond to and learn from complaints. Continue monitoring and review at the ward/department level. |




| Commentary | Suggested Action |
|---|---|
| 36% of the identified themes from complaints received this month were in the area of 'Standard Clinical Care'; 38% involved 'Communication'. These two categories account for 74% of the themes identified in complaints received, similar to previous months. | Continue monitoring. |

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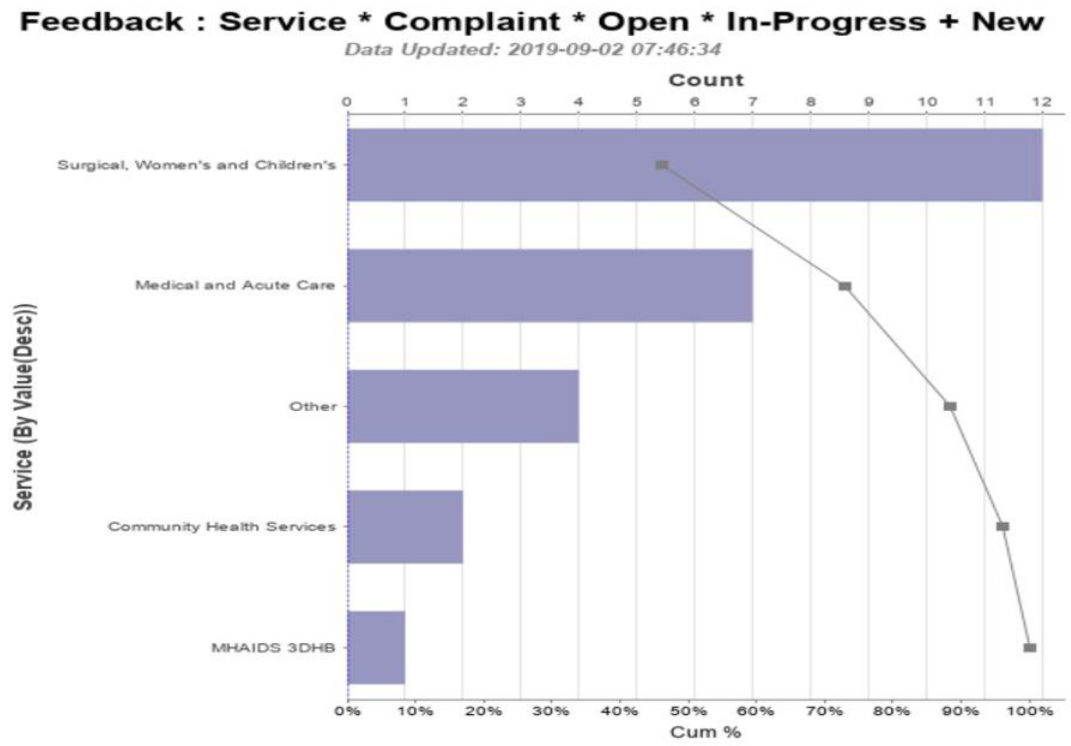


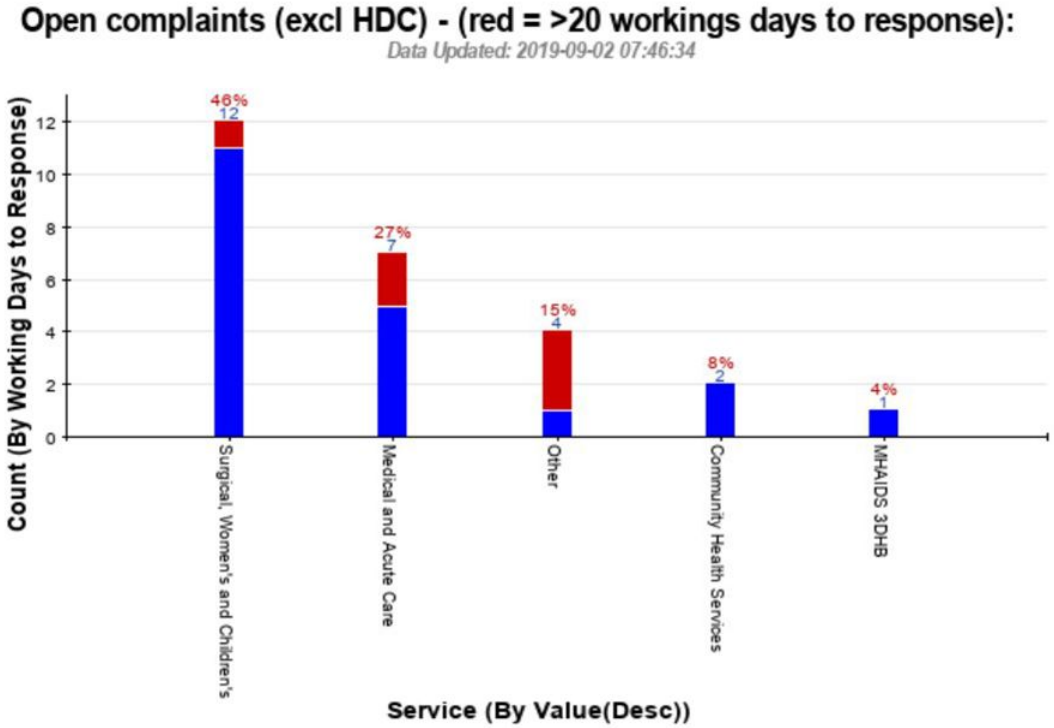


<=20 days >20 days

| Commentary | Suggested Action |
|---|---|
| Of the open complaints (not including HDC) 46.2% (n=12) are in the Surgical, Women's and Children's Service Group and 26.9% (n=7) in Medical and Acute Care. These make up 73.1% of the open complaints. | Continue monitoring. |

| | |
|---|---|
| 23.1% (n=6) are outside the 20 working day response KPI (at 01/09/2019). | |

## 2.3 Certification Audit

Certification is the auditing of inpatient services provided by Hutt Valley DHB to ensure we comply with the Health and Disability Sector Standards. Hutt Valley DHB has a service agreement with the Designated Auditing Agency (DAA) Group to provide certification services as our audit agency.

Hutt Valley DHB underwent an on-site Full Inpatient Certification Audit from 4-7 June 2019.

The final audit report has been received.

The final audit report indicates 25 corrective actions which must be addressed within the required time-frames. Two of the corrective actions were identified as 'high'. The two 'high' actions related to improvements required in the management of risk and the management of recommendations following serious adverse event reviews and similar such reviews that occur in the organisation.

A plan to implement the corrective actions is now underway, with the focus on risk management and the management of serious adverse event review recommendations.

