TE TOKA TUMAI
Auckland DHB

Hospital Advisory Committee Meeting

Wednesday, 18 November 2020

8:30am

Marion Davis Library

Building 43
Auckland City Hospital
Grafton

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Kia kotahi te oranga mo te iti me te rahi o te hāpori

Published 12 November 2020

Agenda
Hospital Advisory Committee
18 November 2020

Venue: Marion Davis Library
Auckland City Hospital, Grafton

Time: 8:30am

Committee Members	**Auckland DHB Executive Leadership**	
William (Tama) Davis (Chair)	Ailsa Claire	Chief Executive Officer
Jo Agnew (Deputy Chair)	Karen Bartholomew	Director of Health Outcomes – ADHB/WDHB
Bernie O'Donnell	Margaret Dotchin	Chief Nursing Officer
Doug Armstrong	Joanne Gibbs	Director Provider Services
Fiona Lai	Dame Naida Glavish	Chief Advisor Tikanga – ADHB/WDHB
Heather Came-Friar	Dr Debbie Holdsworth	Director of Funding – ADHB/WDHB
Michael Quirke	Mel Dooney	Chief People Officer
Michelle Atkinson	Justine White	Chief Financial Officer
Peter Davis	Meg Poutasi	Chief of Strategy
Zoe Brownlie	Dr Mark Edwards	Chief Quality, Safety and Risk Officer
	Shayne Tong	Chief of Informatics
	Sue Waters	Chief Health Professions Officer
	Dr Margaret Wilsher	Chief Medical Officer
	Other Auckland DHB Senior Staff	
	Jo Brown	Funding and Development Manager Hospitals
	Nigel Chee	Interim General Manager Māori Health
	Marlene Skelton	Corporate Business Manager
	(Other staff members who attend for a particular item are named at the start of the respective minute)	

Agenda

Please note that agenda times are estimates only

Karakia

8.30am **1. Attendance and Apologies**

Margaret Wilsher, Chief Medical Officer and Mel Dooney, Chief People Officer.

2. Register and Conflicts of Interest

Does any member have an interest they have not previously disclosed?

Does any member have an interest that may give rise to a conflict of interest with a matter on the agenda?

8.35am **3. Confirmation of Minutes 7 October 2020**

4. Action Points 7 October 2020 - NIL

8:40am **5. PERFORMANCE REPORTS**

5.1 Provider Arm Operational Update

5.2 Financial Update

5.3 Director Equity Update – Cancer and Blood

	5.4	Director Equity Update – Surgical Services
	5.5	Director Equity Update – Perioperative
	5.6	Patient and Whānau Voice – Report
	6.	**GENERAL BUSINESS**
10.15am	**7.**	**RESOLUTION TO EXCLUDE THE PUBLIC**

Next Meeting:	Wednesday, 03 February 2021 at 8.30am A+ Trust Room, Clinical Education Centre Level 5, Auckland City Hospital, Grafton

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Kia kotahi te oranga mo te iti me te rahi o te hāpori

Karakia

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

Kia kotahi ai o matou whakaaro i roto i te tu waatea.

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of life

To the ancient realms of the Creator

Thank you for the life we each breathe to help us be of one mind
As we seek to be of service to those in need.
Give us the courage to do what is right and help us to always be aware
Of the need to be fair and transparent in all we do.

We ask this in the name of Creation and the Living Earth.

Well Being to All.

Attendance at Hospital Advisory Committee Meetings

Members	12 Feb 2020	18 March 2020	22 April 2020	3 June 2020	15 July 2020	26 August 2020	7 October 2020	18 Nov 2020
William (Tama) Davis (Chair)	1	1	c	c	c	c	1	
Joanne Agnew (Deputy Chair)	1	1	c	c	c	c	1	
Michelle Atkinson	1	1	c	c	c	c	1	
Doug Armstrong	1	1	c	c	c	c	1	
Bernie O'Donnell	1	1	c	c	c	c	x	
Michael Quirke	1	1	c	c	c	c	1	
Peter Davis	1	1	c	c	c	c	1	
Zoe Brownlie	1	1	c	c	c	c	1	
Fiona Lai	1	1	c	c	c	c	1	

Key: x = absent, # = leave of absence, c = meeting cancelled, nm = not a member

Note: The meetings cancelled during 2020 were due to cessation of business due to COVID 19.

Conflicts of Interest Quick Reference Guide

Under the NZ Public Health and Disability Act Board members must disclose all interests, and the full nature of the interest, as soon as practicable after the relevant facts come to his or her knowledge.

An "interest" can include, but is not limited to:

- Being a party to, or deriving a financial benefit from, a transaction
- Having a financial interest in another party to a transaction
- Being a director, member, official, partner or trustee of another party to a transaction or a person who will or may derive a financial benefit from it
- Being the parent, child, spouse or partner of another person or party who will or may derive a financial benefit from the transaction
- Being otherwise directly or indirectly interested in the transaction

If the interest is so remote or insignificant that it cannot reasonably be regarded as likely to influence the Board member in carrying out duties under the Act then he or she may not be "interested in the transaction". The Board should generally make this decision, not the individual concerned.

Gifts and offers of hospitality or sponsorship could be perceived as influencing your activities as a Board member and are unlikely to be appropriate in any circumstances.

- When a disclosure is made the Board member concerned must not take part in any deliberation or decision of the Board relating to the transaction, or be included in any quorum or decision, or sign any documents related to the transaction.
- The disclosure must be recorded in the minutes of the next meeting and entered into the interests register.
- The member can take part in deliberations (but not any decision) of the Board in relation to the transaction if the majority of other members of the Board permit the member to do so.
- If this occurs, the minutes of the meeting must record the permission given and the majority's reasons for doing so, along with what the member said during any deliberation of the Board relating to the transaction concerned.

IMPORTANT

If in doubt – declare.

Ensure the full **nature** of the interest is disclosed, not just the existence of the interest.

This sheet provides summary information only - refer to clause 36, schedule 3 of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004 for further information (available at www.legisaltion.govt.nz) and "Managing Conflicts of Interest – Guidance for Public Entities" (www.oag.govt.nz).

Register of Interests – Hospital Advisory Committee – Provider Equity

Member	Interest	Latest Disclosure
Jo AGNEW (Deputy Chair)	Professional Teaching Fellow – School of Nursing, Auckland University Casual Staff Nurse – Auckland District Health Board Director/Shareholder 99% of GJ Agnew & Assoc. LTD Trustee - Agnew Family Trust Shareholder – Karma Management NZ Ltd (non-Director, majority shareholder) Member – New Zealand Nurses Organisation [NZNO] Member – Tertiary Education Union [TEU]	30.07.2019
Michelle ATKINSON	Director – Stripey Limited Trustee - Starship Foundation Contracting in the sector Chargenet, Director & CEO – Partner	21.05.2020
Doug ARMSTRONG	Trustee – Woolf Fisher Trust *(both trusts are solely charitable and own shares in a large number of companies some health related. I have no beneficial or financial interest* Trustee- Sir Woolf Fisher Charitable Trust *(both trusts are solely charitable and own shares in a large number of companies some health related. I have no beneficial or financial interest* Member – Trans-Tasman Occupations Tribunal Daughter – *(daughter practices as a Barrister and may engage in health related work from time to time)* Meta – Moto Consulting Firm – (*friend and former colleague of the principal, Mr Richard Simpson)*	20.08.2020
Zoe BROWNLIE	Partner – Team Leader, Community Action on Youth and Drugs Board Member – Waitakere Health and Education Trust Co-Director – AllHuman	11.11.2020
Peter DAVIS	Retirement portfolio – Fisher and Paykel Retirement portfolio – Ryman Healthcare Retirement portfolio – Arvida, Metlifecare, Oceania Healthcare, Summerset, Vital Healthcare Properties	19.11.2019
Fiona LAI	Member – Pharmaceutical Society NZ Casual Pharmacist – Auckland DHB Member – PSA Union Puketapapa Local Board Member – Auckland Council Member – NZ Hospital Pharmacists' Association	26.08.2020
Bernie O'DONNELL	Chairman Manukau Urban Māori Authority(MUMA) Chairman UMA Broadcasting Limited Board Member National Urban Māori Authority (NUMA) Board Member Whānau Ora Commissioning Agency	27.08.2020
Michael QUIRKE	Chief Operating Officer – Mercy Radiology Group Convenor and Chairperson – Child Poverty Action Group Director of Strategic Partnerships for Healthcare Holdings Limited	27.05.2020
Teulia Pervical	Director Board of Trustees – Pasifika Medical Association Group Employee Clinician – Counties Manukau Health DHB Chairman, Board of Trustees – South Seas Healthcare Trust, Otara Board Member – Health Promotion Agency (te Hiringa Hauora) Senior Lecturer Researcher – University of Auckland Director Researcher – Moana Research	01.10.2020
Heather Came	Primary Employer – Auckland University of Technology Contractor – Ako Aotearoa Acting Co-President – Public Health Association of New Zealand Fellow – Health Promotion Forum	01.10.2020

	Co-Chair – STIR (Stop Institutional Racism) Member – Tamaki Tiriti Workers	
William (Tama) DAVIS (Chair)	Director/Owner – Ahikaroa Enterprises Ltd Whanau Director/Board of Directors – Whai Maia Ngati Whatua Orakei Director – Comprehensive Care Limited Board Director – Comprehensive Care PHO Board Board Member – Supporting Families Auckland Board Member – Freemans Bay School Board Member – District Maori Leadership Board Iwi Affiliations – Ngati Whatua, Ngati Haua and Ngati Tuwharetoa	02.07.2020

Minutes
Hospital Advisory Committee – Provider Equity Meeting
07 October 2020

Minutes of the Confidential Hospital Advisory Committee – Provider Equity meeting held on Wednesday, 07 October 2020 via Zoom at 8.30am

Committee Members Present	**Auckland DHB Executive Leadership Team Present**	
William (Tama) Davis (Chair)	Ailsa Claire	Chief Executive Officer
Jo Agnew (Deputy Chair)	Mel Dooney	Chief People Officer
Doug Armstrong	Dr Mark Edwards	Chief Quality, Safety and Risk Officer
Michelle Atkinson	Joanne Gibbs	Director Provider Services
Zoe Brownlie	Justine White	Chief Financial Officer
Peter Davis	Sue Waters	Chief Health Professions Officer
Fiona Lai	Dr Margaret Wilsher	Chief Medical Officer
Michael Quirke	Margaret Dotchin	Chief Nursing Officer
	Dame Naida Glavish	Chief Advisor Tikanga – ADHB/WDHB
	Auckland DHB Senior Staff Present	
	Jo Brown	Funding and Development Manager Hospitals
	Nigel Chee	Interim General Manager Maori Health
	Marlene Skelton	Corporate Business Manager
	Kay Sevillano	EA to Board Chair and Governance Administration
	(Other staff members who attend for a particular item are named at the start of the minute for that item.)	

Karakia

The Committee Chair, Tama Davis led the Committee in a karakia.

1. ATTENDANCE AND APOLOGIES

That the apology of Committee member Bernie O'Donnell be received.

The Following apologies were received from members of the Executive Leadership team: Meg Poutasi, Chief of Strategy, Shayne Tong, Chief of Informatics, Dr Debbie Holdsworth, Director of Funding Auckland and Waitemata DHBs, Karen Bartholomew, Director of Health Outcomes Auckland and Waitemata DHBs.

2. REGISTER AND CONFLICTS OF INTEREST

There were no updates to the register of Interests required.
There were no conflicts of interest with any item on the open agenda.

3. CONFIRMATION OF MINUTES 18 March 2020 (Pages 1-7)

Resolution: Moved Jo Agnew / Seconded Fiona Lai

That the minutes of the Hospital Advisory Committee for 18th March 2020 be received.

Carried

4. ACTION POINTS

There were no action points to review.

5. PERFORMANCE REPORTS

5.1 Provider Arm Operational Update (Pages 20-24)

Joanne Gibbs, Director Provider Services asked that the report be taken as read, highlighting as follows:

The initial Exceptions Report has since been reframed to strengthen linkages to the DHBs obligations under Te Tiriti o Waitangi and Equity.

All ten clinical directorates made a commitment last year to contribute to equity work. It is proposed that Directors from Cancer and Blood, Surgery and perioperative will attend. All Directorates will attend committee meetings twice a year to discuss equity work, and provide high-level review of performance, risks and issues. Direction on this proposal is sought from the Committee.

Hineroa Hakiaha and Tracy Silva-Garay were appointed as Partnership Leaders for the Mental Health and Addictions Directorate. Dr George Laking, was appointed Chair, of the rōpū Cancer and Blood Directorate (Pou Ārahi) which also includes new appointments to the Kaumātua for Cancer and Blood Services.

To address inequities in access to surgery, Kaiārahi Nāhi led by Dawson Ward was established to assist Māori patients, and the Pacific Planned Care Navigation team led by Pauline Fakalata to assist Pacific patients.

The Provider Incident Management Team has been stood down to Response Team status due to low incidence of COVID in the community and the move of Auckland to Alert Level 1. From 8 October, the visitor screening process will cease, moving back to the normal visitor policy. Planned Care work will transition back to normal but this will be a gradual process over the next couple of months as staffing returns to business-as-usual from supporting the managed isolation facilities, CBACs and ARPHS.
Emergency Department and General Medicine activity has increased in the last couple of weeks, as is the case across the Northern Region and the country. The reason for this is uncertain. There are no increases in respiratory diseases (e.g. flu, pneumonia) reported but there are a number of frailty presentations and some of the increase could be attributed to

catch-up work post lock down.

The following points were covered in the discussion:

Michael Quirke thanked Jo Gibbs for the report and commented that with the new appointments made it appears that the Board is forging ahead into the territory it said it would and work on equity is moving forward. Michael asked whether these new appointees were in a position to comment on their roles so far and whether there had been any surprises. Jo Gibbs advised that these were exciting appointments but it was early days for these staff. Data is just beginning to be looked at through more critical eyes and this is exposing some of the differences that exist. Data for vulnerable and planned care services show that Māori and Pacific patients are waiting longer for surgery compared to other patients. The appointees are in the early stages of working through the complexities around this, and the work that needs to be done going forward.

Heather Came-Friar asked whether data on ethnic breakdown could be shared, with Ailsa Claire confirming that it is provided when available.

Fiona Lai commented that it was exciting to see the progress made she was impressed and was looking forward to further outcomes.

Michelle Atkinson agreed with points made by Michael Quirke in relation to reporting action in addition to the actual strategy.

Resolution: Moved Tama Davis / Seconded Jo Agnew

That the Hospital Advisory Committee receives the Providers Arm Operational Exceptions Report for October 2020.

Carried

5.2 Financial Update (Pages 25-34)

Justine White, Chief Financial Officer asked that the report be taken as read highlighting as follows:

The results for August 2020 YTD were unfavourable by $10.5M or $12.4M YTD. This needs to be considered with some Covid-19 costs excluded which drops the result for August to $1M unfavourable and $180K unfavourable YTD.

$10.5M is COVID-related cost which can be broken down to $7M relating to IDF and the planned revenue provision for that revenue not being received. The other large component; $136M relates to FTE of which $66M is COVID-related and the remaining amount attributable to annual leave and some assumptions made within the budget around the use of annual leave being similar to previous years. What is being seen is that annual leave has been deferred which pushes FTE up and increases cost in comparison to budget. This is a risk that is being closely monitored, as it will also be impacted by planned care catch-up work.

There are some increases in clinical supplies that have been offset by revenue in labs and

pharmacy.

The following points were covered in the discussion:

Peter Davis commented that he would like management to extrapolate out how the Board was tracking in terms of meeting the budget agreed with central government. A clear trajectory along with assumptions was needed. Justine agreed with Peter and confirmed that going forward, the financial report would include a forecast column, in addition to the current monthly, actual, and YTD figures to make tracking against final budget more easily visible.

Peter Davis queried whether judgement on WIES was made independently of budgetary considerations. Further, he asked how decisions were made in relation to staff determining whether to encourage more day stays and reduce WIES where it is not necessary.
Ailsa Claire explained that increases in relation to WIES were a result of the increased number of complexities in patients. WIES was a reflection of the acuity of the patient and the work undertaken based on a nationally determined model which cannot be manipulated. There is a high correlation between income and WIES, and what Auckland DHB gets paid. For tertiary and national services, WIES cost is not met by the price that Auckland DHB is actually paid for WIES. To be efficient, Auckland DHB has targets and processes in place to increase day stay surgery and attempting to move people down the complexity level where possible. This is a whole programme of work that that can be discussed.
Ailsa Claire explained that there is no financial incentive for the Auckland DHB to keep people in hospitals longer because WEIS assumes an average length of stay and going beyond that, payment is not forthcoming. The average length of stay across all specialties has gone down. The EY report highlighted specialty services where they felt the length of stay could be reduced and pre COVID these services were targeted. Accuracy of coding is improving however you cannot over-code as the data used is based on a patient's case notes.
Peter Davis was satisfied that the system had measures in place to make the process efficient.

