AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Hospital Advisory Committee Meeting

Wednesday, 07 October 2020

8:30am

Via Zoom

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Published 1 October 2020

Agenda
Hospital Advisory Committee
07 October 2020

Venue: Zoom Only
Auckland City Hospital, Grafton

Time: 9:45am

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

8.30am **1. Karakia**

Attendance and Apologies

Members:

Executive Staff : Meg Poutasi, Shayne Tong, Debbie Holdsworth, Karen Bartholomew

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 18 March 2020**

4. Action Points 18 March 2020

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

5.1 Provider Arm Operational Update (Jo Gibbs)

	5.2	Financial Update (Justine White)
	5.3	Care Navigators Progress Update – Report & Presentation (Dawson Ward, Clinical Nurse Specialist Lead – Kaiārahi Nāhi Hautū Pauline Fakalata, Nurse Lead – Pacific Planned Care Navigation Project)
	5.4	Patient & Whānau Voice – Report & Presentation (Vanessa Duthie Māori Patient & Whānau Experience Lead, Ara Manawa, James Hita Patient and Whānau Centred Care Council Advisor, Jane Drumm, Patient and Whānau Centred Care Council Advisor)
9.35am	**6.**	**RESOLUTION TO EXCLUDE THE PUBLIC**

Next Meeting:	Wednesday, 18 November 2020 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		
Joanne Agnew (Deputy Chair)	1	1	c	c	c	c		
Michelle Atkinson	1	1	c	c	c	c		
Doug Armstrong	1	1	c	c	c	c		
Bernie O'Donnell	1	1	c	c	c	c		
Michael Quirke	1	1	c	c	c	c		
Peter Davis	1	1	c	c	c	c		
Zoe Brownlie	1	1	c	c	c	c		
Fiona Lai	1	1	c	c	c	c		

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	Director – Belong Director - GenderTick Partner – CAYAD, Auckland Council	20.07.2020
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
18 March 2020

Minutes of the Hospital Advisory Committee – Provider Equity meeting held on Wednesday, 18 March 2020 in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton commencing at 1.30pm

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 (via Zoom)	Mark Edwards	Chief Quality, Safety and Risk Officer
Michelle Atkinson	Joanne Gibbs	Director Provider Services
Zoe Brownlie (via Zoom)	**Auckland DHB Senior Staff Present**	
Peter Davis	Duncan Bliss	General Manager Perioperative Directorate
Fiona Lai	Ian Costello	Director of Clinical Support Services
Bernie O'Donnell	Mr Arend Merrie	Director Surgical Services
Michael Quirke (via Zoom)	Dr Robert Sherwin	Director Women's Health
Also Present	Abel Smith	Acting General Manager, Pacific Health
Ian Ward (via Zoom)	Dr Michael Stewart	Director Cardiovascular
	Dr Richard Sullivan	Director Cancer and Blood and Deputy Chief Medical Officer
	Marlene Skelton	Corporate Business Manager
	(Other staff members who attend for a particular item are named at the start of the minute for that item)	

1. KARAKIA/APOLOGIES

Bernie O'Donnell led the Committee in a Karakia.

The Following apologies were received from members of the Executive Leadership team; Margaret Dotchin, Chief Nursing Officer, Dr Debbie Holdsworth, Director of Funding – ADHB/WDHB, Rosalie Percival, Chief Financial Officer, Meg Poutasi, Chief of Strategy, Participation and Improvement, Shayne Tong, Chief Digital Officer, Sue Waters, Chief Health Professions Officer and Dr Margaret Wilsher, Chief Medical Officer and senior staff member, Rachel Lorimer.

2. REGISTER AND CONFLICTS OF INTEREST

Bernie O'Donnell requested the following change to be made to his interest register: "Member Alcohol and Additions Reference Group, Department of Corrections", to be added.

There were no other conflicts of interest with any item on the open agenda.

3. CONFIRMATION OF MINUTES 12 February 2020 (Pages 8-18)

Resolution: Moved Fiona Lai / Seconded Zoe Brownlie

That the minutes of the Hospital Advisory Committee for 12 February 2020 be rconfirmed as a true and correct record.

Carried

4. ACTION POINTS (Pages 19)

The action "inpatients with Social Complexity – Deep Dive" was closed due to the new focus to be applied to Advisory Committee business.

5. PERFORMANCE REPORTS

5.1 Provider Arm Operational Performance – Executive Summary (Pages 20-23)

Jo Gibbs, Director Provider Services asked that the report be taken as read, advising that the COVID 19 response had been of significant impact on the Provider Arm.