## 2.4 Quality Improvement Programmes and Projects Support – Update

A range of quality improvement programmes and projects are underway at Hutt Valley DHB. These include projects that are led by the Improvement Advisor and other members of the Quality team, and projects and programmes led by others and supported by the Quality team through providing specialist advice (such as data analysis, statistical process control charts, process mapping, PDSA (plan, do, study, act) cycles, and Lean methodology).

The Improvement Advisor has recently completed the Electronic Frailty Screening Service Improvement Project that has focused on improving visibility and early identification of frail elderly patients within the hospital. Once a patient is screened for frailty, the icon will appear on WebPas and the concerto eWhiteboard.

The eHandover Project has now been successfully launched to the medical group of specialties which includes General Medicine, Cardiology and OPRS. The overall impression from the doctors is 'very good,' the tool is very useful to improve patient handover communication between RMOs.

Work is ongoing to support the medicine service improvement project workstreams (improving the teamwork between medical, nursing and allied health teams on the medical ward and making patient flow more efficient); a notable workstream is 'Smooth Sailing' focusing on patient flow from the Emergency Department to the General Medicine Service. Discussions have begun with the surgical group of specialties to run a pilot trial of eHandover for a month. The Quality Team's Improvement Advisor works in an advisory role alongside project managers and clinical staff.

Work is due to begin on a project to reduce medication / drug count errors, redesign of the general medicine assessment note with focus on a robust process for admission and discharge medication reconciliation and the roll out of a Subcutaneous Infusion Medication tool for patients under palliative care.

| **Title: 2DHB Outbreak management of infectious disease** | |
|---|---|
| **Type:** Policy | **HDSS Certification Standard** [optional] |
| **Issued by:** Infection Prevention and Control Committee | **Version:** 2 |
| **Applicable to:** HVDHB and CCDHB | **Contact person:** Infection Prevention and Control CNS CCDHB & IPC CNS HVDHB |
| **Lead DHB:** CCDHB | |

## Purpose:

This policy provides the Infection Prevention and Control Service with the mandate to manage an outbreak situation. In the event of an actual or suspected infectious disease outbreak, this policy details the specific investigation and management processes to be implemented.

## Scope:

All Capital and Coast District Health Board (CCDHB) and Hutt Valley District Health Board (HVDHB) employees, staff and persons working at CCDHB and HVDHB must comply with this policy.

For the purposes of this document, staff will refer to:

All staff within CCDHB and HVDHB, including those not working in direct contact with patients/consumers. Staff is taken to include anyone engaged in working to CCDHB and HVDHB objectives. This may include but is not limited to:

- Employees irrespective of their length of service
- Agency and self-employed workers
- Consultants
- Third party service providers, and any other individual or suppliers working for including personnel affiliated with third parties, contractors, temporary workers and volunteers.
- Students

**For ease of reference they will all be referred to throughout this document as 'staff'.**

## Definitions:

### Outbreak

A greater rate of infection than expected within a population over a period of time, can be a single case, cluster or an epidemic. The point at which intervention is required will vary according to risks of infection to those exposed and pathogen transmissibility.

## Policy content:

In the event of an actual or suspected infectious disease outbreak, specific investigation and management processes are implemented:

- All staff notify Infection Prevention and Control Service of any perceived increase in the incidence of infections occurring in staff or patients.
- The Emergency Management Service Leader is the 'single point of contact' for ALL (national and local) alerts.
- The Infection Prevention and Control Team determine the nature and extent of response required in consultation with relevant staff – this may include forming an outbreak committee.
- The on-call microbiologist or infectious diseases physicians may escalate and report findings and recommendations to the appropriate management.

## Regional or national outbreak

In addition to the above:

- Notification of an actual or potential outbreak affecting more than one DHB may be received from the Regional Public Health Service or the Ministry of Health by the Emergency Management Service Leader.
- Warning alerts of potential outbreaks are received by the C&C Emergency Management Service and disseminated as appropriate - in these circumstances regional or national coordination plans (Appendix 1) will be implemented.

## Procedure

### *Actual/potential outbreak*

Identified by:

- laboratory microbiological data
- surveillance systems (see Surveillance for infection policy)
- staff alert
- Regional Public Health, National or International alerts.

### *Notify on-call Clinical Microbiologist/Infectious Disease Physician*

Notify the on-call microbiologist/infectious disease physician via the operator. He or she will then discuss with other members of the team the following issues.

### *Establish or confirm outbreak*

- Agree case definition. This may rely solely on clinical criteria (as opposed to laboratory testing), at least until a diagnosis is established.
- The threshold for invoking this policy will vary and will be decided between infection control, the clinical area(s) involved and management – not all events require formation of an outbreak committee.

- *Meetings will involve relevant staff as above, be minuted and actions agreed.*
- *Actual and potential outbreak situations will be standing agenda items at the Infection prevention and control Committee for update until resolved.*

- Legal requirements for notification to the Medical Officer of Health (see Appendix 2 - notifiable diseases) will be enacted
- Questions that inform decision making include:
  - *What is the contagiousness and severity?*
  - *What number of people are affected (actual and potential)*
  - *What is the prevalence in the community?*
  - *Are infected people being adequately cared for?*
  - *Are Health Care Workers providing care protecting their own health?*
  - *Does this outbreak need to be reported as per C&C Reportable events policy?*
  - *Are potentially exposed persons properly identified and informed?*
  - *Do Clinical and Senior Management need to be informed?*
  - *Does the Ministry of Health need to be informed?*
  - *What is the media risk – actual or perceived, should the C&C Communications Manager be informed?*

## *Notify Medical Officer of Health*

**Normal hours**

- Routine communicable disease notification: Phone (04) 570-9267
- Urgent notification or immediate advice required: Phone (04) 570-9002
  (The receptionist will ensure your call is put through to the most appropriate person).

**After hours**

Phone (04) 570-9007; ask for Health Protection Officer or Medical Officer of Health. In the unlikely event that RPH Healthline cannot be raised, call either of two rostered on call officers, the first On Call Officer should be the first point of contact:

First On Call Officer Cellphone 027-285-6034

Second On Call Officer Cellphone 027-285-6035

## *Outbreak Control Committee*

**Formation**

When the Clinical Microbiologist/Infectious Diseases Physician determines the need for an Outbreak Control Committee, it will include all, or some of the following:

- *an infectious diseases physician*
- *a clinical microbiologist*
- *an infection prevention and control nurse(s)*
- *an Occupational Health Service representative*
- *relevant senior management*

- *CCDHB communications manager*
- *a representative from Emergency Management*
- *relevant staff from affected clinical areas*
- *a Human Resources representative*
- *Patient Services Coordination Unit manager.*

The Committee may also include if deemed appropriate:

- *a Medical Officer of Health*
- *external experts as appropriate, including by teleconference*
- *a Ministry of Health Representative*
- *Other Government Agency representatives.*