Doug Armstrong commented that he looked to the CEO and/or the CFO to provide a "best guess" as to how financial performance was tracking to end of year. He was concerned about the DHB meeting its electives target, and was aware that in the past the Auckland DHB could be penalised by the Ministry of Health (MoH) for not meeting them. He asked whether a spreadsheet could be provided defining electives by category, looking at total numbers, which included a breakdown of in-house services and the balance that is being contracted out and the associated cost related to contracting out along with any penalties. Ailsa said that information could be provided but would involve a large amount of data given the various services, categories and issues involved.

If the outcome being sought was where the Board was in terms of planned delivery, then that data was already available in reports. Ailsa Claire queried whether Doug's objective was to be able to compare outsourcing vs in-house delivery price. Doug's concern was whether it would be more cost effective to maximise in-house services. Ailsa Claire explained that the

Funding and Planning department takes the funding available for the Auckland population and places contracts in a number of places (e.g. this can include everything from primary care to colonoscopy in the private sector) and it's a mixture of determination of what should be provided by Provider Arm, and what is provided from elsewhere. Outsourcing is not necessarily the correct term to use. Rather, contracts are being placed with other providers and other DHBs and vice versa.

Doug Armstrong commented that he was attempting to gain an understanding of in-house capacity versus that which existed outside the hospital. Ailsa Claire advised that if it was information around capacity constraints that was required then that could be reported on, Auckland DHB had significant capacity restraints.

Peter Davis commented that while not against outsourcing he did have a concern that monopolies could be created outside if public hospitals were not competitive in providing services. The DHB needed to keep it contestable for as many services as possible. Ailsa Claire explained that contracts are made with both the private sector and other DHBs and as providers they deliver services at or below national price which is the benchmark when agreeing to cost of services.

Doug Armstrong sought to clarify the rules around financial penalties for quotas not being met. Jo explained that in the past, penalties were issued to DHBs who did not meet targets, but this system is no longer in place in favour of scheduled payment mechanisms which are graded to Auckland DHB's service delivery. For instance, planned care recovery funding this year will be paid in portions dependent on delivery.

Zoe Brownlie agreed that a forecast going forward would be helpful. She queried how COVID-related costs were being reported. Justine White explained that all DHBs are regularly reporting to the MoH on COVID-related expenses and discussions on how these expenses are to be funded are taking place. It is to be determined what will be given in cash vs what will be a tolerated variance from budget. The decision from last week's Cabinet discussion is yet to be communicated. In addition to reporting COVID expenses, ADHB will also present the organisation's expectations in terms of necessary expenditure to be funded by the MoH in order to continue operating effectively.

Michael Quirke asked whether peripheral costs that have arisen as a result of COVID (e.g. FTE, turnover, annual leave) are being considered in the budget. Justine white explained that all DHBs are required to adhere to what the MoH deems as COVID-related expenses and they are very prescriptive in what they consider a direct cost. As an example staff costs for COVID response work are considered a COVID expense but annual leave and turnover as a result of the pandemic are not able to be included as COVID-related costs.

Michael Quirke asked about FTE trends in relation to vacancy turnover after the first lockdown. From a risk perspective, he asked whether the Auckland DHB was analysing whether these trends were domestic or international movement. If the trends were international, then the Auckland DHB would expect to have the same challenges over the

next 9 months that would need to be managed. Justine White agreed that these risks (e.g. annual leave, vacancies) need to be included in forecast budgeting. Justine is working with Mel Dooney to better understand these risks and is looking at ways to manage them.

Resolution: Moved Tama Davis / Seconded Jo Agnew

That the Hospital Advisory Committee accepts the Financial Update for October 2020.

Carried

5.3 Care Navigators Progress Update

Dawson Ward, Kaiārahi Nāhi rōpū lead provided the following progress update:

The Kaiārahi Nāhi rōpū consists of 9 Māori nurses, working with Dawson facilitating patient surgeries for those who have been on the waitlist for 120 days. They also assist patients with systemic issues who face challenges within their whanau group.

Navigators provide patients with self-determination on how they want their treatment to be carried out.

Navigators spend a considerable amount of time on relationship building with patients and their family. The average contact time spent with patients is 710 minutes (range), 102 minutes (mean), 45 minutes (median).

Most contacts by iwi are Nga Puhi because Ngāti Whātua Ōrakei have their own medical insurance and go through NIB to access planned care.

Ophthalmology and Orthopaedics have dedicated navigators working in their directorates. Since working with navigators, Orthopaedics has brought down their patient waiting time to 30 days. Anyone waiting more than 30 days has been contacted, including patients added to the waitlist after coming off the suspended list. Other services (General Surgery, Cardiology, Urology, Neurosurgery and Gynaecology), have different navigators running systems together. Work with Paediatrics has only just started and context around how support can be provided is still to be determined.

Whanaungatanga is an important principle in practice used by navigators because Māori understand relationship building very well. Manaakitanga is another principle used by navigators as it seeks to respect everyone's mana and is vital when building relationships. Kotahitanga is working in unity with patients and whānau to achieve positive outcomes. In practice, these principles enable patients to self-determine how to go about their healthcare (e.g. deciding on whether to have surgery or not). The patient-centered approach enables patients to decide when they no longer need support.

One of the main issues identified is poor communication. Often when patients move between DHBs, the home domicile DHB lose contact with patients, leaving them uncertain of what happens next in terms of their healthcare. There are long gaps in between when communicating with patients.

Bookers and navigators also have issues in communicating with each other as they often are unable to see what the other is working on and this becomes a problem when working on

the same case.

The Implementation Project team do mail-outs, however some people receive their mail, others receive it a week later, or not at all. This results in patients not showing up for scheduled appointments/surgery. Communication via mobile phone is also confusing for those with no mobile phones or those who cannot afford one, or have no interest in purchasing a modern phone.

The patient journey of Master M was used as an example of a complex case. The work of the navigators has seen significant change in making health services more accessible to patients. Dawson has a number of meetings with the different services. These directorates are interested in facilitating change in their respective areas by applying an equity lens on the way they work with patients.

There are many patients (just like Master M) with complex cases requiring support. It is crucial that directorates and navigators work together to come up with a patient plan that is sustainable and resilient.

Comments from the Committee were as follows:

It is apparent that the work undertaken by Kaiārahi Nāhi rōpū is not just that of a navigator but also that of advocator.

Patients being transferred and referred from one waiting list to another is not just specific to Māori but a problem with the overall system. It was requested that a proposal be submitted to improve the hospital system for all people.

Pauline Fakalata, Pacific Planned Care Navigation team lead provided a progress update:

The Pacific Planned Care Navigation team was established in June 2020 with 6 clinical nurse specialists, focused on Adult Health elective surgery. In August, during the second lockdown, 3 clinical nurse specialists were assigned to Starship. The purpose was to improve equity for planned care for Pacifika by reducing waiting time, deferrals and to improve overall outcomes.

The navigator team has made 30 escalations where navigators needed to liaise with directorates, clinicians, surgeons, clinical nurse specialists and managers, to find solutions to progress cases. Seventeen of these are acute cases and these patients have clinically deteriorated because of the wait and have ended up in ED. Twenty-five patients deteriorated where quality of life was affected because of the wait.

Contacts by ethnicity are Samoan 47%, Tongan 18%, and the rest are Cook Island and other Pacifica ethnicities.

A navigator's role includes calling patients who are on the waiting list, engaging with them to find out what barriers they face, and understand any other issues making it difficult for them to get surgery. The navigator then meets with the applicable services to find solutions to fast track surgeries.

Patients generally find it difficult to deal with the hospital system. Engagement and

communication with patients' needs to improve. The numerous letters sent to patients are usually received late or not received at all. The letters also use medical jargon which patients do not understand.

There is need for professional interpreters. It is not always dependable or helpful for family members to act as interpreter. Interpreters play an integral role to help with cultural awareness. They are also able to communicate efficiently with patients to speed up the process.

Booking of appointments should be patient-focused and not based on what suits the hospital. This will ensure that patients are available and will turn up for their appointment.

Clinical eligibility is also a barrier to accessing surgery. A number of Pacific patients with diabetes have blood sugar levels that are not within acceptable levels to progress to surgery. Navigators have to work with services and clinical staff in order to progress these cases.

Pauline presented two patient examples as illustrations of the work of the navigators and issues being experienced by patients. The following points were covered in the discussion:

Michelle Atkinson commended the work being undertaken and thanked the ELT for the support provided to navigators.

Michael Quirke asked whether there was opportunity for other support to be made available to clinical nurse specialists acting as navigators. Pauline Fakalata agreed that a multi-disciplinary approach was the best way going forward and there is need for social work services, psychologists, and community workers as most cases are complex. From a Māori perspective, Dawson Ward said that there are 10 clinical nurse specialists of Māori decent with the majority being Ngā Puhi. An understanding of Māori culture is important and a multi-disciplinary approach is needed. Māori social workers with connections with Māori health providers exist in the community and the Auckland DHB needs to link up with them and communicate with various rōpū and iwi.

Fiona Lai commended the project and the hard work put into the programme. She asked whether identified opportunities can be considered right at the beginning of the patient's journey to improve services at the outset. Dawson Ward deferred to Meg Poutasi and Rawiri Jansen to answer this. Fiona Lai also suggested that the patient journeys be shared at other committee meetings to create a sense of cultural sensitivity. Dawson Ward advised that he has already been invited to join a number of committees to bring these stories to life within the different specialties.

Resolution: Moved Jo Agnew / Seconded Zoe Brownlie

That the Hospital Advisory Committee:

1. **Receives the Care Navigator Progress Update for October 2020.**
2. **Notes the first 3 months of the Care Navigators team's progress within Planned Care.**
3. **Notes insights into approach, challenges and success for Kaiārahi Nāhi rōpū and Pacific Care Navigation team**

Carried

5.4 Patient and Whānau Voice

Vanessa Duthie, Māori Patient and Whānau Experience Lead, Jane Drumm, Patient and Whānau Centered Care Council Advisor, and James Hita, Patient and Whānau Centered Care Council Advisor, introduced themselves to the committee and provided a progress update on Patient and Whānau Voice.

The paper provided to the committee outlined the functions and work plan of the Patient and Whānau Centered Care Council (PWCCC).

Hospital Advisory Committee meetings will now include a section for PWCC to provide input into the agenda and the committee's plans going forward. Council members will attend Hospital Advisory Committee meetings and Jane Drumm will be present as an advisor.

As per the presentation submitted to the committee, James explained the meaning and essence of 'patient whānau centered'. He also discussed the council's terms of reference (vision, scope, purpose and goals), the work programme, projects/workshops, Te Wharenui, and aims going forward. He then asked that the Committee to champion the Council's work across the Auckland DHB.

The following points were covered in the discussion:

Zoe Brownlie asked for concrete examples that have influenced changes within the Auckland DHB since the establishment of the Council. Jane Drumm explained that there are five consumer council members giving feedback (co-design) to the Heart project. This involvement provides a consumer lens where opportunities for patient whanau interface exist. The Council is also involved in the new survey process by providing the required patient lens. A network meeting was held on 7 October 2020, which was organised by a newly formed national group of consumer chairs from across the country.

James Hita spoke at the Health Excellence Awards, sharing his story and involvement in PWCCC, which has led to conversations to facilitate more work for the Council.

An integral part of the Council's communications strategy is to reach out and engage with consumers to provide continual updates on how changes have, and are being made across the Auckland DHB. Engagement with committee members is also important as the Committee is the best advocate for change and promoting strategy.

Jo Agnew queried whether the Council, as the 'voice of the people', could be involved in DISAC. James Hita said that the Council is currently having conversations with different areas in the organisation as they hope to have representation and involvement across the Auckland DHB.

Michelle Atkinson said she supported the Council and acknowledged the skilful and diverse membership of the group. She reiterated that Council's engagement with ELT is vital going forward and that despite budget constraints, it is important to remember that decisions made at the committee have an impact on the lives of people.

Resolution: Moved Michelle Atkinson / Seconded Zoe Brownlie

That the Hospital Advisory Committee receives the Patient and Whanau Voice report and presentation

Carried

The meeting closed at 11:05 am.

Signed as a true and correct record of the Open Hospital Advisory Committee meeting held on Wednesday, 07 October 2020.

Chair: _____ Date: _____

Tama Davis

Provider Arm Operational Exceptions Report

Recommendation

That the Hospital Advisory Committee receives the Provider Arm Operational Exceptions Report for November 2020.

Prepared by: Joanne Gibbs (Director Provider Services)
Endorsed by: Ailsa Claire (Chief Executive)

Ko tāku rourou, ko tāu rourou
E ora ai te iwi e.
Hikitia, manaakitia
Āwhinatia e!
Our success depends on our working together.
Exalt, be generous and supportive.

Kuputaka : Glossary

Acronym/term	Definition
ARPHS	Auckland Regional Public Health Service
Kāwanatanga	Te Tiriti Article 1. Governance. Ensuring Māori oversight and ownership of decision making processes necessary to achieve Māori health equity. Active partnerships with iwi and Māori communities will ensure that Māori health equity drives, and Māori knowledge informs, the work that we do at Te Toka Tumai
MIQF	Managed Isolation and Quarantine Facility
NRHCC	Northern Region Health Coordination Centre
Ōritetanga	Te Tiriti Article 3. Equity. Demonstrating our performance in the pursuit of Māori health equity for key Māori health areas. Presenting meaningful and insightful information to Māori will support, guide and target our work at Te Toka Tumai to make advances in Māori health
Te Ritenga	Te Tiriti Article 4. Right to belief and values. Honouring the beliefs and values of Māori patients, staff and communities. The services we fund and provide at Te Toka Tumai honour the right of Māori to practise tikanga Māori
Te Toka Tumai	Auckland DHB
Tino Rangatiratanga	Te Tiriti Article 2. Self-determination. Creating opportunities for Māori leadership, engagement and co-design across all of our activities at Te Toka Tumai, especially those with the potential to impact Māori health

1. Exceptions Report

The Executive Leadership Team highlights the following exceptions for the November 2020 Hospital Advisory Committee Meeting. Where possible, linkages to our commitments to Te Tiriti o Waitangi and Equity have been illuminated.

Kāwanatanga; Tino Rangatiratanga; Te Ritenga

- Pou Ārahi from Cancer and Blood Services have partnered with Organisational Development in designing initiatives and activities that sit within Pūmanawa Tāngata, the People Plan, as well as supporting the ongoing engagement with kaimahi Māori throughout the organisation. The focus

has been on Key Result Area 2 (Uphold Te Tiriti o Waitangi as our framework to eliminate racism, build culturally safe practice and achieve health equity) and 3 (Grow and develop ngā kaimahi Māori). Initially, these initiatives and activities will be piloted in Cancer and Blood Services and Mental Health and Addictions, with learnings to inform the organisational roll out of both these Key Result Areas.

Ōritetanga

- In October 2020, Emma Wylie (Consultation & Co-Design Manager, Ara Manawa) and Vanessa Duthie (Ngāti Awa, Māori Patient & Whānau Experience Lead, Ara Manawa) published the Adult Medical Services, Cultural Experience Project Report. This report looks into Māori patient and whānau experience of care in general medicine wards. Themes that emerged from the analysis include: kanohi ki te kanohi (talking face to face), whakawhanaungatanga (building connections), rapua te ara tika (to seek the right path/walking in two worlds), mana motuhake (making autonomous choices), and te mana o te whānau (recognising whānau). Threaded through the themes were strong elements of mana acknowledgement, mana engagement or mana protection. Overlaying each of these themes as an ongoing narrative was the importance of respect, seeing the person in their context outside of the hospital and their physical condition, acknowledging the mana they hold as a whole person and not focusing solely on their current status as a patient. Transforming these finding into tangible actions which enact change is the most important part of this research, with suggested actions and principles for each theme provided that are applicable and effective in the daily reality of the ward.