Jo drew attention to the following:

- The target was not met by the Adult Emergency Departments during January 2020 (80.42%). During February, investment had been made (as per budget) for the commencement of the POD model. Some improvements in the AED waiting times was expected (although overall flow will not be impacted by this investment).
- Performance against the MRI target of 95% of referrals completed within six weeks had improved in February 2020 to 42.1% (41.8% general and 50.9% for Cardiac MRI) compared to performance in January 2020 of 34.8%. There is still a significant gap between wait times, and the National target.
- Work is underway, jointly with the Planning and Funding team to submit a business case to the Ministry of Health for the commencement of Bowel Screening during 2020, as per the National Programme.
- The development of a Surgical Integrated Operations Centre to provide visibility of current processes and identify opportunities to ensure operating rooms at Greenlane Surgical Unit (GSU) are effectively used increasing throughput, are now largely complete.
- The BFTF Programme and Tranche 1 cases have been approved by the Board and will be presented for further regional and CIC endorsement for Crown funding.

There were no questions.

Resolution:

That the Hospital Advisory Committee receives the Provider Arm Operational Performance – Executive Summary for March 2020.

Carried

5.2 Provider Arm Scorecard (Pages 20-25)

Jo Gibbs, Director Provider Services asked that the report be taken as read.

The following point was raised in discussion:

- Bernie O'Donnell drew attention to page 24 of the agenda and the DNA rate for Māori not being met asking for a future discussion on how this issue might be tackled and enable equity to be met.

Resolution:

That the Hospital Advisory Committee receives the Provider Arm Scorecard for March 2020.

Carried

[Secretarial Note: Item 5.4 was considered next.]

5.3 Cancer and Blood Directorate (Pages 26-34)

Dr Richard Sullivan, Director Cancer and Blood and Deputy Chief Medical Officer asked that the report be taken as read and invited questions.

- The "percentage of day surgery rate" currently showing as zero was questioned. If it was not done then it should not be incorporated in the report.
- Jo Gibbs drew attention to page 28 of the agenda and the initiatives around and the success of a recent Greenbelt project. This work showed a demonstrable reduction in the 'did not attend' rate for first specialist appointment for Māori and Pacific patients, based within the breast tumour stream, which had the ability to transfer attributes of that work to other tumour streams.
- Bernie O'Donnell was given a brief overview of the newly established Cancer Control Agency which leads the National Cancer Programme. This independent agency is hosted by the Ministry of Health and is tasked with putting equity first, ensuring every New Zealander has the same access to high quality screening and care. Ailsa Claire as lead CEO for Cancer, Chair of the Cancer Health Information Strategy Group and Chair of the Northern Region Cancer Governance Group and Dr Richard Sullivan as Director Cancer and Blood Directorate, Director Cancer Outcomes Auckland District Health Board and the Director of the Northern Cancer Network are members of the Agency. There are three Māori and three non - Māori members. The Agency has met twice and is still in the forming stage.

  Ailsa as Chair of the Northern Region Cancer Governance Group also supplies a regional lens. Ailsa advised there is a need for a stronger line of sight between regional and national agencies.
- Ian Ward was advised in relation to the completion time for the Brachytherapy Bunker development project that the design phase had been finalised and the business case is due to go CAMP. Final completion time cannot yet be determined

given COVID-19, and the impact on National and local capital budget allocations.

[Secretarial Note: Item 5.5 was considered next.]

5.4 Cardiovascular Directorate (Pages 35-47)

Dr Michael Stewart, Director Cardiovascular asked that the report be taken as read, highlighting key points as follows:

- In relation to equity it was pleasing to see a growing Māori and Pacific workforce as reported on page 39 of the agenda. A hui within the cardiovascular service for Māori nurses was recently held that was aimed at networks which supported their professional and personal development. The nurses are looking at a future work plan for themselves and for patients through different pathways.
- A project underway that encourages Māori patients to attend heart clinics is the result of an earlier Greenbelt project.
- A commencement of a 6-month pilot of extended hours in Ward 31 to increase the day stay volumes for EP and angiography patients began in January. Senior staff have volunteered to help staff during the pilot phase to ensure that this can be done within existing staffing.
- A full time permanent SMO has been successfully recruited into the Vascular Service and to commence in early March 2020 and there have been appointments into the SCD roles for Cardiology and CTSU.
- Of concern is that the service continues to be challenged in meeting PVS volumes and the revenue position reflects a year to date result of $5.13M U. The service is working with the leadership team to ensure every opportunity for full utilisation of lists is happening with escalation plans in place for cancellations across the directorate. Recovery plans are in place to deliver the increased productivity that is required to improve this position, although these are challenged by acute demand, industrial action in CIU, and SMO and allied health workforce shortages.