## *Committee responsibilities*

- Determination of agreed control measures and outbreak management plan will depend on nature and extent of disease. Options may include:
  - *increased infection prevention and control measures*
  - *increased staff education re infection prevention and control measures*
  - *increased auditing of infection prevention and control practice*
  - *cohorting – creating barriers between affected and unaffected patients e.g. isolation of one/more patient in a room (s), categorising rooms based on risk and or isolating or restricting units, services or hospitals*
  - *closing or restricting access/visiting to units/services*
  - *The allocation of staff and other resources to where required.*
- Development of a communication strategy (see Appendix 4 Checklist) to include:
  - *keeping the DHBs staff and patients informed*
  - *Notification to other DHBs/healthcare facilities.*
- Determination of monitoring and reporting requirement to include what information is required at what frequency from what parties.
- Determination of resolution of outbreak
  - *At what point do services return to business as usual?*
- *At what point is organism accepted to be endemic.*
- Evaluation of the management of the outbreak may include:
  - *recommendations for prevention/management of future outbreaks*
  - *cost benefit analysis*
  - *a formal debrief process*

## *Infection prevention and control team responsibilities*

Leadership and advice throughout the outbreak.

### *Service management responsibilities*

Ongoing service provision, ensuring communication and implementation of outbreak management plans.

### *Occupational Health team responsibilities*

- *Monitoring and management of impact on staff including screening, dissemination of results and any implications for affected staff, e.g. Personal family, financial, other.*
- *Provision of relevant staff health reports*

### *Occupational Health team responsibilities*

- *Monitoring and management of impact on staff including screening, dissemination of results and any implications for affected staff, e.g. Personal family, financial, other.*
- *Provision of relevant staff health reports.*

## Related documents:

**CCDHB policies:**

- *Multi drug resistant organisms (MDRO) microbiological screening of patients*
- *Reportable events & Serious and sentinel events*
- *Surveillance for infection*

## References:

Health and Disability Service Standard NZS 8142:2008 Infection prevention and control

Australian Guidelines for the Prevention and Control of Infection in Healthcare (2010)

http://www.nhmrc.gov.au/node/30290

Ministry of Health (2009). *A list of diseases notifiable to the Medical Officer of Health*. Date of publication on the web: July 2005 (Updated May 2009)
http://www.moh.govt.nz/moh.nsf/wpg_index/About-notifiable+diseases

National Health Emergency Plan: Infectious Diseases Central Region Major Incident Health Coordination Plan National Emerging Infectious Disease Clinical Action Plan (NECAP) Ministry of Health 2003.

Public Health Act 1956.

Wellington Region Regional Public Health Pandemic Plan.

## Keywords for searching: [up to four words, to assist staff in finding document]

## Appendices:

Appendix 1: Management of regional and national outbreaks

Appendix 2: Diseases notifiable in New Zealand (include suspected cases) 2009 Update

Appendix 3: Outbreak Committee – Terms of reference

Appendix 4: Communication

## Management of regional and national outbreaks Appendix 1

### *Notification of national outbreaks and pandemics*

The Ministry of Health uses a series of national codes and alerts to advise the sector of emerging infectious diseases; and to activate, and stand-down the National Infectious Diseases Plan (National Health Emergency Plan: Infectious Diseases).

Urgent alerts are disseminated to DHBs by telephone. The on-call microbiologist or infectious diseases physician is the point of contact for CCDHB and Hutt Valley DHB

Routine alerts are disseminated by e-mail. The Emergency Management Service at either or both Capital Coast Health DHB or Hutt Valley DHB is the point of contact.

### *National alert codes and expected DHB actions*

| CODE | DESCRIPTION | DHB RESPONSE |
|---|---|---|
| **Information** (White) | Confirmation of an EID-related incident outside New Zealand | ▪ Advise all relevant staff, services and service providers<br>▪ Notify clinical and public health staff of case definitions, clinical advice, and control measures<br>▪ Review clinical emergency plans |
| **Standby** (Yellow) | Possible EID-related emergency in New Zealand – imported cases without local transmission | ▪ Prepare to activate DHB CIMS structure<br>▪ Prepare to activate regional coordination teams<br>▪ Advise and prepare all staff, services and service providers<br>▪ Manage own DHB clinical response and public health response if affected by the emergency |
| **Activation** (Red) | EID-related emergency in New Zealand – many imported cases and/or local transmission, outbreak or epidemic | ▪ Activate DHB CIMS structure<br>▪ Activate regional coordination teams<br>▪ Advise of regional emergency contact number(s)<br>▪ Manage own DHB response, as required under regional coordination arrangements |
| **Stand-down** (Green) | End of outbreak, epidemic or emergency – services returning to normal | ▪ Deactivate regional coordination teams (where activated<br>▪ Deactivate DHB CIMS structure<br>▪ Resume normal functions<br>▪ Post stand-down – participate in MOH led review of emergency response |

## 2DHB Outbreak management of infectious disease

### *National and regional coordination*

All or some of the following plans will be implemented in support of the CCDHB and Hutt Valley DHB policy Outbreak Management of Infectious Disease to coordinate the management of a regional or national outbreak. In general terms, they are all intended to ensure a coordinated approach to the management of any significant event.

| PLAN | SCOPE |
|---|---|
| **National Health Emergency Plan: Infectious Diseases (NHEP:ID)** | A Ministry of Health plan setting out the roles, responsibilities and procedures for the national management of outbreaks, epidemics, or pandemics of infectious diseases |
| **Central Region Major Incident Health Coordination Plan** | This Plan is intended to meet a requirement of the NHEP:ID that DHBs manage national incidents in 4 regions.<br>The Central Region encompasses the districts covered by the Whanganui, MidCentral, Hawkes Bay, Capital & Coast, Hutt Valley and Wairarapa DHBs.<br>In this context the primary focus of the plan would be to coordinate communications relating to the management of an incident between the 6 DHBs and the MOH.<br>In some cases it may also coordinate the use of resources such as tertiary facilities, staff etc<br>Activities would be undertaken by a Regional Coordination Team |
| **Wellington Region Regional Public Health Pandemic Plan** | This plan outlines the more detailed arrangements for the management of an outbreak as they would apply in the Capital & Coast, Hutt Valley and Wairarapa DHBs.<br>This may include :<br>▪ Clinical management<br>▪ Infection prevention and control<br>▪ Admission procedures<br>▪ Coordination with the primary health sector<br>▪ Isolation procedures<br>▪ Staffing<br>▪ Facilities<br>▪ Communications and education<br>▪ Border control |
| **DHB Operational Plan** | An operational plan may be developed to meet the unique needs of a specific outbreak.<br>This may include :<br>▪ Command and control systems needed to support the Outbreak Control Team<br>▪ Measures needed to ensure the continued operation of essential services<br>▪ The establishment of any additional facilities or services that may be needed (e.g. assessment, treatment, and isolation facilities, vaccination programs) |

**Appendix 2**

**Diseases notifiable in New Zealand (include suspected cases)**

http://www.rph.org.nz/content/9bb56554-2f2d-4b09-ad05-bc22074eb102.html

Follow link to latest update of Notifiable Disease Schedule

**Outbreak Committee – Terms of Reference for CCDHB and/or HVDHB** **Appendix 3**

**Purpose**

To control a defined outbreak within DHB services in order control the risks of infection outbreak for patients, staff and visitors.