Equity

- Since the establishment of the Kaiārahi Nāhi rōpū and Pacific Care Navigation Service, approximately 500 Māori and 700 Pacific patients have been engaged and supported as they progress through planned care journeys from the point of being waitlisted for surgery. The positive impact of the navigation service can be seen in the reduction in wait times for long waiters, particularly in Orthopaedics, General Surgery and Ophthalmology. In those areas, the long wait times for Māori and Pacific peoples are now equivalent to non-Māori and non-Pacific peoples. A new workflow tool, developed in ServiceNow, has gone live and is enabling easier documentation and analysis of the patient experience. This quantitative and qualitative data regarding individual and service level successes and barriers is assisting in identifying opportunities for service improvements. Collaborative work between the Pacific Care Navigation Service, Ara Manawa and Performance Improvement has resulted in the development of a Pacific Model of Care and a future service blueprint. Planning is currently underway to complete an evaluation of the care navigation approach.
- The Gastroenterology Service has been preparing to roll out bowel screening since early 2020. The DHB hosted the Ministry of Health in September 2020 to determine readiness to proceed. The DHB's progress in improving wait times and compliance rates for colonoscopy procedures was one of the main areas of focus. A go-live date of 30 November 2020 has tentatively been agreed and the service is awaiting a decision from the Ministry of Health to proceed.
- Taiao Ora, Ward 51 opened this month. This ward has been purpose-built to care for patients requiring hyper-acute stroke, acute stroke, neurology, inpatient stroke rehabilitation and adult rehabilitation care for under 65-years-old. It will enable all these services and staff to be co-located and provide a more continuous, integrated model of care with the whole inpatient

journey for a stroke patient in one unit. It is an exciting and important development that will improve outcomes and experience for patients and whānau, provide a better working environment for our staff, whilst also freeing up bed capacity elsewhere in the hospital. The name Taiao Ora has been gifted to our ward by the Chief Advisor Tikanga, Dame Naida Glavish. Located opposite the Clinical Education Centre on Level 5, Building 32 in Te Papakāinga Atawhai ō Tāmaki (Auckland City Hospital), our new ward has been designed with Taiao Ora (a wellness environment) in mind. We have created a safe, healing space to support patients and whānau on their journey to improved health and wellbeing, as well as a number of shared spaces to encourage whānau involvement along this journey. Natural elements have been brought into the design; including harakeke, kawakawa, tui, pōhatu and awa; through the use of large murals, colours, textures, lighting and flooring.

Transplant

- Transplant volumes total 33 heart, lung and liver and 48 renal transplants, totalling 81 transplants year to date.

COVID-19

- Te Toka Tumai continues to manage the impacts of COVID-19 on our hospitals and provider services. The COVID-19 response team remains in place to coordinate activity and respond to any increased community transmission. The team continues to work closely with the Northern Region Health Coordination Centre (NRHCC) to ensure regional consistency where appropriate.
- An appropriate screening tool is in use to identify patients presenting with higher index of suspicion or with COVID-19 symptoms, which support the appropriate clinical management of patients and use of personal protective equipment. Although the level of community transmission is very low, a number of patients continue to be identified with symptoms each day and are managed as such until test results and other clinical information is available.
- There are daily admissions from managed quarantine and isolation facilities (MIQFs) for a range of (non-COVID) health complaints. Infection prevention and control measures are in place to ensure that patients and staff remain safe. This includes the appropriate use of personal protective equipment where indicated.
- There continues to be a relatively small number of people deployed to MIQFs and Auckland Regional Public Health Service (ARPHS) to support the on-going activities of both of those services. Further work is progressing to identify surge response teams, particularly for ARPHS. Te Toka Tumai continues to work with the NRHCC to understand the likely on-going demand for staff and balancing that against the need to maintain hospital and community services.
- Planning for any potential future vaccine is in very early stages, working with the Ministry of Health and NRHCC.
- It is apparent that COVID-19 will continue to disrupt the delivery of healthcare and require on-going work to manage. Should further cases emerge, and incident management team can be stood-up at short notice if required.

Summer Plan

- Forecasting likely demands on the health system over the upcoming summer is challenging compared to previous years. There remains the risk that further outbreaks of COVID-19 in the community may require use of contingency staffing to support a system-wide response. In

addition, the border closure is likely to impact on visitors in the city over the summer as well as change Aucklanders holiday habits.

- Planned care recovery plans assume continued delivery of planned care throughout the summer period and this is built into operating room and surgical services plans. This also assumes that annual leave taken is in line with previous years and that no 'catch-up' of leave occurs.
- Wards will be flexed-down where possible to ensure that capacity is matched to demand.

2. Ministry of Health Planned Care Performance Dashboard

The Executive Leadership Team highlights the following updates from the September 2020 Ministry of Health Performance Planned Care Dashboard:

ESPI Performance

- ESPI 5 performance has improved from August to September 2020, whilst ESPI 2 has remained static.
- September 2020 ESPI 2 position is 7.6% noncompliant, compared with 7.6% noncompliant at the end of August 2020. Although the percentage was the same, there was a marginal improvement from 1,082 in August to 1,052 in September.
- September 2020 ESPI 5 position is 13.6% noncompliant, compared with 15.4% noncompliant at the end of August 2020. This is an improvement of 102 patients.
- We have completed 3,783 planned care discharges in September2020 (including Oral Health and Cardiology).
- In September 2020, adult orthopaedic reported 25.2% ESPI5 non-compliance and this is the lowest rate reported in the last 5 years.

2020/21 Planned Care – Year to Date performance:

- For September 2020, the Auckland Provider delivered below plan by 82 cases which was 96%. July, September and October 2020 discharges also exceeded the number of discharges for the same month last year.
- September 2020 activity was higher than August 2020 activity, but was predicted unlikely to achieve 100% of planned discharges for the month.
- Outpatient volumes continue to be delivered at approximately 90% of plan to allow for social distancing to be maintained in outpatient waiting areas. This was reviewed and services have been back up to full capacity since 5 October 2020.
- We have reviewed the August 2020 response and how we mitigate any further impact on planned care by subsequent COVID-19 responses. The shortfall experienced in August has been built in moving forward, however achieving the plan continues to be subject to external forces beyond our control.

Financial Performance

Consolidated Statement of Financial Performance - September 2020

Provider	Month (Sep-20)			YTD (3 months ending Sep-20)			Full Year		
$000s	Actual	Budget	Variance	Actual	Budget	Variance	F/Cast	Budget	Variance
Income									
Government and Crown Agency sourced	13,370	10,101	3,269 F	36,448	30,881	5,567 F	129,085	120,056	9,029 F
Non-Government & Crown Agency Sourced	7,977	9,467	(1,489) U	24,972	26,760	(1,788) U	103,292	105,660	(2,368) U
Inter-DHB & Internal Revenue	1,686	1,565	121 F	4,583	4,155	428 F	18,242	18,242	0 F
Internal Allocation DHB Provider	127,368	130,465	(3,097) U	381,439	391,394	(9,955) U	1,554,578	1,565,578	(11,000) U
	150,401	**151,598**	**(1,197) U**	**447,442**	**453,191**	**(5,748) U**	**1,805,197**	**1,809,536**	**(4,339) U**
Expenditure									
Personnel	96,945	96,022	(923) U	293,977	287,351	(6,626) U	1,186,319	1,179,634	(6,685) U
Outsourced Personnel	3,270	1,567	(1,703) U	8,075	4,677	(3,398) U	20,650	18,707	(1,943) U
Outsourced Clinical Services	4,432	3,568	(864) U	12,118	10,756	(1,363) U	46,281	45,976	(305) U
Outsourced Other	6,068	6,106	38 F	17,397	18,317	920 F	73,293	73,268	(25) U
Clinical Supplies	28,491	28,087	(405) U	83,845	84,470	625 F	327,771	326,540	(1,231) U
Infrastructure & Non-Clinical Supplies	19,502	18,935	(567) U	57,454	54,747	(2,707) U	222,146	219,636	(2,510) U
Internal Allocations	805	805	0 F	2,414	2,414	0 F	9,656	9,656	0 F
Total Expenditure	**159,513**	**155,089**	**(4,423) U**	**475,280**	**462,732**	**(12,549) U**	**1,886,115**	**1,873,417**	**(12,698) U**
Net Surplus / (Deficit)	**(9,112)**	**(3,492)**	**(5,620) U**	**(27,838)**	**(9,541)**	**(18,297) U**	**(80,918)**	**(63,882)**	**(17,037) U**
Covid-19 Net Impact on Bottom Line	**(5,045)**	**45**	**(5,090) U**	**(17,037)**	**550**	**(17,587) U**	**(17,037)**	**0**	**(17,037) U**
BAU Net Impact on Bottom Line	**(4,067)**	**(3,537)**	**(530) U**	**(10,801)**	**(10,091**	**(710) U**	**(63,882)**	**(63,882)**	**0 F**

Consolidated Statement of Personnel by Professional Group – September 2020

Employee Group $000s	Month (Sep-20)			YTD (3 months ending Sep-20)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical Personnel	34,641	34,325	(316) U	106,013	103,809	(2,204) U
Nursing Personnel	32,708	32,649	(59) U	99,033	95,966	(3,067) U
Allied Health Personnel	15,173	14,912	(260) U	45,586	45,240	(346) U
Support Personnel	2,755	2,716	(38) U	8,332	8,217	(115) U
Management/ Admin Personnel	11,669	11,419	(250) U	35,012	34,119	(893) U
Total (before Outsourced Personnel)	**96,945**	**96,022**	**(923) U**	**293,977**	**287,351**	**(6,626) U**
Outsourced Medical	1,470	1,039	(431) U	3,845	3,116	(729) U
Outsourced Nursing	54	66	12 F	138	199	61 F
Outsourced Allied Health	107	60	(47) U	314	180	(134) U
Outsourced Support	42	26	(16) U	132	78	(54) U
Outsourced Management/Admin	1,597	377	(1,220) U	3,646	1,105	(2,542) U
Total Outsourced Personnel	**3,270**	**1,567**	**(1,703) U**	**8,075**	**4,677**	**(3,398) U**
Total Personnel	**100,215**	**97,590**	**(2,626) U**	**302,052**	**292,027**	**(10,024) U**

Consolidated Statement of FTE by Professional Group – September 2020

FTE by Employee Group	Month (Sep-20)			YTD (3 months ending Sep-20)		
	Actual FTE	Budget FTE	Variance	Actual FTE	Budget FTE	Variance
Medical Personnel	1,574	1,536	(38) U	1,558	1,536	(23) U
Nursing Personnel	4,110	4,066	(44) U	4,107	4,067	(40) U
Allied Health Personnel	2,009	2,038	29 F	2,014	2,038	24 F
Support Personnel	536	531	(5) U	536	531	(5) U
Management/ Admin Personnel	1,535	1,554	19 F	1,525	1,554	29 F
Total (before Outsourced Personnel)	**9,764**	**9,725**	**(39) U**	**9,741**	**9,726**	**(15) U**
Outsourced Medical	46	29	(17) U	40	29	(11) U
Outsourced Nursing	1	3	3 F	1	3	3 F
Outsourced Allied Health	5	2	(3) U	6	2	(4) U
Outsourced Support	11	0	(11) U	11	0	(11) U
Outsourced Management/Admin	212	23	(189) U	150	23	(127) U
Total Outsourced Personnel	**275**	**58**	**(217) U**	**208**	**58**	**(150) U**
Total Personnel	**10,039**	**9,783**	**(256) U**	**9,948**	**9,784**	**(164) U**

Consolidated Statement of FTE by Directorate – September 2020

Employee FTE by Directorate Group (including Outsourced FTE)	Month (Sep-20)			YTD (3 months ending Sep-20)		
	Actual FTE	Budget FTE	Variance	Actual FTE	Budget FTE	Variance
Adult Medical Services	1,067	1,035	(31) U	1,068	1,035	(32) U
Adult Community and LTC	595	573	(22) U	588	574	(14) U
Surgical Services	923	906	(17) U	927	906	(22) U
Women's Health	380	389	9 F	385	389	4 F
Child Health	1,407	1,362	(45) U	1,406	1,362	(44) U
Cardiac Services	571	568	(3) U	575	568	(7) U
Clinical Support Services	1,395	1,407	12 F	1,402	1,404	3 F
Patient Management Services	469	465	(4) U	474	465	(9) U
Perioperative Services	789	811	22 F	794	808	14 F
Cancer & Blood Services	414	414	() U	416	414	(2) U
Operational - Others	70	8	(62) U	36	13	(22) U
Mental Health & Addictions	779	806	27 F	779	806	27 F
Ancillary Services	1,180	1,039	(141) U	1,100	1,039	(61) U
Total Personnel	**10,039**	**9,783**	**(256) U**	**9,948**	**9,784**	**(164) U**

Month Result

The Provider Arm result for the month is $5.6M unfavourable. This result is almost entirely driven by the impacts of Covid-19 ($5.1M) which resulted in a reduction in volumes and therefore revenue, combined with additional expenditure in relation to the response.

Overall volumes are reported at 92.8% of base contract for the month - this equates to $9.0M below the month contract. This unfavourable contract position equates to a $4.0M washup liability for planned care and IDF, which has been provided for in the month's result.

Total revenue for the month is $1.2M (0.8%) unfavourable, with a net $1.0M of this variance attributable to Covid-19. The key variances are as follows:

- Provision for planned care and IDF revenue washup - $4.0M unfavourable – reflecting significantly reduced volumes during the Covid-19 resurgence period.
- Non Resident revenue $0.7M unfavourable – reflecting reduced Pacific contract cases as a result of Covid-19.
- MOH side contract income $2.7M favourable due to additional laboratory income for high volumes of Covid-19 testing.
- Public Health income $0.9M favourable reflecting additional MOH Covid-19 funding for additional costs incurred for the year to date.
- Other Income $0.6M unfavourable reflecting additional revenue assumed for budget initiatives not yet received.
- Retail Pharmacy revenue $0.5M favourable (partly offset by additional cost of goods sold).

Total expenditure for the month is $4.4M (2.9%) unfavourable, with $4.0M of this variance due to additional costs arising from Covid-19. The key variances are as follows:

- Personnel/Outsourced Personnel costs $2.6M (2.7%) unfavourable with all of this variance due to unbudgeted Covid-19 related expenditure.
- Outsourced Clinical Services $0.9M (24.2%) unfavourable, with the key variances as follows:
  - Unbudgeted Covid-19 related expenditure of $0.1M (for laboratory sendaway tests).
  - Planned outsourcing for elective surgery and colonoscopy has been phased earlier than budget phasing resulting in a $0.6M unfavourable variance which will correct during the year.
- Clinical Supplies $0.4M (1.4%) unfavourable. Laboratory consumable costs are $0.9M unfavourable due to the extremely high volume of Covid-19 tests processed during the month. Excluding these costs, the underlying Clinical Supplies variance is $0.5M favourable, in line with overall volume performance below contract.
- Infrastructure & Non Clinical Supplies $0.6M (3.0%) unfavourable, with the key variances being:
  - Unbudgeted Covid-19 related expenditure of $1.2M.
  - Cost of Goods Sold $0.5M unfavourable for retail pharmacy (offset by additional retail revenue for the month).

Year to Date Result

The Provider Arm result for the year to date is $18.3M unfavourable. This result is almost entirely driven by the impacts of Covid-19 ($17.6M) which resulted in a reduction in volumes and therefore revenue, combined with additional expenditure in relation to the response.

Overall volumes (for total Auckland DHB and IDF Funders) are reported at 94.5% of the seasonally phased contract, equating to $20.4M below contract. This unfavourable contract position equates to a $11.0M washup liability for planned care and IDF, which has been provided for in the year to date result.

Total revenue for the year to date is $5.7M (1.3%) unfavourable, with a net $7.2M of this variance attributable to Covid-19. The key variances are as follows:

- Provision for planned care and IDF revenue washup - $11.0M unfavourable – reflecting significantly reduced volumes during the Covid-19 resurgence period.
- Non Resident revenue $2.4M unfavourable – reflecting reduced Pacific contract cases as a result of Covid-19.
- MOH side contract income $6.3M favourable due to additional laboratory income for high volumes of Covid-19 testing.
- Other Income $1.9M unfavourable reflecting additional revenue assumed for budget initiatives not yet received.
- Retail Pharmacy revenue $1.7M favourable (partly offset by additional cost of goods sold).
- Research Income $0.8M favourable (offset by additional research costs so bottom line neutral).
- ACC income $0.6M favourable reflecting additional volumes in services such as Reablement and the Regional Pain Service.