The following points were raised in discussion:

- There was a brief discussion around cardiology procedures, in particular day stay volumes and appropriate day stay pathways. This was seen as one way to be able to see more Auckland patients. There was some discussion around the range of accommodation options available for those requiring to stay the night before surgery with it being noted that for those coming from out of Auckland there is currently the option of Te Whare Awhina and Ronald McDonald House. The issue of funding these new pathways has still to be resolved.
- Peter Davis commented that late start times as referred to on page 38 of the agenda must be costing the DHB a considerable amount. Advice was given that reasons for late starts were many and varied. The current PIMs system works well but its age prohibits easy modification so the issue remains difficult to resolve.
- Peter Davis commented that he did not see that the DHB was responsible for the

readmission rates. Once a person had been discharged assistance should be available from within the community. Dr Michael Stewart advised that the DHB had some responsibility to ensure a patient was not readmitted particularly in ensuring that they are treated correctly on the occasion of the first admission.

[Secretarial Note: Item 5.3 was considered next.]

5.5 Clinical Support Services (Pages 48-59)

Ian Costello, Director of Clinical Support Services asked that the report be taken as read, advising as follows:

- There is concern around MRI capacity. Recent approval was gained to outsource 1100 scans. Other imaging modality is still in strike recovery mode.
- The Lab and Radiology accreditation audit was recently held with no major issues being identified. Forensic Pathology Services completed their audit yesterday and only minor corrective actions were identified.

5.6 Perioperative Services Directorate (Pages 60-68)

Duncan Bliss, General Manager Perioperative Directorate asked that the report be taken as read, highlighting the following key point:

- That single instrument tracking a project that had featured in reports for the last 8 years was now completed with all instruments being bar coded. It has however been discovered that the silver nitrate in the water does degrade the bar codes and it is being investigated how this can be remedied.

The following points were raised in discussion:

- Peter Davis commented that the recruiting undertaken in the UK had seemed to be successful and asked how this had been achieved. Duncan advised that this was because teams had been sent to the UK with a remit of encouraging applicants to come to NZ and work for one year and then targeting those that had enjoyed their time here and providing help with visa applications.
- Jo Agnew was advised that the average time to get an anaesthetic technician into NZ was 9 months. There was a brief discussion around the training courses provided in NZ, which might be of 6 to 9 month duration as opposed to the 9 month wait time for someone from overseas. It was advised that both methods were employed as there simply were not enough anaesthetic technicians worldwide to fill countries vacancies. Those from overseas had the added value of coming with experience and perhaps other qualifications.
- Jo Agnew asked what number of Māori staff the DHB had working in theatre and was advised that there was not the number that there should be and that initiatives were being worked on to increase the number.

5.7 Pacific Heath Services (Pages 69-75)

Abel Smith, Acting General Manager, Pacific Health asked that the report be taken as read, drawing attention to key points as follows:

- The Health Science Academy Evaluation on page 70 of the agenda where two schools were signed up with a further two being worked with in anticipation of having them join.
- A PALT (the Pacific Alliance Leadership Team) half day workshop was recently held to discuss and finalise a Pacific Workforce Strategy.
- The Faster Cancer treatment target was met 100% for Pacific People in the December period. The Cancer services had gone through Kapasa training which raises awareness of the data and the value of engaging with the patients appropriately.
- There was a dip for both immunisation rates for 8 months olds and Primary care work with smokers. The target for cervical screening was not met. The target for breast screening was exceeded. Ambulatory Sensitive Hospitalisation rates remain high for 0-4 years old and half the volume for older age groups.
- Hearts and Diabetes checks for Pacific peoples are tracking in a favourable direction. Unfortunately oral care remains problematic for Pacific young people.

The following points were raised in discussion:

- There was a discussion around whether the Pacific Health Service was responsible for delivering to some of the targets which might be seen to be the responsibility of other Directorates. Abel advised that the service was committed to addressing these target gaps, particularly where they feel the service could make a difference.
- Peter Davis felt that some of the measures could not be laid at the door of the hospital but are better seen as the responsibility of primary and community care. Bernie O'Donnell disagreed saying that the hospital needed to show some leadership in promoting change.

5.8 Surgical Services Directorate (Pages 76-85)

The Committee Chair, Tama Davis advised the committee that Mr Arend Merrie was stepping down from the role of Director Surgical Services and returning to his surgical work. On behalf of the Committee Tama thanked Arend for his contribution during his time in the role.

Mr Arend Merrie, Director Surgical Services asked that the report be taken as read advising as follows:

- The Directorate was a diverse one with over 1000 FTE offering a number of complex services. It required a close relationship with Perioperative Services in order to be able to function well and meet its goals

- The Directorate is on track with recruitment
- Ways of accessing equity are being looked at
- Within Planned Care there has been a focus on the Greenlane Surgical Centre. There has been an increase of 1000 discharges allowing 507 extra discharges to be made. This year a further 900 have to be delivered and currently this is tracking to plan
- Financially the net result is unfavourable although the situation is improving in the nursing space.