**Objectives**

The committee will:

- *monitor outbreak control effectiveness, where concerns are identified these are reported to the Strategic Clinical Governance committee (SCGC) and relevant service management*
- *report to and advise (SCGC)/management/Regional Public Health on outbreak matters and recommendations*
- *review and determine practice to control outbreak*
- *inform staff and managers or outbreak management plan and actions*
- *liaise with (and where appropriate) advise other healthcare providers within the sub DHB region and other DHBs*
- *develop, implement and update the subregional DHB plan for the specific outbreak*
- *monitor Infection prevention and control concerns re non-compliance with outbreak plan and make recommendations for implementation of remedial action*
- *monitor and develop plan to manage occupation health issues*
- *work with the local Medical Officer of Health, Ministry of Health other DHBs and agencies as required*

**Decision-making**

Decisions will be made by consensus

**Accountability**

The Outbreak Committee reports to the IPCC, SCGC, Management and Executive teams and Board as required – see Communication Checklist.

**Membership**

As per Outbreak policy.

**Chairperson**

As agreed for specific outbreak

**Quorum**

NA

**Meetings**

Frequency will be determined in relation to specific outbreak requirements. Meetings will be minuted.

**2DHB Outbreak management of infectious disease**

**Communication plan CCDHB and HVDHB** **Appendix 4**

| Outbreak issue | Who gets the information | Delivery method | Frequency | By whom |
|---|---|---|---|---|
| Routine surveillance results | Service leadership | Email and prn face to face discussion | Monthly | Clinical Microbiologist |
| New problem/issue identified | On call Clinical microbiologist/infectious disease physician<br>Chair of the Infection prevention and control Committee (IPCC)<br>Infection prevention and control Team members<br>Medical Officer of Health | Email<br>Face to face discussion<br><br>Phone call | Once | Clinical Microbiologist |
| Alert-Interim advice to affected service(s) on outbreak and recommended containment measures | Clinical Directors<br>Business Managers<br>Service leaders<br>Charge nurse manager /Team leader<br>Associate Directors of Nursing<br>House management (Food and cleaning considerations) | Alert-Email written report of the problem and interim/immediate recommendations | At the beginning | Infection prevention and control Team member |
| Complete Reportable Event Form Part A<br>Alert – as relevant<br>Outbreak – must be completed | Quality Improvement Unit | Form – paper or electronic | Once | Infection prevention and control Team member |
| Outbreak - Convene outbreak committee | See membership (procedure section of policy) | Email/phone call/face to face<br>Committee meetings | As required ASAP | Infection prevention and control Team member |

**2DHB Outbreak management of infectious disease**

| Outbreak issue | Who gets the information | Delivery method | Frequency | By whom |
|---|---|---|---|---|
| | | minuted | | |
| Communicate outbreak management plan developed and agreed by Outbreak Committee | As relevant…….<br>COO: Chief Medical Officer: Director of Nursing Communications<br>Clinical Director (s)<br>Business Manager (s)<br>Service leader(s)<br>Charge nurse/midwife managers/Team leader(s)<br>Associate directors of nursing<br>House management (Food and cleaning considerations)<br>War/ unit staff<br>Materials management<br>After hours management<br>Emergency management<br>Emergency Dept Wgtn, A&M Kenepuru, Hutt<br>Auxillary staff (orderlies, phlebotomy etc)<br>Allied health (physio, OT etc)<br>Radiology<br>Visiting medical staff<br>Micro Laboratory<br>Medical Officer of Health | Email/phone call/face to face – publish documents as relevant, staff education, signage, patient education, publicity | As required | Infection prevention and control Team member or<br>Agreed member of Outbreak Committee |
| Consider need for ongoing outbreak meetings | Outbreak committee<br><br>Update communications | Committee meetings minuted<br>Emailed out | After every meeting | Infection prevention and control Team member |
| Ongoing information to affected services/regions and | As above as relevant and<br>Infection prevention and control Committee (monthly)<br>Strategic Clinical Governance Committee (SCGC) | As above<br><br>Update reports | Ongoing depending on outbreak | Infection prevention and control Team member and |

**2DHB Outbreak management of infectious disease**

| Outbreak issue | Who gets the information | Delivery method | Frequency | By whom |
|---|---|---|---|---|
| to organisation | (quarterly)<br>Executive Management Team and Board (as required) | | complexity | Senior managers of affected service(s) |
| At end of outbreak summary report and recommendations | Outbreak committee with service staff input | Draft report and finalise<br>Ongoing updates prn via routine IPCC reporting | Once at end of outbreak | Outbreak committee |

**PUBLIC**

| | |
|---|---|
| **Date:** 26 September 2019 | **BOARD DECISION** |
| **Author** | Interim General Manager, Strategy, Planning & Outcomes - Rod Bartling |
| **Endorsed by** | Chief Executive Hutt Valley DHB – Fionnagh Dougan |
| **Subject** | **PROGRESS UPDATE AGAINST THE CLINICAL SERVICES PLAN (SEPTEMBER 2019)** |

**RECOMMENDATION**

It is recommended that the Board:

(a) **NOTES** the attached Progress Update against the Clinical Services Plan.

(b) **NOTES** that the Progress Update shows 13 individual projects are on-track for completion, 7 have been delayed but still being progressed, and 4 have been deprioritised at this time.

**APPENDICIES:**

1. Progress Update against the Clinical Services Plan (September 2019).

## 1. PURPOSE OF PAPER

The attached Progress Update provides the Board with an update of progress against our Clinical Services Plan.

## 2. BACKGROUND

In 2018 Hutt Valley DHB completed its *Clinical Services Plan 2018-2028*, which outlines the need to reconfigure its clinical services over the next 5-10 years to address growing health demands and persistent inequities. If no changes are made to Hutt Valley DHB's models of care, the Clinical Services Plan predicts that Hutt Valley DHB will have a $35 million deficit gap by 2030, assuming everything remains equal and it continues to deliver services at the same rate.