Total expenditure for the year to date is $18.3M (2.7%) unfavourable, with $10.4M of this variance due to additional costs arising from Covid-19. The key variances are as follows:

- Personnel/Outsourced Personnel costs $10.0M (3.4%) unfavourable with the key variances as follows:

  - Unbudgeted Covid-19 related expenditure of $6.9M.
  - Budget Personnel vacancy and cost per FTE assumptions not fully achieved $3.1M unfavourable
- Outsourced Clinical Services $1.4M (12.7%) unfavourable, with the key variances as follows:
  - Unbudgeted Covid-19 related expenditure of $0.3M (for laboratory sendaway tests).
  - Diagnostic genetics $0.2M unfavourable due to delay in repatriation of tests previously not done in house – this variance will reduce once repatriation is complete.
  - Planned outsourcing for colonoscopy has been completed earlier than budget phasing resulting in a $0.4M unfavourable variance which will correct during the year.
  - Additional MRI outsourcing $0.3M unfavourable for which additional one off MOH funding has been received.
- Clinical Supplies $0.6M (0.7 %) favourable. Laboratory consumable costs are $1.8M unfavourable due to the extremely high volume of Covid-19 tests processed during August and September. Excluding these costs, the underlying Clinical Supplies variance is $2.5M favourable, in line with overall volume performance below contract.
- Infrastructure & Non Clinical Supplies $2.7M (4.9%) unfavourable, with the key variances being:
  - Unbudgeted Covid-19 related expenditure of $2.3M
  - Cost of Goods Sold $1.4M unfavourable for retail pharmacy, offset by additional retail revenue for the year to date.
  - Other Operating Expenses such as Professional Fees and Training $1.0M favourable.

Year End Forecast

The $17M full year forecast variance to budget is primarily due to the year to date adverse impact of Covid-19. No assumptions have been made yet regarding potential future Covid-19 outbreaks and the financial impacts of these, and no further provision has been made for Holidays Act remediation.

FTE

Total FTE (including outsourced) for September were 10,039 which is 256 higher than budget. 214 of this variance is for unbudgeted FTE for Covid-19, and the balance of the variance reflects budgeted vacancy/turnover assumptions not met.

Volume Performance

1) Combined DRG and Non-DRG Activity (All DHBs)

		Sep-2020				YTD (3 months ending Sep-20)			
		$000s				$000s			
Directorate	**Service**	**Cont**	**Act**	**Var**	**Prog %**	**Cont**	**Act**	**Var**	**Prog %**
Adult Community & LTC	Ambulatory Services	1,507	1,784	276	118.3%	4,751	5,074	323	106.8%
	Community Services	2,072	2,153	81	103.9%	6,217	6,392	175	102.8%
	Diabetes	592	719	127	121.4%	1,776	2,026	251	114.1%
	Palliative Care	39	39	0	100.0%	117	117	0	100.0%
	Reablement Services	2,147	2,233	86	104.0%	6,470	6,709	240	103.7%
	Sexual Health	354	579	226	163.8%	1,061	1,660	599	156.4%
Adult Community & LTC Total		**6,711**	**7,506**	**795**	**111.8%**	**20,391**	**21,979**	**1,588**	**107.8%**
Adult Medical Services	AED, APU, DCCM, Air Ambulance	2,875	2,588	(288)	90.0%	8,366	8,027	(339)	95.9%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	14,956	14,161	(795)	94.7%	45,421	42,588	(2,833)	93.8%
Adult Medical Services Total		**17,831**	**16,749**	**(1,082)**	**93.9%**	**53,787**	**50,615**	**(3,172)**	**94.1%**
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	10,810	10,930	120	101.1%	33,138	32,359	(779)	97.6%
	N Surg, Oral, ORL, Transpl, Uro	12,343	10,642	(1,701)	86.2%	36,028	33,939	(2,089)	94.2%
	Orthopaedics Adult	5,085	4,623	(462)	90.9%	15,554	14,855	(700)	95.5%
Surgical Services Total		**28,238**	**26,195**	**(2,043)**	**92.8%**	**84,720**	**81,152**	**(3,568)**	**95.8%**
Cancer & Blood Services	Cancer & Blood Services	12,186	11,758	(428)	96.5%	36,432	35,043	(1,390)	96.2%
	Genetics	349	341	(8)	97.7%	1,048	1,109	61	105.8%
Cancer & Blood Services Total		**12,535**	**12,099**	**(436)**	**96.5%**	**37,480**	**36,151**	**(1,329)**	**96.5%**
Cardiovascular Services		**15,256**	**13,590**	**(1,666)**	**89.1%**	**44,449**	**40,138**	**(4,311)**	**90.3%**
Children's Health	Child Health Community Services	3,299	2,119	(1,180)	64.2%	9,898	6,974	(2,924)	70.5%
	Child Health Medical	6,976	6,063	(913)	86.9%	20,318	17,176	(3,142)	84.5%
	Child Health Surgical	11,959	9,936	(2,022)	83.1%	33,485	30,876	(2,609)	92.2%
Children's Health Total		**22,233**	**18,118**	**(4,115)**	**81.5%**	**63,701**	**55,026**	**(8,675)**	**86.4%**
Clinical Support Services		**4,077**	**4,079**	**2**	**100.0%**	**12,232**	**11,896**	**(336)**	**97.3%**
DHB Funds		**9,912**	**9,772**	**(139)**	**98.6%**	**29,724**	**30,176**	**452**	**101.5%**
Perioperative Services		**18**	**3**	**(15)**	**16.2%**	**53**	**21**	**(32)**	**38.9%**
Public Health Services		**155**	**155**	**0**	**100.0%**	**464**	**464**	**0**	**100.0%**
Support Services		**102**	**102**	**0**	**100.0%**	**307**	**307**	**0**	**100.0%**
Women's Health Total		**8,308**	**7,960**	**(348)**	**95.8%**	**26,440**	**25,375**	**(1,065)**	**96.0%**
Grand Total		**125,376**	**116,329**	**(9,048)**	**92.8%**	**373,748**	**353,299**	**(20,449)**	**94.5%**

2) Total Discharges for the YTD (3 Months to September 2020)

		Cases Subject to WIES Payment		All Discharges			Same Day discharges		Same Day as % of all discharges	
		Inpatient								
Directorate	**Service**	**2020**	**2021**	**Last YTD**	**This YTD**	**% Change**	**Last YTD**	**This YTD**	**Last YTD**	**This YTD**
Adult Community & LTC	Ambulatory Services	460	406	464	407	(12.3%)	436	390	94.0%	95.8%
	Community Services	0	0	0	4	0.0%	0	3	0.0%	75.0%
	Reablement Services	0	0	402	344	(14.4%)	24	19	6.0%	5.5%
Adult Community & LTC Total		460	406	866	755	(12.8%)	460	412	53.1%	54.6%
Adult Medical Services	AED, APU, DCCM, Air Ambulance	2,520	2,585	2,573	2,598	1.0%	1,816	1,860	70.6%	71.6%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	3,910	3,510	3,976	3,530	(11.2%)	634	660	15.9%	18.7%
Adult Medical Services Total		6,430	6,095	6,549	6,128	(6.4%)	2,450	2,520	37.4%	41.1%
Cancer & Blood Total		937	792	1,129	879	(22.1%)	633	431	56.1%	49.0%
Cardiovascular Services Total		1,500	1,385	1,566	1,422	(9.2%)	405	399	25.9%	28.1%
Children's Health	Child Health Community Services	662	311	665	311	(53.2%)	44	43	6.6%	13.8%
	Child Health Medical	2,225	1,773	2,434	2,048	(15.9%)	1,724	1,511	70.8%	73.8%
	Child Health Surgical	1,902	1,630	2,019	1,720	(14.8%)	832	696	41.2%	40.5%
Children's Health Total		4,789	3,714	5,118	4,079	(20.3%)	2,600	2,250	50.8%	55.2%
Clinical Support Services Total		0	0	3	0	0.0%	2	0	66.7%	0.0%
DHB Funds Total		283	297	285	298	4.6%	212	218	74.4%	73.2%
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	3,387	3,029	3,659	3,218	(12.1%)	2,019	1,740	55.2%	54.1%
	N Surg, Oral, ORL,	2,166	2,029	2,312	2,168	(6.2%)	932	858	40.3%	39.6%
	Orthopaedics Adult	819	863	848	896	5.7%	135	195	15.9%	21.8%
Surgical Services Total		6,372	5,921	6,819	6,282	(7.9%)	3,086	2,793	45.3%	44.5%
Women's Health Total		3,713	3,412	3,850	3,516	(8.7%)	1,421	1,254	36.9%	35.7%
Grand Total		**24,484**	**22,022**	**26,182**	**23,359**	**(10.8%)**	**11,267**	**10,277**	**43.0%**	**44.0%**

3) Caseweight Activity for the YTD (3 Months to September 2020 (All DHBs))

		Acute							Elective							Total						
		Case Weighted Volume			$000s				Case Weighted Volume			$000s				Case Weighted Volume			$000s			
Directorate	Service	Con	Act	Var	Con	Act	Var	Prog %	Con	Act	Var	Con	Act	Var	Prog %	Con	Act	Var	Con	Act	Var	Prog %
Adult Community & LTC		**330**	**322**	**(8)**	**1,829**	**1,785**	**(44)**	**97.6%**	**30**	**7**	**(23)**	**167**	**40**	**(128)**	**23.7%**	**360**	**329**	**(31)**	**1,996**	**1,824**	**(172)**	**91.4%**
Adult Medical Services	AED, APU, DCCM, Air Ambulance	1,043	1,055	12	5,782	5,850	68	101.2%	0	0	0	0	0	0	0.0%	1,043	1,055	12	5,782	5,850	68	101.2%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	5,682	5,128	(554)	31,510	28,435	(3,074)	90.2%	9	0	(9)	49	0	(49)	0.0%	5,691	5,128	(563)	31,559	28,435	(3,124)	90.1%
Adult Medical Services Total		**6,725**	**6,183**	**(542)**	**37,292**	**34,286**	**(3,006)**	**91.9%**	**9**	**0**	**(9)**	**49**	**0**	**(49)**	**0.0%**	**6,734**	**6,183**	**(551)**	**37,341**	**34,286**	**(3,055)**	**91.8%**
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	2,474	2,507	33	13,720	13,901	181	101.3%	1,990	1,832	(157)	11,033	10,159	(873)	92.1%	4,464	4,339	(125)	24,752	24,061	(692)	97.2%
	N Surg, Oral, ORL, Transpl, Uro	2,665	2,664	(1)	14,779	14,775	(4)	100.0%	2,023	1,770	(253)	11,217	9,816	(1,401)	87.5%	4,688	4,435	(253)	25,997	24,591	(1,406)	94.6%
	Orthopaedics Adult	1,589	1,572	(17)	8,809	8,717	(92)	99.0%	1,008	794	(215)	5,592	4,401	(1,190)	78.7%	2,597	2,366	(231)	14,401	13,118	(1,283)	91.1%
Surgical Services Total		**6,728**	**6,743**	**15**	**37,308**	**37,393**	**85**	**100.2%**	**5,021**	**4,396**	**(625)**	**27,842**	**24,377**	**(3,465)**	**87.6%**	**11,749**	**11,139**	**(610)**	**65,150**	**61,770**	**(3,380)**	**94.8%**
Cancer & Blood Services		**1,691**	**1,518**	**(173)**	**9,378**	**8,418**	**(960)**	**89.8%**	**0**	**0**	**0**	**0**	**0**	**0**	**0.0%**	**1,691**	**1,518**	**(173)**	**9,378**	**8,418**	**(960)**	**89.8%**
Cardiovascular Services		**4,442**	**4,137**	**(306)**	**24,633**	**22,938**	**(1,695)**	**93.1%**	**2,711**	**2,245**	**(466)**	**15,034**	**12,450**	**(2,584)**	**82.8%**	**7,153**	**6,382**	**(772)**	**39,667**	**35,388**	**(4,279)**	**89.2%**
Children's Health	Child Health Community	1,023	485	(538)	5,675	2,690	(2,985)	47.4%	0	0	0	0	0	0	0.0%	1,023	485	(538)	5,675	2,690	(2,985)	47.4%
	Child Health Medical	2,316	1,893	(423)	12,840	10,496	(2,344)	81.7%	16	15	(1)	87	83	(3)	96.2%	2,331	1,908	(423)	12,927	10,579	(2,348)	81.8%
	Child Health Surgical	2,895	2,555	(341)	16,056	14,167	(1,889)	88.2%	2,010	1,851	(159)	11,147	10,266	(881)	92.1%	4,905	4,406	(499)	27,202	24,433	(2,769)	89.8%
Children's Health Total		**6,234**	**4,933**	**(1,302)**	**34,571**	**27,353**	**(7,218)**	**79.1%**	**2,026**	**1,866**	**(159)**	**11,233**	**10,349**	**(884)**	**92.1%**	**8,260**	**6,799**	**(1,461)**	**45,804**	**37,702**	**(8,102)**	**82.3%**
Women's Health Services		**2,808**	**2,524**	**(284)**	**15,570**	**13,997**	**(1,572)**	**89.9%**	**602**	**616**	**14**	**3,339**	**3,417**	**78**	**102.3%**	**3,410**	**3,140**	**(269)**	**18,908**	**17,414**	**(1,494)**	**92.1%**
DHB Funds		**68**	**0**	**(68)**	**374**	**0**	**(374)**	**0.0%**	**512**	**575**	**63**	**2,839**	**3,190**	**350**	**112.3%**	**580**	**575**	**(4)**	**3,214**	**3,190**	**(24)**	**99.3%**
Grand Total		**29,026**	**26,360**	**(2,666)**	**160,955**	**146,170**	**(14,784)**	**90.8%**	**10,911**	**9,706**	**(1,205)**	**60,504**	**53,822**	**(6,682)**	**89.0%**	**39,936**	**36,065**	**(3,871)**	**221,458**	**199,992**	**(21,466)**	**90.3%**
Excludes caseweight Provision																						

September volumes increase after the return to Level 2, although acute delivery was still lower than last year.

Acute Services

- Acute medical discharges are still down by 12% compared to the same period last year. The reduction is mainly in paediatric services which has dropped by 27%, due to drops in General Paediatrics and the Emergency Department. Paediatric sub-speciality services have remained stable year on year however. There was also a 7% reduction in Adult Medical services, predominantly in General Medicine and Respiratory services. The other medical specialities have not had any significant change. Average WIES is nearly 3% lower and ALOS just over 1% lower.
- Acute surgical discharges are also down by 9% compared to the same period last year. The main decreases are in Adult ORL, Paediatric ORL and Paediatric Orthopaedics. The drop in ORL appears to fewer cases of acute tonsillitis and ear infection (again a benefit of a lower rate of respiratory infection across the country). The drop in Paediatric Orthopaedics is due to a significant drop in injuries. Average WIES is 8% higher than the same period last year (which means that overall WIES is still only 3% lower than the same period last year despite the volume drop), while ALOS is 6% higher.
- Obstetric numbers have picked up slightly and are now 13% lower than the same period last year, with actual birth numbers being 10% lower than the same period last year. Average WIES is up 2% on the same period last year overall. Newborn discharges have increased significantly in comparison (although they are very small numbers) and are now only 4% lower than the same period last year, with a 2% drop in average WIES and a 10% drop in LOS.

Elective Services

There was an increase in elective output in September with performance to contract for the month improving to 90% of the contract (up from 70% for the month of August). While the overall elective discharges are still 2% lower than the same period last year this is due to the effect of Covid-19 in August which saw discharges drop from around 2,400 per month to just under 2,000 for the month. Average WIES is only down by 1% and ALOS is down by 3%.