The following points were raised in discussion:

- Peter Davis was advised that outsourcing for orthopaedics was not a new phenomenon and had been in place for the last three years.
- An explanation was given that a patient attender was a health care assistant who requires additional training to provide assistance at bedside, usually with issues around frailty and dementia, or other behaviours of concern.

5.9 Women's Health Directorate (Pages 86-97

Dr Robert Sherwin, Director Women's Health asked that the report be taken as read and drew attention to:

- The Equity Dashboard mentioned on page 87 of the agenda which has been formulated to assist in the identification of inequities
- Te Manawa o Hine mentioned on page 87 of the agenda and recruitment within that service, particularly the appointment of Nicole Pihema
- The work commenced to increase the number of Māori midwives in the workforce to improve service to Māori.
- The directorate is $1.3M favourable year to date.

There were no questions.

5.10 Provider Arm Financial Performance Report (Pages 98-108)

Jo Gibbs, Director Provider Services asked that the report be taken as read, advising that the January month had been a complicated one with the requirement to right size the financial reporting given the approval of the $20M deficit budget. The Provider Arm was $6M unfavourable to budget.

Resolution:

That the Provider Arm reports 5.3 to 5.10 be received.

Carried

6. RESOLUTION TO EXCLUDE THE PUBLIC (Pages 109-111)

Resolution: Moved Michelle Atkinson / Seconded Fiona Lai

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 12 February 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 Term of Reference & Meeting Forward Plan	**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]
6.1 Clinical Support Oversight Report – MRI Capacity	**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)] **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.	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]
6.2 Head and Neck Oversight 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 [Official Information Act 1982 s9(2)(i)] **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.	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]
6.3 Perioperative Services – Shortage of Perioperative Workforce Oversight 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 [Official Information Act 1982 s9(2)(i)] **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.	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]
6.4 Radiotherapy Workforce Oversight 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 [Official Information Act 1982	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

	s9(2)(i)] **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.	6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.5 Women's Health – Midwifery Recruitment and Retention Oversight 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 [Official Information Act 1982 s9(2)(i)] **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.	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 and Safety Service 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 [Official Information Act 1982 s9(2)(i)] **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.	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]
7.2 Policies and Procedures (Controlled Document Management)	**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]
8.1 Theatres Workforce Project	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if	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

	that information was made public [Official Information Act 1982 s9(2)(i)] **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.	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]

Carried

The meeting closed at 4.00pm.

Signed as a true and correct record of the Hospital Advisory Committee meeting held on Wednesday, 18 March 2020

Chair: _____ Date: _____

Tama Davis

Provider Arm Operational Exceptions Report

Recommendation

That the Hospital Advisory Committee receives the Provider Arm Operational Exceptions Report for October 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
Kaiārahi Nāhi	Nurse Navigator
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
Rōpū	Group
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 October 2020 Hospital Advisory Committee Meeting. Where possible, linkages to our commitments to Te Tiriti o Waitangi and Equity have been illuminated.

Tino Rangatiratanga

The positioning of key Māori leadership, particularly within service areas of high utilisation by Māori include:

- In July 2020, Hineroa Hakiaha (Ngāti Awa, Ngāi Tūhoe, Ngāti Maniapoto, Ngāi Tahu) and Tracy Silva-Garay were appointed as Partnership Leaders of the Mental Health and Addictions Directorate. This new partnership model is an important first for our DHB, which demonstrates progression in upholding our commitments to Te Tiriti o Waitangi and improving our Mental Health and Addiction services.
- In July 2020, a by Māori, for Māori, as Māori rōpū was established in liaison with Dame Naida Glavish within the Cancer and Blood Directorate. The name gifted for this rōpū by Dame Naida Glavish is Pou Ārahi. The purpose of the Pou Ārahi is to reinvent the Cancer and Blood Service so that it honours Te Tiriti o Waitangi, is fit for purpose for Māori, reaches into the community from start to finish of the whānau journey, and establishes a working pattern for care that leads to equitable health outcomes across the board, starting with Māori. Pou Ārahi will work alongside Hineroa Hakiaha and the Mental Health and Addiction Directorate on work that focuses on Māori health gain and achieving equitable health outcomes. The appointed Chair of this rōpū is Dr George Laking (Te Whakatōhea) Medical Oncologist. Membership also includes Tame Hauraki (Ngāti Whātua, Ngāpuhi, Ngāti Whānaunga) our newly appointed Kaumātua for Cancer and Blood Services, 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. Within the next 6 months, Pou Ārahi will utilise data that is currently collected within the hospital in order to identify and make transparent apparent disparities in the cancer pathway that warrant further in-depth causal analysis which can provide guidance on where and how to intervene, and measures/metrics which can be used to monitor the effectiveness of quality improvement efforts to achieve equitable care. A deep dive into this work will be provided at the next HAC meeting.