The Clinical Services Plan concludes that Hutt Hospital will run out of inpatient beds if it keeps on doing things the same way. Its bed use rate will accelerate to and beyond capacity within a few years, particularly in general medicine. It also concludes that Hutt Valley DHB's operating costs will become increasingly unaffordable unless changes are made.

In response to the findings in the Clinical Services Plan, Hutt Valley DHB has started implementing a plan to strengthen primary and community services, keep people well and out of hospital, and constrain the growing demand on hospital services. It includes roll out of the Health Care Home model of care, timely specialist advice to general practice, and the development of 'Neighbourhood Teams' where DHB services (older persons, community nursing, allied health and assistant workforce) support general practice teams. The attached Progress Update provides the Board with an update on this work. It shows that 13 individual projects are on-track for completion, 7 have been delayed but still being progressed, and 4 have been deprioritised at this time.

# Update on progress against the Clinical Services Plan – September 2019

| Project / Workstream | | Update | |
|---|---|---|---|
| Place Based Planning | 1. Scoping and Relationship Building | • Enhanced governance and membership of the Alliance Leadership Team was supported by ELT in August - Revised ToR and membership due to go to Hutt INC in September<br>• Enhanced relationship development underway via the Wellbeing work programme particularly with Hutt City Council , NGOs and Public Health<br>• Leverage from First 1000 days co-design project analysis activity (see #4) to inform next steps of placed-based needs analysis | |
| First 1,000 days | 2. Children's outpatient project | • Clinical leader appointed: Dr Pat Touhy. | |
| | | Workstream One – Data<br>• Data collection and analysis for service improvement and reporting complete. | |
| | | Workstream Two – Secondary Care Pathways<br>• Triage process has been implemented<br>• New Health Pathways have been identified based on referral volumes and appropriateness for primary care intervention.<br>• A Virtual First Specialist Appointment enhancement has been requested from ICT.<br>• Inter-service referral processes between paediatrics, ICAFS and Te Haika have been developed and agreed.<br>• This work has identified opportunities for investment to accelerate this and other related integration work. An investment request will be presented to the Board in due course. | |
| | | Workstream Three – Nursing Model<br>• Value stream mapping has identified the potential of freeing up 35 hours per week of clinical and administrative work. This work is currently being done by outpatient registered nurses and could be reallocated to enrolled nurses or administration staff. This would release a registered nurses time to run community clinics. Awaiting approval to provide formal proposal to proceed to ELT. Likely costs are one-off funding of $65k to get clinics established.<br>• Models for Community-based clinics with primary care are ready for implementation, subject to ELT approval. The model involves bringing specialist child health registered nurses in to community clinics – either in primary care, in the patient's home or in other settings (ideally, supporting practice and nurses in iwi-based providers). | |
| | 3. Child Development Service | • De-prioritised at this time. | |
| | 4. Implement findings of the first 1,000 days co-design project | • Engagement Phase completed.<br>• Child Health Network and Hutt Inc to determine next steps. Update to Board will be provided in October 2019 to proceed to next phase. | |
| | 5. Implement a maternal mental health service | • Procurement approach to be finalised in September 2019. | |
| | 6. Revise the New Born Enrolment process | • Work occurring to support a) general practice uptake of newborns, and b) appropriate clinical handover between providers. | |
| | 7. Implement recommendations of the Women's Health review | • The Steering Group is in place.<br>• A workshop was held to agree the work breakdown structure and key principles. Next steps include setting up workstream groups and the project team.<br>• In parallel to project planning, a number of urgent actions are being addressed relating to recruitment, refurbishment and purchase of essential equipment. | |

| Project / Workstream | | Update | |
|---|---|---|---|
| **Building Strong Primary and Community Care** | 8. Implement Health Care Home model | • Nine GP practices within Hutt Valley DHB have implemented the full Health Care Home (HCH) standards and are HCH practices.<br>• In June 2019, the application process to become HCH became an 'open application' process and the first application was received in August 2019. | |
| | 9. Implement specialist support for primary care. | • Direct access to SMO advice: The acute phone consult liaison model continues in Geriatrics, Paediatrics, Cardiology and Mental Health (with ongoing improvements and promotion to be progressed by the Mental Health Network<br>• Specialist support (including case collaboration) for primary care: Various specialist support models for primary care are underway across a range of specialist services (Diabetes, Mental health, Respiratory, Cardiology) and primary care providers.<br>• The specialist community services are exploring a rotation of specialist nursing training (Respiratory, Diabetes, Rheumatology and Cardiology) for primary care nursing in the Upper Hutt Neighbourhood. | |
| | 10. Develop one DHB community team | • Three staff workshops have been held with community service allied health staff to develop a model of working for 'one DHB community team'. | |
| | 11. Access to acute responsive community services model | • The Supported Discharge and Rapid Response functionality is being scoped in parallel with the changes to the 'One DHB Community team' – see previous section.<br>• The current Early Supported Discharge function, based in MAPU, has been moved to come under the management of the Community Health Services directorate<br>• A repeat 'Day of Care' audit is being conducted in Q2, 2019/20 to assist in identifying the gaps in current service provision that could be filled by investing in supported discharge / rapid response function. | |
| **Wellbeing of Older People** | 1. Identify gaps in service for people with dementia against the national dementia framework | • A workshop was held to identify the current process for people living with advancing dementia who had increasing health needs. With the information from previous consumer forums and a national dementia stocktake that takes place in September and October will support the development of dementia framework implementation plan. | |
| | 2. Establish a medicine prescribing quality improvement programme and medicines management programme | • A plan to implement the pharmacy strategy (including a prescribing quality component) is being drafted for comment by Hutt INC in September 2019 prior to DHB approval in October. The prescribing quality component is likely to be developed in 2019/20 and implemented in 2020/21. | |
| | 3. Implement the palliative care strategy | • Te Omanga Hospice is rolling out an integrated model of specialist palliative care nursing and medical support<br>• Two Palliative Care Facilitators have been appointed for clusters of General Practices with final facilitator to be appointed by the end of the year. These 3 facilitators will lead the changing model of integrated care in their respective neighbourhoods.<br>• Primary care funding is now embedded for planning and end of life care.<br>• Training for Link nurses in general practice, residential care and in hospital has taken place and will continue.<br>• InterRAI Palliative Care tool has been rolled out<br>• Advance Care Planning clinics for specialty appointments are being developed. | |