4) Non-DRG Activity (ALL DHBs)

		Sep-2020				YTD (3 months ending Sep-20)			
		$000s				$000s			
Directorate	**Service**	**Cont**	**Act**	**Var**	**Prog %**	**Cont**	**Act**	**Var**	**Prog %**
Adult Community & LTC	Ambulatory Services	918	1,113	195	121.3%	2,755	3,250	495	118.0%
	Community Services	2,072	2,153	81	103.9%	6,217	6,392	175	102.8%
	Diabetes	592	719	127	121.4%	1,776	2,026	251	114.1%
	Palliative Care	39	39	0	100.0%	117	117	0	100.0%
	Reablement Services	2,147	2,233	86	104.0%	6,470	6,709	240	103.7%
	Sexual Health	354	579	226	163.8%	1,061	1,660	599	156.4%
Adult Community & LTC Total		**6,122**	**6,836**	**714**	**111.7%**	**18,395**	**20,155**	**1,760**	**109.6%**
Adult Medical Services	AED, APU, DCCM, Air Ambulance	888	685	(203)	77.1%	2,584	2,177	(407)	84.2%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	4,622	4,642	20	100.4%	13,862	14,152	290	102.1%
Adult Medical Services Total		**5,511**	**5,327**	**(183)**	**96.7%**	**16,446**	**16,329**	**(117)**	**99.3%**
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	2,795	2,738	(57)	98.0%	8,385	8,298	(87)	99.0%
	N Surg, Oral, ORL, Transpl, Uro	3,344	2,938	(405)	87.9%	10,031	9,348	(684)	93.2%
	Orthopaedics Adult	384	584	199	151.8%	1,153	1,736	583	150.5%
Surgical Services Total		**6,523**	**6,260**	**(263)**	**96.0%**	**19,570**	**19,382**	**(188)**	**99.0%**
Cancer & Blood Services	Cancer & Blood Services	9,018	8,830	(188)	97.9%	27,054	26,624	(430)	98.4%
	Genetics	349	341	(8)	97.7%	1,048	1,109	61	105.8%
Cancer & Blood Services Total		**9,368**	**9,171**	**(197)**	**97.9%**	**28,103**	**27,733**	**(369)**	**98.7%**
Cardiovascular Services		**1,594**	**1,499**	**(94)**	**94.1%**	**4,782**	**4,750**	**(32)**	**99.3%**
Children's Health	Child Health Community Services	1,408	1,457	49	103.5%	4,223	4,284	61	101.4%
	Child Health Medical	2,464	2,053	(410)	83.4%	7,391	6,597	(794)	89.3%
	Child Health Surgical	2,094	2,087	(8)	99.6%	6,283	6,443	160	102.5%
Children's Health Total		**5,966**	**5,597**	**(368)**	**93.8%**	**17,897**	**17,324**	**(573)**	**96.8%**
Clinical Support Services		**4,077**	**4,079**	**2**	**100.0%**	**12,232**	**11,896**	**(336)**	**97.3%**
DHB Funds		**8,837**	**8,970**	**133**	**101.5%**	**26,511**	**26,986**	**476**	**101.8%**
Perioperative Services		**18**	**3**	**(15)**	**16.2%**	**53**	**21**	**(32)**	**38.9%**
Public Health Services		**155**	**155**	**0**	**100.0%**	**464**	**464**	**0**	**100.0%**
Support Services		**102**	**102**	**0**	**100.0%**	**307**	**307**	**0**	**100.0%**
Women's Health Total		**2,511**	**2,477**	**(34)**	**98.7%**	**7,532**	**7,961**	**429**	**105.7%**
Grand Total		**50,782**	**50,477**	**(305)**	**99.4%**	**152,290**	**153,307**	**1,016**	**100.7%**

September performance to contract improved, as expected, with increases in all services. Year to date performance to contract is now 101%.

Te Pūriri O Te Ora – Cancer and Blood Services

Prepared by: George Laking (Te Whakatōhea, Medical Oncologist, Kaihautū - Pou Ārahi); Deirdre Maxwell (General Manager)
Speakers: Richard Sullivan (Director); Dr George Laking (Te Whakatōhea, Medical Oncologist, Kaihautū - Pou Ārahi)

E tipu, e rea, mō ngā rā o tōu ao, ko tō ringa ki ngā rākau a te Pākehā hei ora mo te tinana, ko tō ngākau ki ngā taonga a ō tīpuna Māori hei tikitiki mō tō mahuna, ā ko tō wairua ki tō Atua, nāna nei ngā mea katoa

Tā Apirana Ngata

1. Te Pou Ārahi

Whakapapa

In July 2020, a by Māori, for Māori, as Māori rōpū was established in liaison with Dame Naida Glavish within Te Pūriri O Te Ora. The name gifted for this rōpū by Dame Naida is Pou Ārahi. The purpose of Pou Ārahi is to reinvent the Cancer and Blood Service so it:

1. Honours Te Tiriti o Waitangi and becomes fit for purpose for Māori,
2. Is underpinned and permeated by Mātauranga Māori,
3. Reaches into the community from start to finish of the whānau journey, and
4. Establishes a pattern for care that leads to equitable health outcomes across the board, starting with Māori.

Whānau

The appointed Chair of Pou Ārahi is Dr George Laking (Te Whakatōhea) Medical Oncologist. Membership includes Tame Hauraki (Ngāti Whātua, Ngāpuhi, Ngāti Whānaunga) our newly appointed Kaumātua for Te Pūriri O Te Ora, Ingo Lambrecht (Ngāi Tiamani, whāngai nā Ngāti Whātua) Clinical Psychologist, Kadin Latham (Ngāi Tahu) Project Coordinator and Troydyn Raturaga (Ngāti Whātua, Ngāpuhi) Business Manager Provider Services and HR. Membership is open to all kaimahi who carry the Pou Ārahi kaupapa.

2. Kāwanatanga

Pūmanawa Tāngata

Since October 2020, Te Pou Ārahi have partnered with Organisational Development in designing and piloting initiatives and activities that sit within Pūmanawa Tāngata, the People Plan. We have focused on Key Result Area 2 ("Uphold Te Tiriti o Waitangi as our framework to eliminate racism, build culturally safe practice and achieve health equity") and 3 (Grow and develop ngā kaimahi Māori). Pou Ārahi has been integral in Organisational Development's ongoing socialisation of Pūmanawa Tāngata. So far we have facilitated key consultative hui with groups including Te Toka Tumai Māori Health leadership, the DHB Executive Leadership Team, ngā Kaiārahi Nāhi Māori Nurse Navigators, Rata Māori, Māori Senior Medical Officers, and Kaimahi Māori at Te Pūriri O Te Ora.

Staff Education

A theme emerging from these hui is the need for staff education at a fundamental (often even remedial) level on themes of New Zealand history and Mātauranga Māori. Te Pou Ārahi intends to create a safe space for staff at Te Pūriri O Te Ora to enquire and learn. This will include a regular forum, similar to the previous Manaakitanga Round, where staff can share success stories and learnings, and ultimately progress to critical self-reflection and peer review. In association with Ngāti Whātua Ōrākei, we are commissioning a wānanga series curated to support the learning/education pathway of the workforce that will bring scholars from around the motu to educate on Mātauranga Māori as it intersects with whānau-centred cancer care.

Learning/education objectives are currently being finalised and ready for design. The senior leadership team within Te Pūriri O Te Ora will be one of the first groups across the DHB that will actively lead and support this kaupapa and act as change agents. This work with leadership is anticipated to commence before the end of this year.

3. Tino Rangatiratanga

Kaimahi Māori

29 October 2020 marked the first ever monthly hui and whakawhanaungatanga with kaimahi Māori at Te Pūriri O Te Ora. We assembled the whānau that covers disciplines including Health Care Assistance, Scheduling, Reception and Patient Service Coordination, Radiation Therapy, Medical, Specialist Cancer Nursing, Psychology, and Genetic Counselling.

Rata Matua Māori

Likewise the hui on the same day with Rata Matua Māori, Māori Senior Medical Officers of the DHB, was to our knowledge the first such hui held on site. We intend to use it as the basis for an ongoing forum for Māori medical leadership at Te Toka Tumai.

Hei Āhuru Mōwai

Te Pou Ārahi has close engagement with Hei Āhuru Mōwai, Māori Cancer Leadership New Zealand. This offers access to national resources of Mātauranga, and reformative energy, in relation to Cancer Care. Te Pou Ārahi will engage with a reformed Northern Regional Kaupapa Māori Cancer Leadership group, collaborating with Northland DHB, as part of Hei Āhuru Mōwai.

Te Manawanui

Te Pou Ārahi is building a professional alliance with Te Manawamui Māori Mental Health Unit, under the leadership of its Co-Director Māori, Hineroa Hakiaha (Ngāti Awa, Ngāi Tūhoe, Ngāti Maniapoto, Ngāi Tahu).

4. Ōritetanga

Lung Cancer Equity

By May 2020, Te Pou Ārahi will utilise data currently collected by Business Intelligence to identify and reveal disparities in the cancer pathway that warrant further in-depth causal analysis. That in

turn will provide guidance on where and how to intervene, and will provide metrics which can be used to monitor the effectiveness of quality improvement efforts to achieve equitable care. The novel aspect of this work is we expect to set up a real-time prospective data query structure that enables us to monitor the impact of changes to the system as they happen. Previous such analyses could only be retrospective, making the study of change highly arduous, as the analysis itself had to be replicated each time. A deeper dive into this work will be provided at the next HAC meeting.

5. Te Ritenga

Mihi Whakatau

Together with Organisational Development, and with support from Dame Naida Glavish, Te Pou Ārahi is establishing monthly Mihi Whakatau to properly welcome new whānau who engage with our service. This will start with staff whānau and grow to include whānau tangata māuiui (service-user whānau). The kawa will be modelled initially on that already in practice at Te Manawanui Māori Mental Health Unit. We expect the Mihi Whakatau to become the key forum for all staff development in Mātauranga Māori, in dimensions including karakia, waiata, pepeha, kapa haka, Reo Māori, and proficient adoption of a Mātauranga Māori worldview. This will be in place from December and ongoing.

Āhuatanga

Part of the purpose of Te Pou Ārahi is that Te Pūriri O Te Ora be underpinned and permeated by Mātauranga Māori. A Manea stone has been sourced, carved, and is awaiting to be placed within Building 8, before the end of this year. Ongoing and intentional work will be implemented to profile key aspects including mihi whakatau, wānanga, everyday use of Te Reo including karakia and waiata, and physical attributes such as the Manea stone, toi Māori, visual design, and signage.

Workplace Experience

With support of Organisational Development we will implement “interviews”, to better understand the experience of our current staff. We will also create safe pathways to report racism, and will implement Hohou i te Rongo in our workplace. A bespoke work plan of Māori workforce development (Key Result Area 3 of Pūmanawa Tāngata) activity for Te Pūriri O Te Ora is currently being finalised with commencement this quarter.

6. Equity

Prioritisation

Te Pūriri O Te Ora propose to reduce inequity for Māori and Pacific peoples by putting them at the front of the prioritisation queue within each risk group. This has been in effect since October. We see this as a relatively small change we can make, that will help redress part but by no means all of the inequity within our health system. It will also be our first pass on an equity intervention, and help us to understand the impact and sometimes unexpected outcomes of intervening for equity.

Local Delivery of Oncology – Medical Oncology Full Breast Tumour Stream Delivery

Te Pūriri O Te Ora staff are working with regional colleagues to deliver oncology services closer to home, obviating the need for whānau to travel to the Auckland City Hospital site. Work has been underway to provide full medical oncology breast tumour stream delivery at both Counties Manukau and Waitematā DHBs. Agreement has been reached to deliver the full cytotoxic provision in the next months. We are currently managing the final implementation processes, providing proof of concept of full tumour stream services locally. Concurrently we are working on a Local Delivery Plan for 2-5 years within this medical oncology context, where we would see further tumour streams delivered locally also. This is consistent with wider work to establish radiation therapy provision in Northland DHB, as agreed in the Northern Region Radiation Oncology Plan.

Integrated Cancer Service

Te Pūriri O Te Ora staff continue to work with University of Auckland colleagues to progress the rebuild of the Cancer and Blood Building (Building 8). We seek a fit-for-purpose environment that provides outpatient, day patient and inpatient services into the future. This will include appropriate facilities for whānau, including mihimihi provision space, and will support increased academic/research capability. A seed funding case is being presented through the Building for the Future Programme.

7. Exceptions

COVID-19

Te Pūriri O Te Ora continues to manage the impacts of Covid-19 to minimise any impacts on our cancer and blood whānau. The in-house Covid-19 Incident Management Team have stood down now that we are in a low Covid-19 risk setting. We are confident that our Service has documented and practiced Covid-19 response processes for levels 1, 2 and 4 and we can stand these up again should they be required. Level 3 poses ongoing challenges around physical distancing and the space requirements, and screening.

The volumes of patients presenting to the Service have remained static across recent months. Throughout all Covid-19 lockdowns we have continued to treat all of our medical oncology and haematology patients, and radiation oncology patients aligned to national Covid-19 guidelines. We have not observed any equity disparity. As an example, our medical oncology service continues to see a 10% increase in medical oncology treatment activity, consistent with previous years trends. This is attributed to increased numbers of lines of treatment, increased numbers of drugs funded by Pharmac, and patients having longer survival times. This has been unaffected by Covid-19. The only variation pertains to a 2 month period of lowered inpatient admissions within our oncology ward. We are currently exploring this in detail to understand potential drivers/impacts.

Our screening practices saw us stand up a tent external to Building 8 to manage whānau access and flow. This has recently been removed as we work with the Performance Improvement Team to determine in-house flow patterns to accommodate screening. The whānau experience outside the building was not favourable, and the traffic flow changes as a result of facilities decommissioning work mean that the tent needed to be disestablished.

Current pressures pertain to sufficient numbers of clinic rooms, organised in such a way that physical distancing protocols can be re-enacted if required. Telehealth solutions form part of this picture,

with a balance required between face-to-face activity and remote engagement to ensure safe clinical practice.

Regional Oncology Electronic System

Te Pūriri O Te Ora staff have been engaged with regional colleagues to establish a regional electronic cytotoxic prescribing system. This is an essential tool to ensure clinically safe and consistent practice as we extend local delivery, and during Covid-19 constrained environments where remote working means paper-based systems are difficult to work with. We are engaged with regional procurement processes to determine the best outcome and will seek to progress implementation in due course.

Closed System Transfer Device Regional Procurement

As part of the wider regional context, our Te Pūriri O Te Ora staff have been working with healthAlliance in a procurement process to secure a regionally consistent Closed System Transfer Device for chemotherapy provision. This work has been underway for approximately 4 years and to date has not landed a product for use. Closed System Transfer Devices ensure that staff are not required to spike/de-spike chemotherapy bags, thus removing possible exposure to cytotoxic medications. Current practice utilises guarding and Personal Protective Equipment. Our staff have agreed to manage this regional process as a means to expedite this work.

Aspergillus/Fungal Spore Mitigation for Immuno-compromised Patients

As a consequence of the planned Facilities Infrastructure Renewal Programme work, deconstruction of a range of existing buildings is required. This commences with Building 13, and later includes Buildings 7 and 9. Due to the proximity of this work to the Cancer and Blood Building, our staff are engaged with Facilities and Infectious Diseases staff to understand and manage any potential risk of aspergillus exposure for vulnerable patient groups. To mitigate this infection risk, our haematology service will relocate to Rangitoto ward for a period, commencing 23 November 2020.