Kāwanatanga; Te Ritenga

- In July 2020, the Kaiārahi Nāhi rōpū led by Dawson Ward (Ngāti Whātua, Ngāpuhi) was established. This rōpū of Clinical Nurse Specialists walk alongside Māori patients on their journey to surgery. This rōpū provides oversight of, and are active partners in, critically reviewing planned care pathways and identifying changes we need to make as an organisation to achieve equitable care. By utilising Te Whare Tapa Whā and values of whanaungatanga, kotahitanga, manaakitanga and rangatiratanga, ngā Kaiārahi Nāhi are improving access to surgical bookings through improved engagements and connections between whānau Māori and kaimahi.

Ōritetanga

- The Women's Health Service has been awarded a Health Delivery Research Activation Grant, "Activating communities to improve outcomes for wāhine Māori". This project will leverage

community strengths and build partnerships to underpin a community-based participatory research approach that will more effectively advocate for wāhine Māori.

Equity

- The Pacific Planned Care Navigation team, led by Pauline Fakalata, has also been established. This team of Clinical Nurse Specialists support Pacific patients navigate their path to surgery, whilst also contributing on a bigger scale to improving the experience and health outcomes of Pacific people, and improving systems and processes in order to deliver true patient-focused care. The Pacific Care Navigation service utilise talanoa (open free flowing conversation) and the Fonofale model that considers the physical, spiritual, mental and cultural aspects of health, all underpinned by a connection to family and community.
- The Women's Health Service has developed a 'Creating Equity' paper, which provides an overview of a wide range of improvement work, planned and underway. Organising this work into a programme will assist in monitoring progress on an ongoing basis, improve accountability and support realising our goal of achieving equity. The Women's Health Service has also joined the Institute for Healthcare Improvement's Pursuing Equity Learning and Action Network. This network is designed to foster systemic action by health systems to get measurable results and achieve improvements in equity. This is an 18 month programme and will support a team from the directorate and the wider DHB to commit to two key service improvement projects.
- Within Children's Health, the Starship Clinical Excellence programme has a targeted focus of reducing healthcare inequity for Māori patients. A reduction in healthcare inequities for Pacific patients is also a targeted focus of this programme. All services are reviewing inequities in their own delivery of care in the following domains: access, timeliness, clinical care delivery, clinical outcomes and patient experience. In addition, services are assessing three common priority areas within their speciality with a focus on equity, and improvement plans are being developed when an area of inequity is identified. This work is closely aligned with the equity focussed planned care programme. Surgical services will be working in partnership with our navigation teams to identify and address inequity issues as they arise.

COVID-19

- Te Toka Tumai continues to manage the impacts of COVID-19 on our hospitals and provider services. The COVID-19 response team returned to an incident management state when new community cases were announced on 11 August 2020. Our incident management team continues to work closely with the Northern Region Health Coordination Centre (NRHCC) to ensure regional consistency where appropriate.
- The hospitalisation of COVID-19 patients has been higher during this second outbreak, however numbers of admissions have remained small and there have be no patients admitted to Starship Hospital or critical care within Te Toka Tumai. One patient sadly passed away in our care. Te Toka Tumai has 11 managed isolation and quarantine facilities (MIQFs) in its catchment. There are daily admissions from these facilities 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.
- A case of community acquired COVID-19 was reported in a member of staff that works in one of our inpatient facilities. Appropriate action was taken at the time, including stopping new admissions and discharges, coordinating with regional centres, contact tracing, and

communicating with patients and whānau. All patients and staff that displayed any symptoms consistent with COVID-19 were tested. No further positive cases were reported.

- During the most recent community outbreak, over 100 staff from Te Toka Tumai have been redeployed to support the response, including to Auckland Regional Public Health Service, MIQFs, community testing centres and the NRHCC. This has required some reduction in planned care to release people – including closing of the surgical winter ward early. 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.
- It is apparent that COVID-19 will continue to disrupt the delivery of healthcare and require on-going work to manage. The incident management team will begin to transition to a readiness state as the number of community cases reduce and so does the impact on provider services. Should further cases emerge, and incident management team can be stood-up at short notice if required.

Emergency Department

- The Adult Emergency Department has been exceptionally busy over the last couple of weeks. This is also reflected in the wider northern region. Early evidence suggests that we may be experiencing a "catch up" of some delayed presentations following the impact of the second COVID-19 outbreak.