| Project / Workstream | | Update | |
|---|---|---|---|
| Flows through the hospital | 1. Implement Medicine improvement programme | • Patient flow: The data reporting tool, called Smooth Sailing, has been designed, built and is now operating. The tool measures in real time delays in patient flow in ED, in to MAPU and through the Medical Ward.<br>• Nursing leadership model redesign: High level options paper is complete and awaiting approval before progressing with formal staff processes.<br>• SMO workplan testing is scheduled for Sept 2019. Recruitment of additional general medicine tenths was successful. This will result in a major change to the medicine service model of care from March 2020 (acute clinics, a formal support to primary care programme). SMOs are leading interviews with GPs in the Valley in October.<br>• A Day of Care survey is schedule for October. All patient records will be reviewed to understand their appropriateness for admission and potential community based options if these were in existence.<br>• A Frequent Attendee electronic whiteboard enhancement has been built. This is undergoing testing. It will highlight patients who come to hospital often so contact and joint care planning can occur with their primary care provider and the patient's other community support services. | |
| | 2. Improve theatre scheduling systems | • The ScOPe software was selected through a procurement process, and implementation is currently well underway. The final round of user testing is about to begin, and plastics is anticipating a soft go-live in the end of September. All specialties will be using the software by mid-November 2019. | |
| | 3. Develop enhanced pre-assessment model of care | • Work on this project is planned to begin in Q3, once the software is fully in use. This is because the software impacts on current processes in pre-assessment. | |
| | 4. Develop surgical short stay concept to improve surgical flow | • De-prioritised at this time. | |
| | 5. Expand Red2Green programme to Older Persons Rehabilitation Services (OPRS) wards | • OPRS group has formed. IT enhancement has been logged with the team who creates the electronic whiteboard columns and is awaiting prioritisation. Changes to business processes underway. | |
| Networked Hospital | 1. Establish 2 DHB governance structure and processes to support joint planning | • A 2DHB Joint Governance structure is being developed to progress the Hospital Services Network, the Joint DHB Long Term Investment Plan, the Mental Health Improvement Plan, and the Information Management Alliance. Feedback is being sought from ELTs on the proposed structure. | |
| | 2. Establish Renal Service Delivery closer to home through development of a satellite clinic in the Hutt Valley | • CCDHB Operational team has been evaluating the community options for a Renal satellite clinic in the Hutt Valley.<br>• A business case including financials will be submitted to September Board to progress. | |
| | 3. Support implementation of Medical Days stay credentialing recommendations as a precursor for Hutt to commence oncology services on site in 20/21 | • De-prioritised at this time. | |

| Project / Workstream | | Update |  |
|---|---|---|---|
| | 4. Develop oncology model of care for ambulatory oncology service delivery at Hutt hospital | • New Executive Director, Oncology at CCDHB has met with Clinical leaders at Hutt Valley DHB to build closer connections between the two teams.<br>• Initial discussions focused on improving inpatient pathways have commenced. Ambulatory service delivery conversations will likely come after the inpatient work given Hutt Valley's Medical day stay capacity issues. These require local work to resolve to enable ambulatory oncology care capacity. | |
| | 5. Develop Hutt inpatient pathway for patients under oncology care | • See above. | |
| | 6. Complete Scoping for joint planning in ENT services | • Joint planning workshop for ENT leaders across both sites is planned for October 2019. | |
| | 7. Complete Scoping exercise for joint planning in Gastroenterology/Colonoscopy services | • De-prioritised at this time. | |
| | 8. Complete Scoping exercise for joint planning in Cardiology services | • Joint planning workshop for Cardiology leaders across both sites is planned for October 2019 | |

**PUBLIC**

| | |
|---|---|
| **Date:** September 2019 | **BOARD INFORMATION** |
| **Author** | Director of Nursing, Clinical Council Co-Chair – Chris Kerr<br>Chief Medical Officer, Clinical Council Co-Chair - Dr Sisira Jayathissa |
| **Endorsed by** | Chief Executive Hutt Valley DHB - Fionnagh Dougan |
| **Subject** | **HUTT VALLEY CLINICAL COUNCIL UPDATE – SEPTEMBER 2019** |

**RECOMMENDATIONS**

It is **recommended** that the Board:

**(a) NOTES** that the HV Clinical Council (the Council) met on 5 September 2019

**(b) NOTES** that the Council noted the following papers:

- Innovation fund update: Patient Controlled Oral Analgesia (PCOA) ost caesarean section delivery;
- Hutt Valley DHB Quality and Safety update;
- Replacement of the Hutt Valley DHB paging system;
- Process for MHAIDS change: proposal for lead DHB update.

**(c) NOTES** that the Council noted the:

- Progress to date for the PCOA outlining the innovation fund allocation, development of patient information pamphlet and participant information sheet study trial;
- August 2019 update for Quality and Safety;
- Boards' decision and current staff engagement process for the MHAIDS change proposal

**(d) NOTES** that the Council recommended the**:**

- Progression of the Hutt Valley DHB paging system upgrade business case to the next stage for approval.

**APPENDICES**

1. **NIL**

## 1. INTRODUCTION

### 1.1 Purpose

The purpose of this report is to update the Board on the papers discussed at the Hutt Valley Clinical Council's September meeting.

## 2. DISCUSSION

### 2.1 Innovation Fund Update: Patient Controlled Oral Analgesia (PCOA) Post Caesarean Section Delivery

Johanna Pigou, Consultant Anaesthetist

Clinical Council **noted the**:

(a) Break-down of spend to date of the approved $12,000.00 via the Innovation Fund;

(b) Patient Information Pamphlet: Pain Relief After your Caesarean Delivery;

(c) Ethics Form: Participation information sheet;

(d) Hospital Protocol Policy: Post Caesarean Delivery Patient-Controlled Oral Analgesia (PCOA) Invasive Procedures.

Council discussed the risks of Tramadol as part of the medication blister pack. The chief medical officer had sought advice from Medsafe given they are the legal authority and their opinion for the potential for harm was light as opposed to the use of a stronger opioid. The issue around criteria and who would determine this was discussed to ensure there was oversight of the patient's overall medications for signoff and that this should lie solely with the anaesthetists. A 12 month study trial is underway for this initiative and Council are looking forward to a progress update following the trial.

## 2.2 Hutt Valley DHB Quality & Patient Safety update

Presented by Dr Saira Dayal, Quality Clinical Leader

Clinical Council **noted**:

(a) The report for August 2019;

(b) The workforce development initiatives;

(c) The rate of cardiac arrests per 1,000 admissions, noting the actual number is low;

(d) The Consumer Council update.

The target for falls risk assessments are not being met, Council discussed the current process for screening. There was an indepth review of three falls events at the serious event review committee and although it appeared all measures were put in place to prevent the falls, they still occurred. Given some of these patients are older and frail, a system wide view is required. On the flip side there is also the practice of proactively mobilising these patients early to avoid deconditioning, this could also be a contributing factor.

Delays to close complaints was raised given a large number were outside the 20 working day timeframe. Council discussed staff taking a proactive approach to avoiding formal complaints escalating and to take initial steps to attempt to solve issues at the bedside or to meet with the patients to avoid escalation occurring.