8. Scorecard

Auckland DHB - Cancer & Blood Services

HAC report for September 2020

Equitable - equity is measured and reported on using stratification of measures in other domains				
Safety				
Metric		**Actual**	**Target**	**Previous**
Medication errors with major harm	*PR215*	0	Lower	0
Nosocomial pressure injury point prevalence (% of in-patients)	*PR097*	R/U		R/U
Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	*PR185*	R/U		R/U
Number of falls with major harm	*PR199*	0	Lower	0
Number of reported adverse events causing harm (SAC 1&2)	*PR084*	0	Lower	1
Unviewed/unsigned Histology/Cytology results >=30 days	*PR596*	0	Lower	3
% Hand hygiene compliance	*PR195*	**92.16%**	>=80%	95.81%

Patient-centred

Metric		Actual	Target	Previous
% Patients cared for in a mixed gender room at midday - Adult	PR175	6.67%	Lower	29.97%
% hospitalised smokers offered advice and support to quit	PR129	93.94%	>=95%	100%
% DNA rate for outpatient appointments - Māori	PR057	6.38%	<=9%	7.36%
% DNA rate for outpatient appointments - Pacific	PR058	5.08%	<=9%	6.82%
% DNA rate for outpatient appointments - All Ethnicities	PR056	2.76%	<=9%	3.17%
% DNA rate for outpatient appointments - Deprivation Scale Q5	PR338	4.03%	<=9%	5.95%
% Very good and excellent ratings for overall inpatient experience #	PR154	100%	>=90%	88.9%
% Very good and excellent ratings for overall outpatient experience #	PR179	96%	>=90%	91.1%
% Very good and excellent ratings for coordination of care after discharge #	PR493	100%	>=90%	100%
% Response rate to ADHB patient experience inpatient survey	PR315	14%	>=25%	14%
Number of CBU Outliers - Adult	PR173	14	<=300	64

Timeliness

Metric		Actual	Target	Previous
31/62 day target - % of non-surgical patients seen within the 62 day target	PR181	94.59%	>=90%	98.39%
31/62 day target - % of surgical patients seen within the 62 day target	PR182	100%	>=90%	100%
62 day target - % of patients treated within the 62 day target	PR184	97.65%	>=90%	99.3%
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Pacific	PR330	0	Lower	0
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Total	PR328	0	Lower	0
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Deprivation Scale Q5	PR332	0	Lower	0
BMT Autologous Waitlist - Patients currently waiting > 6 weeks	PR186	0	Lower	1
% Cancer patients receiving radiation/chemo therapy treatment within 4 weeks of DTT	PR070	100%	100%	100%
% Chemotherapy patients (Med Onc and Haem) attending FSA within 4 weeks of referral	PR059	99.45%	100%	99.4%
% Chemotherapy patients (Med Onc and Haem) attending FSA within 2 weeks of referral	PR508	79.43%	100%	62.18%
% Radiation oncology patients attending FSA within 2 weeks of referral	PR509	46.01%	100%	53.17%
% Radiation oncology patients attending FSA within 4 weeks of referral	PR064	89.83%	100%	94.25%
% Patients from Referral to FSA within 7 days	PR180	24.49%	TBC	21.85%

Effectiveness				
Metric		**Actual**	**Target**	**Previous**
28 Day Readmission Rate - Māori	# PR079	**44.44%**	<=6%	50%
28 Day Readmission Rate - Pacific	# PR080	**36%**	<=6%	16.67%
28 Day Readmission Rate - Total	# PR078	32.05%	TBC	27.89%
28 Day Readmission Rate - Deprivation Scale Q5	# PR322	**51.35%**	<=6%	40%

Efficiency				
Metric		**Actual**	**Target**	**Previous**
% Day Surgery Rate	PR052	R/U	>=70%	R/U
Average LOS for WIES funded discharges (days) - Acute	PR219	4.64	TBC	5.15
Average LOS for WIES funded discharges (days) - Elective	PR220	0		0

Equitable:	Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.
Safety:	Avoiding harm to patients from the care that is intended to help them.
Patient-centred:	Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
Timeliness:	Reducing waits and sometimes harmful delays for both those who receive and those who give care.
Effectiveness:	Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
Efficiency:	Avoiding waste, including waste of equipment, supplies, ideas, and energy.

Amber	Variance from target not significant enough to report as non-compliant. This includes percentages/rates within 1% of target, or volumes within 1 value from target.
#	Actual is the latest available result prior to September 2020
R/U	Result Unavailable
	% Day Surgery Rate
	Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)
	Nosocomial pressure injury point prevalence (% of in-patients)
	Results Unavailable

Please note: Numbers for 28 Day Readmission Rates are small, and we will investigate further with the clinical teams to determine any trends/remediation needed

Surgical Directorate

Prepared by: Rebecca Stevenson (General Manager)
Speaker: Duncan Bliss (Interim Associate Director)

Kuputaka : Glossary

Acronym/term	Definition
DNA	Did Not Attract/Service Failed to Engage
Kaiārahi Nāhi	Nurse Navigator
NETP	Nursing Entry To Practice
SIOC	Surgical Integrated Operations Project

1. Kāwanatanga

- The Kaiārahi Nāhi rōpū have been walking alongside our Māori patients on their journey to surgery. To date, this rōpū have been providing support for adult surgical patients largely during the pre-admit and surgery stages of the surgical pathway. The Kaiārahi Nāhi rōpū have started to identify some of the system issues which lead to poor experiences and outcomes. Poor communication and poor patient experience due to interaction with service providers and/or services are the leading issues. A deeper dive into these issues has identified more detailed information which highlights opportunities to improve, learn and redesign for our Māori patients and whānau.
- As a Directorate we see an opportunity to support our teams to be involved in Te Tiriti o Waitangi in practice training sessions which are available through Te Toka Tumai.

2. Tino Rangatiratanga

- Appointments in Surgical Services this quarter have included three Māori (1 Medical; 2 Non-Clinical). Appointments of Māori are at a rate higher than the rate of applications which supports building a workforce which better reflects the communities we serve.
- Surgical Directorate has this quarter retained all current 21 Māori employees.
- Nursing Entry To Practice (NETP) Registered Nurses intake took place during October 2020. Māori candidates were prioritised to attend our assessment centres. In additon to Māori advocates being part of the assessment centre, our Kaiārahi Nāhi Hautū offered cultural knowledge and support on the day.
- Two members of our Surgical rōpū are our Champions for Māori patient experience. The role of our Champions include implementing the five truths of a gold standard Māori patient / whānau experience, monitoring Māori workforce participation and progression in our Directorate and applying Te Reo and Tikanga across our Directorate which includes the capability of our workforce to correctly pronounce Māori names and words.

3. Ōritetanga

- An equity adjusted weighting tool for surgical booking is being trialled in the Urology Service. Patients on the Urology surgical waitlist accumulate 'points' for the number days they are over the clinically appropriate target treatment time. Higher priority cases accumulate more points per day than lower priority. Māori patients receive an equity adjustor so they accumulate points at a higher rate. The Urology surgical waitlist is now ordered based on points and provides the booking team with the priority order in which to book patients onto operating lists.
- This tool is in the process of being developed in Ophthalmology and Orthopaedics before being developed for other services. Ophthalmology and Orthopaedics have been prioritised for implementation due to high volumes and the number of long waiting patients. In the meantime, an equity adjusted priority surgical waitlist report has been developed for all surgical services and is being used.

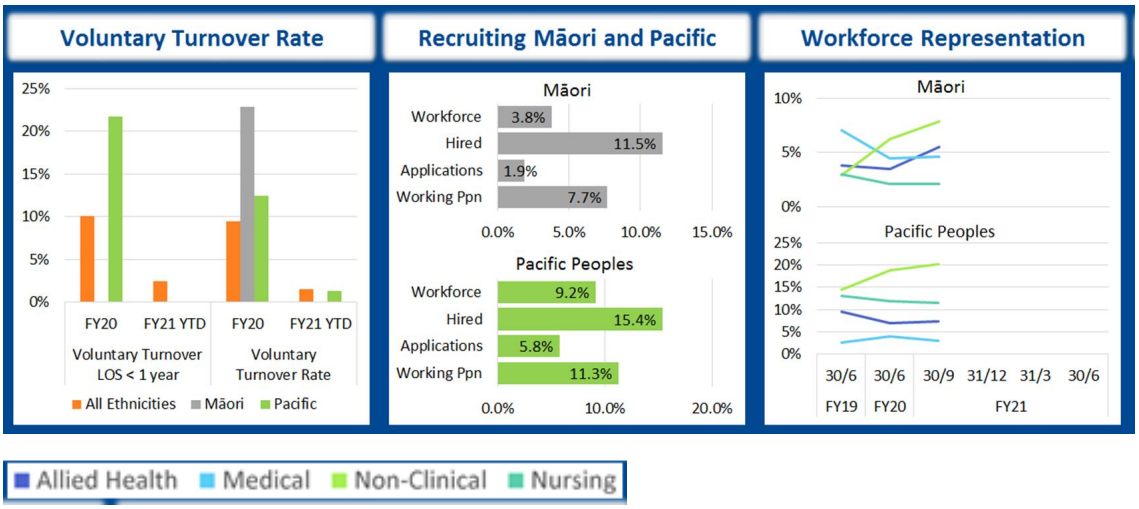
4. Te Ritenga

- During Te Wiki o Te Reo Māori, some teams started the surgical huddle in Te Reo and carried out introductions in Te Reo for the time-out. Some teams have continued to kōrero in Te Reo beyond Te Wiki o Te Reo Māori.
- As a Directorate we see an opportunity to support our teams to be involved in Tikanga in Practice and Te Tiriti o Waitangi in practice training sessions which are available through Te Toka Tumai.

5. Equity

- The Pacific Health Navigators are being utilised to improve the patient journey, identify and address system issues and barriers to access and reduce the waiting time, initially from wait listing to surgical treatment across all Surgical Services. The partnership between Surgical Services and the Pacific Care Navigation team is working very well to support our Pacific patients on the planned care pathway. Referrals to the Navigation team from Surgical Services are on the rise, many of which are direct referrals from Senior Medical Officers. The cultural knowledge and support that the Navigators can provide our Pacific patients is becoming more and more recognised and valued by surgical teams. In terms of intervention by point in the planned care pathway, the Navigators are largely involved at the time of pre-admission, booking and surgery. As the Navigation team has been established for five months, there are system insights that are becoming more prevalent which impact the planned care pathway for our Pacific patients which are engagement, opportunity and access. These insights will help consolidate what we have learned and systems changes that are required moving forward to improve the planned care journey for our Pacific patients.
- Within the Urology Service, Pacific patients also receive an equity adjustor so they accumulate points at a higher rate.

- The Patient Access, Booking and Choice policy for Te Toka Tumai is being reviewed at present by members of the equity group. The updated policy will be implemented by Surgical Services once revised.
- The Leading for Equity training programme has been completed by 3 people leaders in the Surgical Directorate. A focus is for all people managers to complete this course next quarter.
- For the NETP Registered Nurses intake, Pacific candidates were prioritised to attend our assessment centres.
- Appointments in Surgical Services this quarter have included four Pacific Peoples (1 Allied Health; 3 Non-Clinical). Appointments of Pacific Peoples are at a rate higher than the rate of applications which supports building a workforce which better reflects the cultural diversity of the communities we serve.
- One of our 79 Pacific employees resigned from Auckland DHB voluntarily during this quarter.

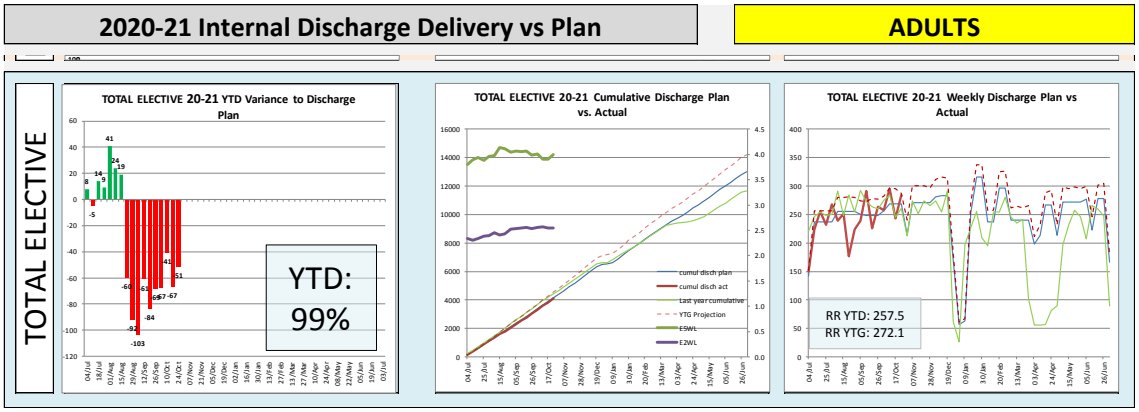


6. Exceptions

ESPI performance

- ESPI 2 and ESPI 5 performance has improved from August to September 2020.
- September ESPI 2 position is 367 for Surgical Services; this is an improvement of 177 patients. Our ESPI 2 position for our Māori and Pacific patients has improved for September.
    - DNA rate for outpatient appointments for all ethnicities has reduced to 5.99%. We have seen an improvement in our DNA rate for outpatient appointments for our Māori and Pacific patients for September (13.66% and 12.4% respectively) but both are still above the target of <=9%
- September ESPI 5 position is 715 for Surgical Services (836 for August 2020). The number of patients breaching ESPI 5 has reduced for our Pacific patients and has remained static for our Māori patients in September.

2020/21 Planned Care – Year to Date performance

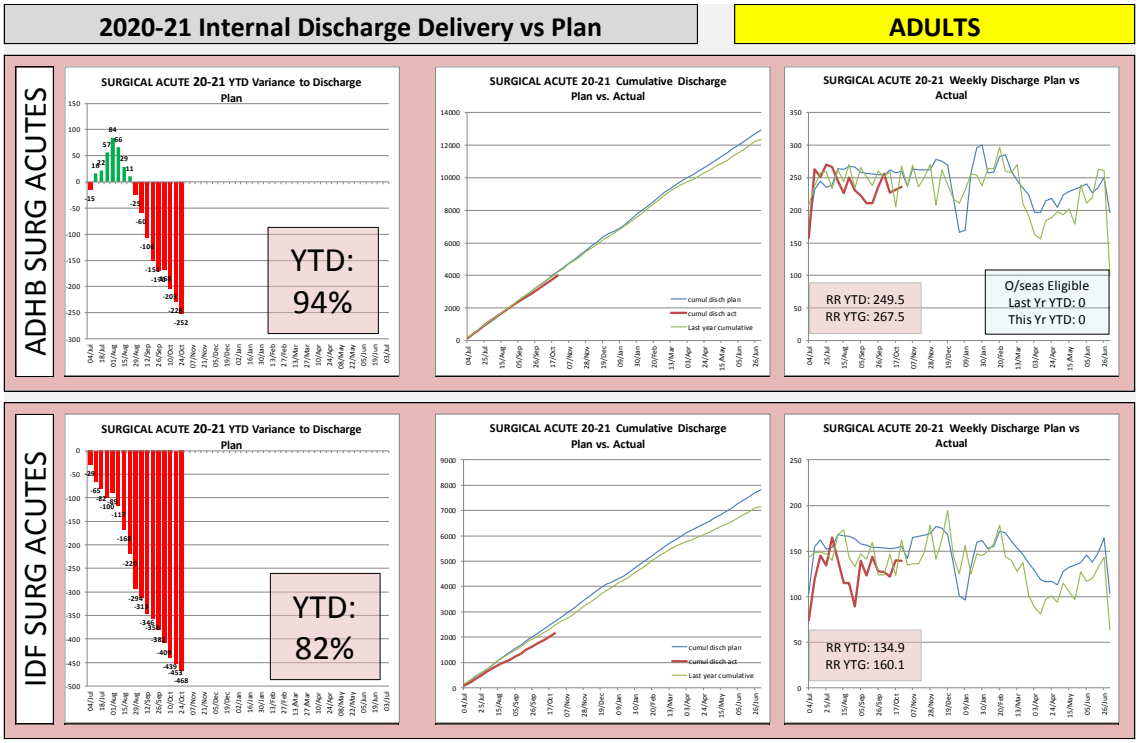


- Adult Surgical Services internal delivery against the PVS is currently at 99%.
- Work is currently underway to establish a scorecard to include performance against the Ministry of Health Planned Care Recovery Plans.
- A sprint for the Surgical Integrated Operations Project 2.0 (SIOC) is currently underway which will embed services improvements similar to those implemented at GSU earlier in the year.

Surgical Integrated Operations Project (SIOC) 2.0 Overview

- Timeline of <u>what</u> needs to be done by <u>when</u> prior to a theatre event (T-7).
- Agreement on who is responsible and accountable for those tasks (RACI).
- Reports and templates to show how we are doing against those tasks (leading indicators on session allocation and booking levels (OR Session Planner and TH70/69 reports).
- Weekly meetings to bring the right people (service, bookers and periop) together to review this and mitigate or escalate issues (SIOC meetings 8am Mon, 2-4pm Thurs).
- Retrospective review of performance to see how we did (T+1 report, cases and sessions report).
- Process to capture systemic issues, escalate them to be solved and track progress (System issues MOS board).

Acute performance



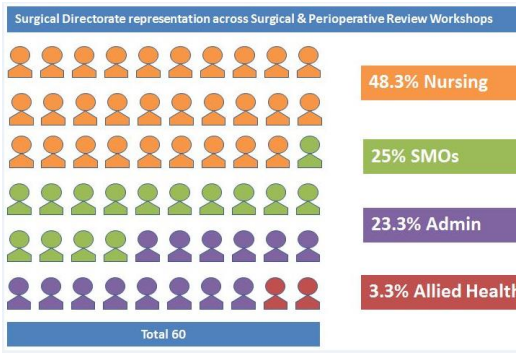
- There has been a significant reduction of acute presentations whilst Auckland was on COVID-19 Alert Level 3 in August 2020.
- As a result acute volumes for adult surgery are tracking lower than plan.
- Future planning in in place to increase planned care volumes further if there is a further impact of COVID-19 to acute volumes.