2. Ministry of Health Planned Care Performance Dashboard

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

ESPI Performance

- Both ESPI 2 and ESPI 5 performance has improved from June to August 2020.
- August 2020 ESPI 2 position is 7.6% noncompliant, compared with 15.5% noncompliant at the end of June 2020. August 2020 ESPI 5 position is 16% noncompliant, compared with 25.9% noncompliant at the end of June 2020. This is an improvement of 528 patients.
- We have completed 4,313 planned care discharges in the months of July and August 2020 (including Oral Health and Cardiology).

2020/21 Planned Care – Year to Date performance:

- For July 2020, the Auckland Provider delivered above plan. July 2020 discharges also exceeded the number of discharges for the same month last year (July 2019) by over 100. However, the August lockdown had a detrimental impact on the delivery of planned care services during this month.
- For the combined months of July and August 2020, discharges have been below plan, with at least half of this shortfall being in Dental services alone with Dental Council guidance to stop all non-acute work due to COVID-19 risk to Aerosol Generating Procedures.
- Early indications are that September 2020 activity is higher than August 2020 activity, but this is not likely 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 will be reviewed again on 5 October 2020.
- We are reviewing the August 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 is subject to external forces beyond our control.

Additional Planned Care 2020/21

- Government has prioritised additional funding over three years to support the waiting list backlog recovery. Te Toka Tumai has submitted proposals to the Ministry of Health for additional funding to support service improvement activities that help us optimise use of planned care capacity including operating rooms and outpatient services, and capital funding for additional Cardiac Cath Lab capacity, Ophthalmology clinic capacity and IT enablers to support telehealth and equity focussed planned care recovery.
- In addition to this funding we have submitted a plan to undertake more diagnostic, outpatient clinic and day surgery activity in 2020/21 in addition to the current PVS including:
    - More MRIs and CTs to reduce waiting list backlogs
    - More colonoscopy procedures to reduce waiting times ahead of the Bowel Screening rollout in November 2020
    - More Ophthalmology clinic services delivered from additional community locations
    - More Dental assessments and treatment for children
    - More spinal procedures for adults and children.

Financial Performance

Consolidated Statement of Financial Performance - August 2020

Provider	Month (Aug-20)			YTD (2 months ending Aug-20)		
$000s	Actual	Budget	Variance	Actual	Budget	Variance
Income						
Government and Crown Agency sourced	11,917	10,190	1,727 F	23,078	20,779	2,299 F
Non-Government & Crown Agency Sourced	8,745	8,543	202 F	16,995	17,293	(299) U
Inter-DHB & Internal Revenue	1,426	1,295	131 F	2,897	2,590	307 F
Internal Allocation DHB Provider	123,638	130,465	(6,827) U	254,071	260,930	(6,859) U
	145,726	**150,493**	**(4,767) U**	**297,042**	**301,593**	**(4,551) U**
Expenditure						
Personnel	100,140	95,208	(4,931) U	197,032	191,328	(5,703) U
Outsourced Personnel	2,551	1,555	(996) U	4,805	3,109	(1,696) U
Outsourced Clinical Services	3,761	3,601	(161) U	7,687	7,188	(499) U
Outsourced Other	5,666	6,106	440 F	11,329	12,211	882 F
Clinical Supplies	28,257	28,702	445 F	55,354	56,384	1,030 F
Infrastructure & Non-Clinical Supplies	19,475	17,897	(1,578) U	37,952	35,813	(2,139) U
Internal Allocations	805	805	(0) U	1,609	1,609	0 F
Total Expenditure	**160,654**	**153,874**	**(6,781) U**	**315,768**	**307,642**	**(8,125) U**
Net Surplus / (Deficit)	**(14,928)**	**(3,380)**	**(11,547) U**	**(18,726)**	**(6,050)**	**(12,677) U**
Covid-19 Net Impact on Bottom Line	**(10,504)**	**0**	**(10,504) U**	**(12,497)**	**0**	**(12,497) U**
BAU Net Impact on Bottom Line	**(4,424)**	**(3,380)**	**(1,044) U**	**(6,229)**	**(6,050)**	**(180) U**

Consolidated Statement of Personnel by Professional Group – August 2020

Employee Group $000s	Month (Aug-20)			YTD (2 months ending Aug-20)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical Personnel	36,116	34,582	(1,534) U	71,372	69,484	(1,888) U
Nursing Personnel	34,167	31,624	(2,543) U	66,325	63,316	(3,008) U
Allied Health Personnel	15,203	15,144	(59) U	30,413	30,328	(85) U
Support Personnel	2,805	2,677	(128) U	5,578	5,501	(77) U
Management/ Admin Personnel	11,849	11,181	(668) U	23,343	22,700	(644) U
Total (before Outsourced Personnel)	**100,140**	**95,208**	**(4,931) U**	**197,032**	**191,328**	**(5,703) U**
Outsourced Medical	1,186	1,039	(148) U	2,375	2,077	(298) U
Outsourced Nursing	33	66	34 F	84	133	49 F
Outsourced Allied Health	123	60	(63) U	207	120	(87) U
Outsourced Support	47	26	(21) U	90	52	(38) U
Outsourced Management/Admin	1,162	364	(798) U	2,049	728	(1,321) U
Total Outsourced Personnel	**2,551**	**1,555**	**(996) U**	**4,805**	**3,109**	**(1,696) U**
Total Personnel	**102,690**	**96,763**	**(5,927) U**	**201,837**	**194,438**	**(7,399) U**