## 2.3 Evaluation of Hutt Valley DHB pager upgrade

Paper presented by Rupert Applin, Team Lead Business Analysis, 3DHB ICT

Clinical Council **noted**:

(a) The existing paging system at Hutt Valley DHB is no longer supported from August 2019 and has experienced recent failures;

(b) The collaborative work on integration and rationalisation of the 2DHB call centres;

(c) The capital expenditure cost of moving to the recommended solution, AtHoc critical messenger and mobiles phones of $165,500;

(d) The implementation costs of the preferred solution of $70,000;

(e) The annual operational costs of $56,450;

(f) The ongoing operational expense for mobile phone connections will be charged to relevant departments;

(g) The purchase of these mobile phones will be required in the future to enable the successful implementation of the mobile strategy.

(h) The recommendation that Hutt Valley DHB adopt the recommendations of the Business Case and approves the case to move from the existing pager platform to a combination of mobile phones and AtHoc critical messenger.

Council were presented with an initial update in April 2018 and at a subsequent meeting April 2019 where the following **recommendations** were put forward:

(a) Evaluation of the CCDHB upgrade from pager to mobile be undertaken and presented to Council before any investment is made;

(b) Consider moving in the direction of an app for smartphones rather than the purchase of new phones for all staff;

(c) Investigate the solutions undertaken by Canterbury DHB (Celo) and Auckland DHB.

(d) The mobile strategy be presented to the Executive Leadership Team;

(e) This business case be submitted to the Clinical User Group to further explore options to ensure whatever solution is endorsed that it fits the needs of all clinical users going forward;

(f) Evaluation of the CCDHB pager upgrade be presented to council.

The Chief Executive wanted to be assured that the Chief Digital Officer, 3DHB ICT, was aware of the upgrade and had oversight in terms of planning going forward. This has since been confirmed. Council raised concerns again around multiple phones as opposed to an App on one phone. A large number of medical staff, particularly consultants, use their personal mobile device rather than carrying multiple phones around. Security issues and reimbursement for usage was discussed given there is no confirmed process or rules if this is the preferred option.

## 2.4 Other Business

Clinical Council noted the MHAIDS change consultation Lead DHB Model update with the Chief Executive providing a summary of discussion to date from the staff forums.

**DRAFT Minutes of the 3DHB DSAC**
**Held on Monday 10 September 2019 at 10am**
**Board Room, Level 11, Grace Neill Block**
**Wellington Regional Hospital**
**PUBLIC SECTION**

**PRESENT:**

**BOARD**
Dame Fran Wilde (Chair)
Eileen Brown (CCDHB)
Roger Blakeley (CCDHB)
Sue Kedgley (CCDHB)
Prue Lamason (HVDHB)
Derek Milne (WrDHB)
Jane Hopkirk (WrDHB)
Alan Shirley (WrDHB)
John Terris (HVDHB)
Sue Driver (CCDHB)
'Ana Coffee (CCDHB) *arrived 10.10am*
Sue Emirali (Sub-Regional Disability Advisory Group)
Dr Tristram Ingham (Maori Partnership Board)

**STAFF:**
Fionnagh Dougan, Chief Executive, Capital & Coast and Hutt Valley DHBs
Dale Oliff, Chief Executive, Wairarapa DHB
Rachel Haggerty, Director, Strategy Innovation and Performance, CCDHB
Rod Bartling, Acting General Manager, Strategy, Planning and Outcome, HVDHB
Sandra Williams, Acting Executive Leader, Planning and Performance, WrDHB
Rachel Noble, General Manger, 3DHB Disability Responsiveness
Nigel Fairley, General Manager, 3DHB Mental Health Addictions and Intellectual Disability Services
Rod Bartling, Mental Health Improvement Manager HVDHB
Arawhetu Gray, Director, Maori Health, CCDHB
Rawinia Mariner, General Manager Commissioning Mental Health & Addictions
Rachel Noble, General Manager Commissioning 3DHB Disability
Gerardine Clifford-Lidstone, General Manager Commissioning Child Youth & Localities
Sandra Murray, Project Manager, Living Life Well, Mental Health & Addictions

## 1 PROCEDURAL BUSINESS

### 1.1 PROCEDURAL

The Karakia was led by Dr. Tristram Ingham. Committee Chair, Fran Wilde, welcomed the members and DHB staff.

### 1.2 APOLOGIES

Apologies received from Andrew Blair, Yvette Grace, Lisa Bridson, Tino Pereira, Kim Smith

### 1.3 INTERESTS

#### 1.3.1 REGISTER OF INTERESTS

Jane Hopkirk advised she is no longer a member of the Occupational Therapy Board of New Zealand.

**1.4 CONFIRMATION OF PREVIOUS MINUTES: 4 February 2019**

2 The minutes of the 3DHB Disability Advisory Committee meeting held on 6 May 2019, were confirmed as a true and correct record.

**Moved:** Jane Hopkirk **Seconded:** Roger Blakeley **CARRIED**

**2.1 MATTERS ARISING**

**2.2 ACTION LIST**

The reporting timeframes on the other open action items were **noted**.

**2 DISCUSSION**

**2.1 Accessibility Charter**

The paper was taken as **read**.

The Committee:

a) **Noted** the range of accessible formats to be considered for the implementation of the Accessibility Charter;

b) **Noted** the commitment form the Disability team and the Disability community;

c) **Noted** that significant additional investment will need to be committed to by our 3DHBs to achieve the outcomes sought from this Plan;

d) **Endorsed** a five year commitment to progressing the use of the Accessibility Charter across the three DHBs leveraging existing resources only in this 2019/20 financial year; and

e) **Noted** the progress in key activities.

**Discussion:**

1. The outpatient project is a CCDHB project. As a patient-facing department with high engagement with disabled people, this creates an opportunity to leverage the work the Accessibility Charter can do from the baseline such as simplifying the language. The DHB has engaged professionals to assist us with this piece of work.
2. It is intended for this approach to be applied throughout CCDHB and other DHBs if this is successful.
3. It was suggested to keep an eye of examples of excellence in other DHBs and adopt good examples.
4. The Disability Advisory Group (DSAC) to monitor and evaluate this work.
5. The Board commends the work that is undertaken, believed that it be made available to all patients.
6. The work should be submitted for the Plain Language Award once it has passed the testing.

**Recommendations to the Boards**

a) *To note the paper; and*

b) *To endorse a five year commitment to progress the use of the Accessibility Charter across the 3DHBs leveraging existing resources only in this 2019/20 financial year.*

**Moved:** Fran Wilde **Seconded:** Eileen Brown **CARRIED**

**2.2 3DHB Mental Health & Addiction Strategy – Living Life Well 2019 – 2025: Population Outcomes Framework**

The paper was taken as **read**.