Surgical and Perioperative Review

- The Discovery Phase of the Surgical and Perioperative Review has progressed. Information gathering with leaders and employees regarding opportunities to move towards the review vision for the surgical patient care pathway commenced in September 2020. The review vision statements are:

    1. Quality outcomes and experiences for patients, whānau and employees
    2. Surgical system designed to achieve equitable outcomes; we deliver on our obligations under Te Tiriti o Waitangi
    3. We are united in our commitment and aligned in our approach to the surgical patient care pathway
    4. We take a systems approach to optimise long term solutions and eliminate siloed thinking and behaviour

- Engagement has been broad, as shown below. Deep dive workshops are scheduled to be completed in November.



- A Discovery Review Group has been established with 18 people representing professions across the two Directorates. The purpose of this group is to strengthen the diversity of leadership input and engagement in sense checking themes before reporting. Information gathering will be completed by the end of November 2020, with sharing themes with stakeholders to follow in January 2021.

6. Scorecard

Auckland DHB - Surgical Services

HAC report for September 2020

Equitable - equity is measured and reported on using stratification of measures in other domains

Safety

Metric		Actual	Target	Previous
Medication errors with major harm	*PR215*	0	Lower	0
Nosocomial pressure injury point prevalence (% of in-patients)	*PR097*	R/U		R/U
Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	*PR185*	R/U		R/U
Number of falls with major harm	*PR199*	0	Lower	1
Number of reported adverse events causing harm (SAC 1&2)	*PR084*	1	Lower	2
Unviewed/unsigned Histology/Cytology results >=30 days	*PR596*	34	Lower	67
% Hand hygiene compliance	*PR195*	**80.59%**	>=80%	86.81%

Patient-centred

Metric			Actual	Target	Previous
% Patients cared for in a mixed gender room at midday - Adult		PR175	40.69%	TBC	38.57%
% hospitalised smokers offered advice and support to quit		PR129	96.69%	>=95%	97.86%
% DNA rate for outpatient appointments - Māori		PR057	13.66%	<=9%	20.34%
% DNA rate for outpatient appointments - Pacific		PR058	12.4%	<=9%	16.58%
% DNA rate for outpatient appointments - All Ethnicities		PR056	5.99%	<=9%	8.79%
% DNA rate for outpatient appointments - Deprivation Scale Q5		PR338	8.94%	<=9%	13.84%
% Very good and excellent ratings for overall inpatient experience	#	PR154	88%	>=90%	88.7%
% Very good and excellent ratings for overall outpatient experience	#	PR179	90%	>=90%	90.2%
% Very good and excellent ratings for coordination of care after discharge	#	PR493	50%	>=90%	51.1%
% Response rate to ADHB patient experience inpatient survey		PR315	23%	>=25%	28%
Number of CBU Outliers - Adult		PR173	208	<=300	153

Timeliness

Metric		Actual	Target	Previous
31/62 day target - % of non-surgical patients seen within the 62 day target	PR181	94.59%	>=90%	98.39%
31/62 day target - % of surgical patients seen within the 62 day target	PR182	100%	>=90%	100%
62 day target - % of patients treated within the 62 day target	PR184	97.65%	>=90%	99.3%
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Māori	PR329	35	Lower	53
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Pacific	PR330	52	Lower	66
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Total	PR328	367	Lower	544
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Deprivation Scale Q5	PR332	81	Lower	119
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Māori	PR323	83	Lower	82
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Pacific	PR324	103	Lower	118
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Total	PR327	715	Lower	836
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Deprivation Scale Q5	PR326	191	Lower	218

Effectiveness

Metric		Actual	Target	Previous
28 Day Readmission Rate - Māori	# PR079	10.81%	<=6%	14.63%
28 Day Readmission Rate - Pacific	# PR080	10.66%	<=6%	11.81%
28 Day Readmission Rate - Total	# PR078	10.78%	<=10%	11.26%
28 Day Readmission Rate - Deprivation Scale Q5	# PR322	10.58%	<=6%	11.32%

Efficiency

Metric		Actual	Target	Previous
Elective day of surgery admission (DOSA) rate	PR048	83.15%	>=68%	77.92%
% Day Surgery Rate	PR052	55.69%	>=70%	52.19%
Average LOS for WIES funded discharges (days) - Acute	PR219	3.23	TBC	3.44
Average LOS for WIES funded discharges (days) - Elective	PR220	1.12	TBC	1.27
HT2 Elective discharges cumulative variance from target	PR035	0.98	>=1	0.96
Inhouse Elective WIES through theatre - per day	# PR053	61.52	TBC	65.1

Equitable: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Safety: Avoiding harm to patients from the care that is intended to help them.

Patient-centred: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

Timeliness: Reducing waits and sometimes harmful delays for both those who receive and those who give care.

Effectiveness: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).

Efficiency: Avoiding waste, including waste of equipment, supplies, ideas, and energy.

Amber	Variance from target not significant enough to report as non-compliant. This includes percentages/rates within 1% of target, or volumes within 1 value from target.
#	Actual is the latest available result prior to September 2020
R/U	Result Unavailable

Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)

Nosocomial pressure injury point prevalence (% of in-patients)

Results Unavailable

Perioperative Services

Prepared by: Nigel Robertson (Interim Director, Perioperative Services); Leigh Anderson (Nurse Director); Elizabeth Kanivatoa & Shirley Ray (Nurse Consultants); Prue Hames (Associate Nurse Director); Jay van der Westhuizen (Specialist Anaesthetist); Louise Bull (HR Manager); Tressy Menezes (Personal Assistant)
Speaker: Nigel Robertson (Interim Director, Perioperative Services)

1. Kāwanatanga

Kaupapa	*Tātou mahi tahi*	*Current status*	*Target state*
Tikanga whakaaro-Governance	**Te Tiriti Article 1: Governance. Ensuring Māori oversight and ownership of decision making processes necessary to achieve Māori health equity. Active partnerships with iwi and Māori communities will ensure that Māori health equity drives, and Māori knowledge informs, the work that we do at Te Toka Tumai**	*Focus point for perioperative services*	*Embedded in practice across directorate*
Kaiārahi Nāhi	Fast pathway to planned care in clinics and preadmission -prioritising and waiting time evaluation. Regular review of waitlist and working towards transparency for patients as to where they are in the process with more regular communication. Analysis of barriers to proceed to surgery- identifying and optimising health related barriers to surgery. Working closely with Kaiārahi Nāhi.	• Pathway made to send data straight to Kaiārahi Nāhi rōpū • Sharing of success stories and patient experiences	• Review in December 2020 with improvement plan to move forward • Strengthening relationships with Kaiārahi Nāhi
Workforce Hui	Perioperative Māori workforce hui feedback utilised as a guide for on-going actions such a signage, greetings and pronunciation of Māori names and place names. Hui was at Manawanui Marae and incorporated the community of Manawanui, kaumātua and the Māori Nurse Director was the facilitator.	• Asking for support to help with the hui and strengthening Māori staff connections	• Managers to start having professional development discussions with individual Māori staff
Te Reo	Perioperative leaders booked onto Te Wānanga o Aotearoa –Tikanga Papa Reo course to build up knowledge of Te Ao Māori to use every day with staff and patients.	• Using greetings with staff and in emails • Bilingual signage in the public spaces and on OR doors	• In progress with leadership • Action points for Tika Rōpū
Ko Awatea	Engaging with Māori training day to be added to mandatory learning for all staff.	• Review of mandatory training for staff	• Better staff engagement in Ko Awatea learning
Ngāti Whātua Iwi –Mana whenua	Building a relationship with Ngāti Whātua iwi and asking to have a hui to discuss how we can deliver better care to Māori in a system that is not set up to serve Māori and gain perspective of how health insurance is helping Ngāti	• In progress. Liaise with Lead of PEC and deputy chair of ADHB board Tama Davis as to who would we engage	• Improved integration of healthcare with ADHB for iwi and hapū. Aim for December 2020

	Whātua iwi and what we can replicate.	with at Ngāti Whātua Ōrākei	

2. Tino Rangatiratanga

Kaupapa	*Tātou mahi tahi*	*Current status*	*Target state*
Tikanga whakaaro: tino Rangatiratanga	**Te Tiriti Article 2. Self-determination. Creating opportunities for Māori leadership, engagement and co-design across all of our activities at Te Toka Tumai, especially those with the potential to impact Māori health**	*Focus point for perioperative service*	*Embedded in practice across directorate*
Equity immersion	Āhua Tohu Pokāngia Tika rōpū created from perioperative Māori workforce hui. Whakawhanaungatanga with 7 members working on creating space for equitable opportunities /processes for perioperative services. Using hui kawa from Tika rōpū to be used in each member's own forums. Starting and ending hui with karakia, whakawhanaungatanga- using pepeha. Leadership using tikanga in any space to demonstrate the direction and role modelling to their teams. Education on tikanga given from Tika Rōpū members at in-service education schedules and sharing the kaupapa of our rōpū. **CHALLENGES**: trying to get communications out and connecting to all our people.	• Hui kawa/meeting protocol • Leadership role modelling hui tikanga and kawa as normalisation • Being more connected with the staff at the clinical frontline	• Monthly action points seen by staff • Design about communication strategies to reach all our people
Optimal health for surgery	The required HbA1c level and hypertension management for optimal non-urgent elective surgery working with the improvement team to reach out to the community and the GP's to commence optimisations earlier in the patient's surgical pathway-upon FSA.	• Project team established to analyse barriers to planned care , including GP, diabetes specialist and whānau/ consumer advocate	• Reduce deferral or suspension of planned care and improve patient care through early intervention
Surgery cancellations	Data showing higher rates of day of surgery cancellations in Māori and Pacific groups. Having data sent straight from data analysts daily and weekly to Kāiarahi Nāhi rōpū of surgery cancellations for Māori. **OPPORTUNITIES:** To keep working towards reducing cancellations for Māori patients.	• Process established to refer Māori and Pacific patients cancelled for surgery to navigators	• Reduced cancellations in Māori and Pacific population groups to be reported

3. Ōritetanga

Kaupapa	*Tātou mahi tahi*	*Current status*	*Target state*
Tikanga whakaaro- Ōrietetanga	**Te Tiriti Article 3. Equity. Demonstrating our performance in the pursuit of Māori health equity for key Māori health areas. Presenting meaningful and insightful information to Māori will support, guide and target our work at Te Toka Tumai to make advances in Māori health**	*Focus point for perioperative services*	• MoH equity posters up in spaces • Equity focus on top of agenda of quality hui
Prioritisation visible	Patients who are prioritised are identifiable on every OR elective list and all clinicians should understand coded data and provide the care that is needed to enhance Māori health outcomes.	• Patient booking grids reviewed and improved. E4P will reduce gaps in booking and scheduling • Review of prioritisation regularly and ensuring on all elective lists	• All Māori patients prioritised appropriately and with clarity • In progress will need review by February 2021
Review of pre-admit clinics	Strategies initiated with text messaging, letters about surgery on day. Review of patient information and plan to make bilingual is stalled due to PEC process.	• Fast Pathway to Planned Care project • My operation booklet translation	• Engaged with navigator team. Clear understanding of per-admit process for patients • All patient information available in Te Reo Māori

*****Appendix1. Percentage cancellation report by Māori patients comparing period Jul-Oct for the past four years***

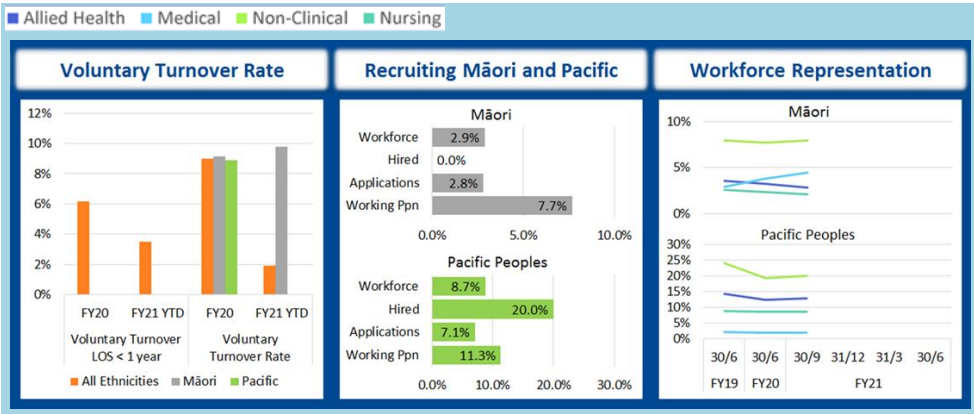
4. Te Ritenga

Kaupapa	*Tātou mahi tahi*	*Current status*	*Target state*
Tikanga whakaaro: Te Ritenga	**Te Tiriti Article 4. Right to belief and values. Honouring the beliefs and values of Māori patients, staff and communities. The services we fund and provide at Te Toka Tumai honour the right of Māori to practise tikanga Māori**	*Focus points for perioperative services*	*Embedded in practice across directorate*
Tikanga practices	Karakia being respected alongside the OR team working with the patient. Karakia conducted on the ward or in the OR so team looking after patient included in tikanga practice of karakia. When karakia	• Already in practice for meetings • Quality team setting up process for the ORs • Efforts by staff to	• Surgeons leading this to date • Support staff how to coordinate this care

	occurs in the OR this is conducted before the sign in (surgical safety checklist component).	respect cultural requests and team able to meet these needs with ward and whānau	
Tissue for return	Return of tissue (whenua/placenta or any tissue) is expedited so if Māori patient/whānau requests this and does not need to go to laboratory for testing there is a process for return immediately following surgery. Process of return of tissue following laboratory examination is per our kawa/protocol and patient/whānau given information in regard to this.	• Already in practice. Ongoing education of staff • Consent process followed through with whānau request to take immediately or information of collection process	• Maintain and enhance current practice • Need to liaise with ward as to information pamphlet given and discussed
Whānau support	Whānau support in delivery suite encouraged in OR next of kin supported to be part of birth experience. When whānau needed in PACU this is encouraged usually with all tamariki and some situations as needed but is usually due to space.	• Already in practice • Whānau included in care in a partnership role	• Maintain and enhance current practice
Forensics instrumentation	Instrumentation pathway via CSSD for forensic services went through senior leadership to mitigate the Māori cultural kawa /tikanga concepts of tapu and noa. Tautoko and manaaki was shown throughout the process of finding better solutions, still supporting forensic services.	• Issue identified in April 2020 and litigated with clinical support • Forensics have stopped previous practice through CSSD	• Mutually agreeable solution agreed and enacted • Ongoing CSSD support to find a suitable solution for forensic instruments by December 2020
Care of Tūpapaku	Māori tikanga alongside Te Toka Tumai guidelines for care of Tūpapaku. Tūpapaku not to be left alone. Whānau able to view their loved one in an appropriate space and be with them with their whānau. Karakia /blessing performed upon patient leaving the OR to honour and respect the patient and whānau , staff involved and all the future patients who will use the OR (tapu and noa).	• Already in practice but requires ongoing staff education and review of information pack • Tikanga upheld for tūpāpuku and karakia in OR. • Whānau made welcome part of process in private area	• Maintain and enhance current practice • Frontline staff conducting karakia/blessing • Tūpāpuku resource box with standardised blessing • Chaplain availability if no staff available

5. Equity

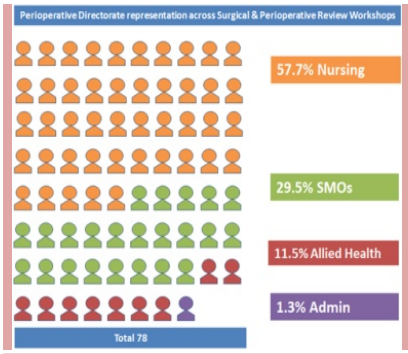
Tikanga whakaaro	*Tātou mahi tahi*	*Current status*	*Target state*
ADHB Values	**Welcome – Haere Mai** **We are welcoming of patients and their families/whānau/supporters at all times.** We greet patients and their familes/whānau in a manner that is culturally appropriate. We use 'equity-based practice' to work with families/whānau to identify and support what is already working well for them and to build on these. **Challenges**: Level of understanding of Te Ao Māori not up to level it should be.	• Immerse into staff orientation • Used in professional development discussions	
	Respect – Manaaki **We respect people's inherent dignity and the responsibility we have to act in a way that is caring and respectful of others' beliefs and culture.** We partner with patients and their families in all aspects of care, and support patients and their families/whānau to identify goals and care aspirations. We champion the voice of patients and families/whānau at all levels of organisational decision-making. We work in partnership with the women and their families/whānau in a relationship of trust, shared decision-making and responsibility, negotiation, and shared understanding.	• Living our ADHB values in all our mahi	
	Together – Tūhono **We encourage and welcome togetherness, and family/whānau involvement in the planning, implementation and evaluation of care.** We support patients and families/whānau to navigate the healthcare system and create the opportunity to gain confidence in our service and care. We ensure that a patient's safety is a significant consideration in their healthcare journey and that where patients are unable to voice their concerns, families/whānau/supporters can act in their interests.	• Using concept and waiata of "Tutira mai ngā iwi "to extend unity and collectivism	
	Aim High – Angamua **We aim to provide patient and family/whānau centered models of care that deliver the outcomes important to patients and their families/whānau**.	• Celebrating our successes and sharing with all our people. • Aiming to	

	We ensure the needs of patients and families/whānau are at the centre of new developments in service design and provision. We work in collaboration with colleagues to explore innovative models of practice that improve patient and family/whānau determined. Outcomes, and redress inequalities in access and service provision.	understand concepts of Te Whare Tapa Whā • Look at the Meihana Model for clinician/patient interactions	
Wellness	Development of information on perioperative/anaesthesia web pages and the identification of staff welfare officers within each department.	• Incorporate the Kia Ora Tō Wāhi Mahi - look at tool - to fit with our team	
Planned care Māori and Pacific nurse specialist navigators	Building relationships and working closely with these teams. Getting expert cultural specific nursing advice on how to achieve equity and what we can do better. Appointments this quarter have included three Pacific Peoples (1 Medical; 1 Nursing; 1 Allied Health). Appointments for Pacifc candidates are at a rate higher than the rate of applications for the priority pools. This is the desired approach to increase representation in the workforce for both Māori and Pacific. Perioperative Directorate has this quarter **retained** all current 67 Pacific employees and 2 of the 20 kaimahi Māori (staff) resigned voluntarily from ADHB. The **Leading for Equity** training programme has been completed by 1 of the 42 People Leaders in the Perioperative Directorate. Directorate senior leaders are aware of their reponsibility to complete the training programme and we will continue to monitor and report progress.	• Continue to strengthen relationships • Learn and share the barriers for our Māori and Pacific patients	
		

Welcome greeting words	Poster to be placed in clinical areas, ORDA , pre-op in regard to identifying Māori and Pacific ethnicity on front sheet and matching by using appropriate greeting. This reaffirms the haere mai ADHB value- I welcome you, I see you and your whānau are welcome too.	• Start using greeting words • Post up "greet people in their language" poster created by GSU CN and team administrator	
Pronunciation of Māori and Pacific names	Asking how to say a person's name and making the effort to say it. Using the Māori AkeAke app to learn sounds. Not feeling whakamā (ashamed/shy) to speak Māori , encouraging and supporting learning te reo.	• Don't be whakamā to korero Māori	

6. Exceptions

Kaupapa	*Tātou mahi tahi*	Current status	Target
Surgical & Perioperative services review	ADHB project to establish a strategic leadership structure for the Surgery and Perioperative Services Information gathering with employees in relation to the Vision statements for the surgical patient care pathway started in September 2020. The Vision statements are: 1. Quality outcomes and experiences for patients, whānau and employees 2. Surgical system designed to achieve equitable outcomes; we deliver on our obligations under Te Tiriti o Waitangi 3. We are united in our commitment and aligned in our approach to the surgical patient care pathway 4. We take a systems approach to optimise long term solutions and eliminate siloed thinking and behaviour 	• Interim Director group leading the directorates and stakeholder process underway • A Discovery Review Group was established with 18 people representing professions across the two directorates to strengthen engagement and validate themes for reporting.	• Information gathering will be completed by the end of November and sharing themes with stakeholders to follow through January • Final recommendations to executive by June 2021

			
Funding	Fiscal envelope constrained. Major equipment fleet ageing and starting to fail. Capex process to replace equipment such as OR tables, OR lights, microscopes, endoscopic equipment, guidance systems.	• Major Capex request list signed off last week. Significant progress	• Replace all significantly ageing/failing major equipment items on capex list by Q4 2020/21
Institutional racism	Systems and processes not set up to engage all patients/ clients, especially Māori.	• Equity lens on planned care. Staff training and systems reviews	• Strengthen staff training through Ko Awatea. Links to primary and iwi based organisations
System design	Patient preparation for surgery still relatively inflexible. Telehealth not used optimally. Patients and whanau find navigating process challenging at times, with delays and poorer outcomes.	• Working with Kaiārahi Nāhi rōpū to develop better pathways and navigation of process. Establishing better partnerships with primary care and iwi- based healthcare	• Better compliance on wait times for surgery, fewer late cancellations and better surgical outcomes for Māori
COVID-19	Disruption to planned care service. Major risk to staff and anxiety during lock-down. Ongoing complex pathways to manage for actual or potential cases. Planned care recovery now in progress but capacity constraints exacerbated. Staff turnover / hiring impeded by labour market.	• OR's delivering normal to increased volumes. Staff much better trained. Long-term change embedded in practice	• Complete planned care recovery project. Keep staff safe and well in event of another community outbreak • Embed new safe practices for dealing with hazards in the OR
Transplant services	Increasing volumes of solid organ transplant, especially renal transplant in 2020. Resource required is time sensitive and cannot flex up to manage the demand. This is an equity issue, as Māori patients are highly represented as recipients of transplant grafts.	• Renal transplant, especially at the weekend, leads to deferral of routine unplanned work	• Budget FTE approved for increasing OR weekend capacity from March 2021 to mitigate the risk of procedures being deferred

7. Scorecard

Auckland DHB - Perioperative Services

HAC report for September 2020

Equitable - equity is measured and reported on using stratification of measures in other domains

Safety

Metric		Actual	Target	Previous
Medication errors with major harm	PR215	0	Lower	0
Number of reported adverse events causing harm (SAC 1&2)	PR084	0	Lower	0
% Hand hygiene compliance	PR195	68.45%	>=80%	82.35%
Wrong site surgery	PR255	0	Lower	0

Patient-centred

Metric		Actual	Target	Previous
Number of complaints received	PR085	3		0
Number of compliments received	PR336	R/U		R/U

Timeliness

Metric		Actual	Target	Previous
% Cases with unintended ICU / other area stay	PR258	0.63%	<=3%	0.45%
% CSSD incidents	PR260	4.61%	<=2%	4.03%
% Acute index operation within acuity guidelines	PR254	85.94%	>=90%	88.33%

Effectiveness

Metric		Actual	Target	Previous
% 30 day mortality rate for surgical events	PR259	0.3%	<=2%	0.31%
% Patients with Hypothermia in PACU	PR271	3.72%	<=1%	0.9%
% Patients with PONV in PACU	PR272	2.22%	<=5%	2.28%

Efficiency

Metric		Actual	Target	Previous
% Elective sessions planned vs actual	PR261	95.18%	>=97%	88.98%
% Adjusted theatre utilisation - All suites (except CIU)	PR262	84.42%	>=85%	82.28%

Equitable:	Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.
Safety:	Avoiding harm to patients from the care that is intended to help them.
Patient-centred:	Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
Timeliness:	Reducing waits and sometimes harmful delays for both those who receive and those who give care.
Effectiveness:	Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
Efficiency:	Avoiding waste, including waste of equipment, supplies, ideas, and energy.

Amber	Variance from target not significant enough to report as non-compliant. This includes percentages/rates within 1% of target, or volumes within 1 value from target.
R/U	Result Unavailable

Number of compliments received

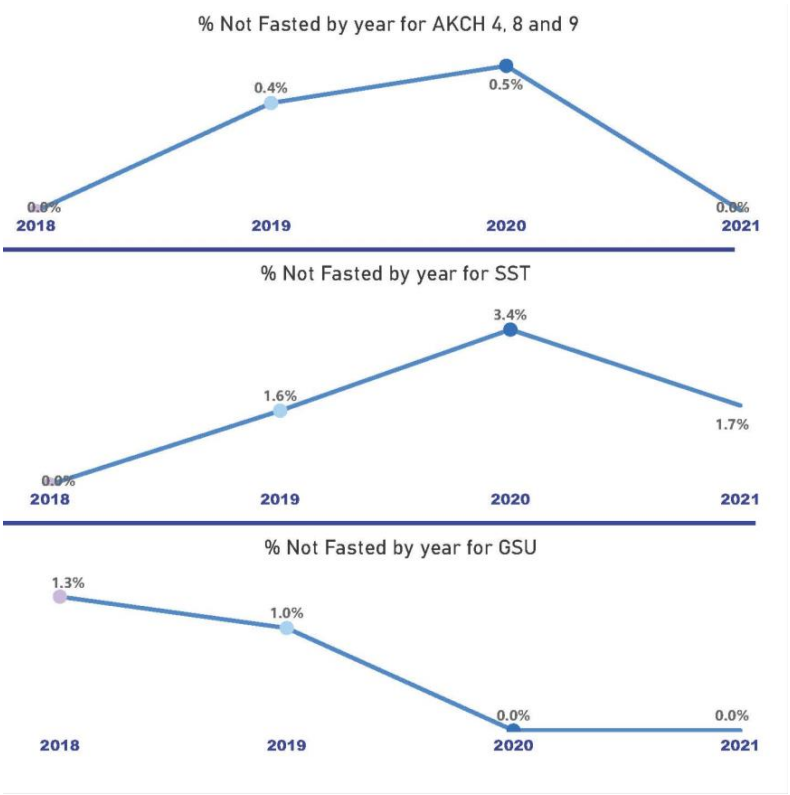
Results Unavailable

Scorecard Commentary

- There were 5 medication incidents reported for September 2020. Each department holds a monthly quality meeting where all incidents are reviewed and investigated. This is monitored by a directorate quality meeting where any recurring trends are reviewed and action plans agreed as necessary.
- Hand hygiene compliance is good overall. The gold auditor training was held with a 90% success rate, a working group has been put to focus on targeting the poorer performing groups and develop strategies to improve the compliance rate
- There were 3 complaints received for Perioperative services for September 2020.
- No Severity Assessment Code (SAC 1) or (SAC 2) incidents, and 2 always report and review (SAC 4) were reported in the three months from 1 July to 30 September 2020.
- Recommendations from previous Root Cause Analysis have been implemented. Formal auditing of the surgical safety check list is ongoing, with good rates of engagement and compliance.
- CSSD incidents are up due to production pressure as a result of vacancies. Recruitment is underway.

8. Appendix1. Percentage cancellation report by Māori patients comparing period Jul-Oct for the past four years

Groups with <100 cases have been excluded



Patient and Whānau Voice – Patient and Whānau Centred Care Framework for Auckland DHB

Recommendation

That the Hospital Advisory Committee:

1. **Receives the report.**
2. **Endorses the suggested approach to developing a framework for patient and whānau centred care.**

Prepared by: Vanessa Duthie (Māori Patient and Whānau Experience Lead, ADHB); Jane Drumm (Co-Chair, Patient and Whānau Centred Care Council), Iani Nemani (Patient and Whānau Advisor, Patient and Whānau Centred Care Council)
Endorsed by: Mark Edwards (Chief Quality, Safety and Risk)

1. Executive Summary

Historically Auckland DHB held Planetree certification enabling access to resources that support the practical application of the Planetree person-centred care domains and criteria. Auckland DHB's Planetree certification lapsed but there was also a desire to more strongly orientate towards indigenous rights, approaches and outcomes rather than retro-fit these to an inherently western framework. This sentiment is being echoed at other DHBs around the country and work to collectively progress a Te Tiriti o Waitangi framework for patient and whānau centred care is in its infancy. The current Auckland DHB Patient and Whānau Centred Care Council structure has enabled Māori participation; its activities and strategic planning have engaged with Māori and prioritised Māori patient and whānau issues through collective decision-making. Supporting Auckland DHB to continue its journey to becoming a patient centred-care organisation requires both upholding Te Tiriti o Waitangi and exploring alignment with international best practice. A suggested approach to developing a framework is described.

2. Background

Planetree International is a not for profit organisation that has partnered with over 700 healthcare organisations in 25 countries for over 40 years. It is a mission based institute transforming how care is delivered across the care continuum. It emphasises the quality of human interactions that occur within health care settings, the importance of connecting healthcare personnel to the purpose and meaning of their work, and practical strategies for engaging patient and family members as true partners in their care and treatment.

In summary, the purpose of this programme is to provide a structured, operational framework for evaluating the organisational systems, processes and practices necessary to achieve the aim of improving quality, patient loyalty and staff engagement by building a continuously learning person-centred organisational culture driven by the voice of the patients (Planetree, 2017).

In 2018, Auckland DHB had been a member of Planetree international for over six years paying an annual subscription to access a range of online resources supporting practical strategies to enable person centred care.

As part of the identification and exploration phase of the Auckland DHB patient and whānau centred care (PWCC) strategic priority, key staff attended the annual international Planetree conference in October 2018 to explore the applicability of the Planetree criteria and certification programme for Auckland DHB.

From there, gaps were identified around the ability or capacity of the Planetree programme to comprehensively support an organisation to better serve its indigenous population. There were few tangible outcomes specific to indigenous peoples, nor narrative about the presence of indigenous peoples, their needs being well understood, or their care preferences being met to a high standard.

This is at odds with the current policy and practice of the PWCCC, where its documentation (Terms of Reference) and activities (a new Community of Practice around Champions of Māori Patient and Whānau Experience) point to the honoured place of Māori as Tangata Whenua, and processes including recruitment and engagement consistently consider the aspirations, norms and priorities of that group.

3. Response

Te Tiriti o Waitangi provides in and of itself a framework for patient and whānau centred care practice that has not yet been adopted for this purpose in earnest by DHB consumer councils despite being referred to by many.

A Te Tiriti o Waitangi analysis of the Planetree framework could help develop a bespoke approach to patient and whānau centred care for DHBs in Aotearoa/New Zealand. The table below is a very early version which shows the concept of mapping Te Tiriti articles to the Planetree framework. This will provide the basis for an approach to discussions and workshop for the PWCCC to grapple with towards having our framework reflect our practices in relation to Māori in our Auckland DHB context.

4. Conclusion

Auckland DHB's Patient and Whānau Centred Care Council has recognised the need to develop and adapt international patient and whānau centred care frameworks to consider indigenous populations. The council is working to develop a bespoke alternative, based on Te Tiriti o Waitangi and reflective of its current policy and practice with respect to upholding those obligations. This work is in its infancy but presents an opportunity to further influence and support the organisation to undergo the culture shift necessary to becoming a patient centred care organisation.

Appendix 1.

DRAFT Te Tiriti o Waitangi based patient and whānau centred care framework for Auckland DHB

		Te Tiriti o Waitangi Articles			
		Wāhanga 1: Kāwanatanga	Wāhanga 2: Tino Rangatiratanga	Wāhanga 3: Ōritetanga	Wāhanga 4: Te Ritenga
Planetree International 5 guiding principles	**Create organisational structures that promote engagement**	Description to be added	Description to be added	Description to be added	Description to be added
	Connect values, strategies and actions	Description to be added	Description to be added	Description to be added	Description to be added
	Implement practices that support partnership	Description to be added	Description to be added	Description to be added	Description to be added
	Know what matters	Description to be added	Description to be added	Description to be added	Description to be added
	Use evidence to drive improvement	Description to be added	Description to be added	Description to be added	Description to be added

Appendix 2.

Membership of Auckland DHB Patient and Whānau Centred Care Council as at 2 November 2020

Ours is unique amongst other DHB consumer councils for its level of Executive Leadership Team and Senior Leadership Team representatives including the Chief Executive Officer. Patient and Whānau Advisors recognise and value the opportunity to influence and input into strategic conversations through sharing insights directly and networking together with these Staff Members.

Resolution to exclude the public from the meeting

Recommendation

That in accordance with the provisions of Clauses 32 and 33, Schedule 3, of the New Zealand Public Health and Disability Act 2000 the public now be excluded from the meeting for consideration of the following items, for the reasons and grounds set out below:

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
1. Karakia Attendance and Apologies	N/A	N/A
2. Conflicts of Interest	As per that stated in the open agenda	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3. Confirmation of Confidential Minutes 7 October 2020	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4. Confidential Action Points	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.1 Women's Health Review – Verbal Update	**Privacy of Persons** Information relating to natural person(s) either living or deceased is enclosed in this report. **Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

	made public [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time [Official Information Act 1982 s9(2)(k)]	
6.1 Major Risk & Issues – Verbal Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public. **Prejudice to Health or Safety** Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time. **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time [Official Information Act 1982 s9(2)(k)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.1 Clinical Quality & Safety Report	**Prejudice to Health or Safety** Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time. **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time [Official Information Act 1982 s9(2)(k)] **Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]