The Committee:

a) **Noted** the intention to use a collective impact measurement system to bring together providers and other agencies to support outcomes for populations;

b) **Noted** the population outcome framework;

c) **Endorsed** the approach to outcome measurement using population indicators;

d) **Endorsed** the approach to service performance and dashboards to be applied to all existing and new services; and

e) **Recommends** the endorsed approach to the respective Boards.

**Discussion:**

1. There is a significant shift in how money is invested in Mental Health from medical intervention to accessibility to mental health services such as talking therapy. CCDHB has approximately 80,000 prescriptions for mental health drugs across the population and less than 10% of the population has interactions with the mental health services.
2. CCDHB is working with the big four PHOs to supply a RFP response to get coverage for mental health services across all GP practices in the 3DHBs. We continue to work with Ora Toa and our Iwi partners around the whanau-ora centric model.
3. Mental Health and Wellbeing is not a health problem alone and must be treated as a whole of government problem. Good progress is being made. We are in much stronger position data wise due to the work of the Integrated Data Information (IDI) and Social Investment Agency). Government agencies are sharing information for the purpose of improving wellbeing.
4. The Chair pointed out that this is more than just the whole of government. It should be a joint approach with the private sector across the services.
5. The framework measures the population thriving across a number of domains (being valued, being socially included etc).
6. The Chief Executive for CCDHB-HVDHB commented that it is good to hear the passion and significant interest expressed by the Boards. It is key to think about the continuum of service we are commissioning that can deliver on the framework with the health sector as well as in terms of our partnerships with other agencies.

**Recommendations to the Boards**

a) *To note the paper; and*
b) *To endorse the approach*

**Actions**:

1. Committee Secretary to remove the draft appendix from the main paper.

**Moved:** Eileen Brown **Seconded:** Sue Driver **CARRIED**

**2.3 Preventing Suicide and Suicidal Behaviour in our Communities Update**

The paper was taken as **read**.

The Committee:

f) **Noted** that suicide continues to be a significant issue for our communities and the Coroner's data shows that deaths in Capital & Coast DHB (CCDHB) are increasing at a faster rate than the NZ total, and the gap between the national rate and CCDHB is getting smaller;

g) **Noted** that a review of health service responses to suicide and suicidal behaviour was completed to explore opportunities to improve suicide prevention activity across all service services;

h) **Noted** significant improvement in suicide prevention and postvention with increased postvention activity and greater engagement with community network;

i) **Noted** the implementation of reporting and analysis of all suicides, once notified, to inform incident review in addition to informing activities to prevent suicide; and

j) **Noted** that a revised 3DHB suicide prevention and postvention action plan is being developed and will align to the Ministry of Health's release of the new national strategy.

**Discussion:**

1. Primary care mental health services such as counselling and talking therapy services are critical. The biggest challenge identified in postvention crisis is the challenge to find services to support the people.
2. The Strategy, Innovation and Performance (SIP) team commissioned a piece of work led by the 3DHB Disability team is developing on mental health and addiction needs for people with disability. The team identified a gap between in our understanding and knowledge where we build our suicide and prevention in our Mental Health and Wellbeing approaches. The team also identified a number of disability communities who helped our understanding in what the mental health and wellbeing looks like.
3. There are substantial publications and research evidence that the Ministry of Health and the 3DHB use to form our strategy. We have a clear understanding of why suicide occurs but what we do not know is if there is a single fix that takes the problem away. We need to ensure support services are available for drug and alcohol misuse and addiction. The Ministry's Suicide Prevention Strategy 2019-2029 will reinforce the importance of suicide prevention.

**Recommendations to the Boards**

a) *To note the paper.*

**Actions**:

2. Management to bring back the discussion on the relationship between suicide and alcohol. The current work on the Addiction Model of Care (misuse of drugs and alcohol) recognises the risks (the cause and effect of alcohol).

## 3 INFORMATION

### 3.1 Update on the Annual Sub-Regional Disability Forum

The paper was taken as **read**.

The Committee:

a) **Noted** the recommendations from the Sub-Regional Disability Forum;

b) **Noted** the changes to the Disability Team including people with disability;

c) **Noted** the progress in activities related to the implementation of the Disability Strategy; and

d) **Noted** the commitment to strengthen links between the Sub-Regional Disability Advisory Group, the Maori Disability Roopu and the Pacific Disability Steering Group to enhance our ability to deliver on the recommendations from the Forum.

**Recommendations to the Board**

a) *To note the paper.*

*The meeting closed at 11.45am.*

## 2 DATE OF NEXT MEETING

18 November 2019, CSSB Lecture Room, Ground Floor, Clinical & Support Services Building, Wairarapa DHB, Masterton.

**PUBLIC**

| | |
|---|---|
| HUTT VALLEY DHB | **BOARD DECISION PAPER** |
| | **Date: 26 September 2019** |
| **Author** | Board Chair - Andrew Blair |
| **Subject** | **RESOLUTION TO EXCLUDE THE PUBLIC** |

**RECOMMENDATIONS**

It is recommended that the Board:

a) **AGREES** that the public be excluded from the following parts of the Meeting of the Board in accordance with the NZ Public Health and Disability Act 2000 ("the Act") where the Board is considering subject matter in the following table;

b) **NOTES** that the grounds for the resolution is the Board, relying on Clause 32(a) of Schedule 3 of the Act, believes the public conduct of the meeting would be likely to result in the disclosure of information for which good reason exists under the Official Information Act 1982 (OIA), in particular:

| SUBJECT | REASON | REFERENCE |
|---|---|---|
| Public Excluded Minutes | For the reasons set out in the 27 June 2019 Board agendas | |
| Public Excluded Matters Arising from previous Public Excluded meeting | For the reasons set out in the 27 June 2019 Board agendas | |
| Chief Executive's report | Information contained in the paper may be subject to change as the information has not yet been reviewed by the FRAC<br>Paper contains information and advice that is likely to prejudice or disadvantage negotiations | Section 9(2)(f)(iv)<br>Section 9(2)(j) |
| Clinical Council report | Papers contain information and advice that is likely to prejudice or disadvantage commercial activities and/or disadvantage negotiations. | Section 9(2)(i)(j) |
| Sub-committee draft minutes | | |
| Radiology equipment upgrade and refurbishment tender | | |
| Renewal of 3DHB Laboratory Contract with Wellington Southern Community Laboratories | | |
| Contract for Provision of ICT Network Services | | |
| Sale of Taupo Holiday Home | | |
| Register of Board Chair executed documents | | |
| Update on Facilities and Infrastructure Risks | | |
| NZ Health Partnerships Shareholders' Review Group Report | Subject to Ministerial and/or Cabinet approval | Section 9(2)(f)(iv) |

* Official Information Act 1982.