Consolidated Statement of FTE by Professional Group – August 2020

FTE by Employee Group	Month (Aug-20)			YTD (2 months ending Aug-20)		
	Actual FTE	Budget FTE	Variance	Actual FTE	Budget FTE	Variance
Medical Personnel	1,554	1,536	(19) U	1,550	1,536	(15) U
Nursing Personnel	4,103	4,067	(35) U	4,106	4,068	(38) U
Allied Health Personnel	2,020	2,038	18 F	2,016	2,038	21 F
Support Personnel	539	531	(7) U	536	531	(5) U
Management/ Admin Personnel	1,534	1,554	20 F	1,520	1,554	34 F
Total (before Outsourced Personnel)	**9,749**	**9,726**	**(23) U**	**9,729**	**9,726**	**(3) U**
Outsourced Medical	37	29	(7) U	37	29	(8) U
Outsourced Nursing	1	3	3 F	1	3	3 F
Outsourced Allied Health	7	2	(5) U	6	2	(4) U
Outsourced Support	11	0	(11) U	12	0	(12) U
Outsourced Management/Admin	116	23	(93) U	119	23	(96) U
Total Outsourced Personnel	**171**	**58**	**(113) U**	**174**	**58**	**(116) U**
Total Personnel	**9,920**	**9,784**	**(136) U**	**9,903**	**9,784**	**(119) U**

Consolidated Statement of FTE by Directorate – August 2020

Employee FTE by Directorate Group (including Outsourced FTE)	Month (Aug-20)			YTD (2 months ending Aug-20)		
	Actual FTE	Budget FTE	Variance	Actual FTE	Budget FTE	Variance
Adult Medical Services	1,070	1,035	(35) U	1,068	1,035	(33) U
Adult Community and LTC	588	574	(14) U	584	574	(10) U
Surgical Services	928	905	(23) U	929	905	(25) U
Women's Health	382	389	7 F	388	389	1 F
Child Health	1,409	1,362	(47) U	1,406	1,362	(44) U
Cardiac Services	577	568	(8) U	577	568	(9) U
Clinical Support Services	1,409	1,396	(13) U	1,405	1,396	(9) U
Patient Management Services	474	463	(11) U	476	463	(13) U
Perioperative Services	794	805	12 F	797	805	9 F
Cancer & Blood Services	416	416	() U	416	416	(1) U
Operational - Others	29	26	(3) U	19	26	7 F
Mental Health & Addictions	773	806	33 F	779	806	27 F
Ancillary Services	1,071	1,039	(33) U	1,060	1,039	(21) U
Total Personnel	**9,920**	**9,784**	**(136) U**	**9,903**	**9,784**	**(119) U**

Month Result

The Provider Arm result for the month is $11.5 M unfavourable. This result is almost entirely driven by the impacts of Covid-19 ($10.5M) which resulted in a reduction in volumes and therefore revenue, combined with additional expenditure in relation to the response.

Overall volumes are reported at 86.7% of base contract for the month - this equates to $17.0M below the month contract. This unfavourable contract position equates to a $7.0M washup liability for planned care and IDF, which has been provided for in the month's result.

Total revenue for the month is $4.8M (3.2%) unfavourable, with the key variances as follows:

- Provision for planned care and IDF revenue washup - $7.0M unfavourable – reflecting significantly reduced volumes during the level 3 lockdown period.
- Non Resident revenue $0.8M unfavourable – reflecting reduced Pacific contract cases as a result of Covid-19
- MOH Public Health funding $0.7M unfavourable, for additional costs relating to Covid-19, for which MOH funding is still to be confirmed.
- MOH side contract income $2.7M favourable due to additional laboratory income for high volumes of Covid-19 testing
- Retail Pharmacy revenue $0.6M favourable (partly offset by additional cost of goods sold)

Total expenditure for the month is $6.8M (4.4%) unfavourable, with $4.7M of this variance due to additional costs arising from Covid-19. The key variances are as follows:

- Personnel/Outsourced Personnel costs $5.9M (6.1%) unfavourable with the key variances as follows:

  - Unbudgeted Covid-19 related expenditure of $2.7M
  - Budget Personnel vacancy and cost per FTE assumptions not achieved $1.6M unfavourable
  - One off backdated costs $0.3M unfavourable
- Clinical Supplies $0.4M (1.6%) favourable. 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 $1.3M favourable, in line with overall volume performance below contract.
- Infrastructure & Non Clinical Supplies $1.6M (8.8%) unfavourable, with the key variances being:
  - Unbudgeted Covid-19 related expenditure of $0.7M
  - Bad and Doubtful Debts $0.4M unfavourable – this varies from month to month and reflects current assessment of outstanding non resident debts
  - Cost of Goods Sold $0.3M 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 $12.7M unfavourable. This result is almost entirely driven by the impacts of Covid-19 ($12.5M) 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 93.8% of the seasonally phased contract, equating to $15.4M below contract. This unfavourable contract position equates to a $7.0M 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 $4.6M (1.5%) unfavourable, with the key variances as follows:
- Provision for planned care and IDF revenue washup - $7.0M unfavourable – reflecting significantly reduced volumes during the level 3 lockdown period.
- Non Resident revenue $1.7M unfavourable – reflecting reduced Pacific contract cases as a result of Covid-19
- MOH Public Health funding $1.4M unfavourable, for which MOH funding is still to be confirmed, partly for additional Covid-19 expenditure and partly for business as usual
- MOH side contract income $3.6M favourable due to additional laboratory income for high volumes of Covid-19 testing
- Retail Pharmacy revenue $1.3M favourable (partly offset by additional cost of goods sold)

Total expenditure for the year to date is $8.1M (2.6%) unfavourable, with $6.3M of this variance due to additional costs arising from Covid-19. The key variances are as follows:
- Personnel/Outsourced Personnel costs $7.4M (3.8%) unfavourable with the key variances as follows:
  - Unbudgeted Covid-19 related expenditure of $3.5M
  - Budget Personnel vacancy and cost per FTE assumptions not achieved $3.0M unfavourable
  - One off backdated costs $0.3M unfavourable
- Clinical Supplies $1.0M (1.8%) favourable. Laboratory consumable costs are $1.0M unfavourable due to the extremely high volume of Covid-19 tests processed during the month. Excluding these costs, the underlying Clinical Supplies variance is $2.0M favourable, in line with overall volume performance below contract.
- Infrastructure & Non Clinical Supplies $2.1M (6.0%) unfavourable, with the key variances being:
  - Unbudgeted Covid-19 related expenditure of $1.1M

- Bad and Doubtful Debts $0.3M unfavourable – this varies from month to month and reflects current assessment of outstanding non resident debts
- Cost of Goods Sold $0.8M unfavourable for retail pharmacy, offset by additional retail revenue for the year to date.

FTE

Total FTE (including outsourced) for August were 9,920 which is 136 higher than budget. 66 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)

		Aug-2020				YTD (2 months ending Aug-20)			
		$000s				$000s			
Directorate	**Service**	**Cont**	**Act**	**Var**	**Prog %**	**Cont**	**Act**	**Var**	**Prog %**
Adult Community & LTC	Ambulatory Services	1,628	1,520	(109)	93.3%	3,243	3,203	(40)	98.8%
	Community Services	2,072	2,003	(69)	96.7%	4,145	4,229	84	102.0%
	Diabetes	592	632	40	106.8%	1,184	1,309	125	110.6%
	Palliative Care	39	39	0	100.0%	78	78	0	100.0%
	Reablement Services	2,157	2,200	44	102.0%	4,323	4,473	150	103.5%
	Sexual Health	354	486	132	137.5%	707	1,082	374	152.9%
Adult Community & LTC Total		**6,842**	**6,880**	**38**	**100.6%**	**13,680**	**14,374**	**694**	**105.1%**
Adult Medical Services	AED, APU, DCCM, Air Ambulance	2,811	2,590	(221)	92.1%	5,491	5,397	(94)	98.3%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	15,117	13,534	(1,583)	89.5%	30,465	28,132	(2,334)	92.3%
Adult Medical Services Total		**17,928**	**16,123**	**(1,805)**	**89.9%**	**35,956**	**33,528**	**(2,428)**	**93.2%**
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	11,732	10,121	(1,611)	86.3%	22,328	21,274	(1,054)	95.3%
	N Surg, Oral, ORL, Transpl, Uro	12,267	9,995	(2,272)	81.5%	23,685	22,922	(763)	96.8%
	Orthopaedics Adult	5,387	4,552	(835)	84.5%	10,469	9,909	(561)	94.6%
Surgical Services Total		**29,386**	**24,668**	**(4,718)**	**83.9%**	**56,482**	**54,105**	**(2,377)**	**95.8%**
Cancer & Blood Services	Cancer & Blood Services	12,310	11,093	(1,217)	90.1%	24,246	22,977	(1,269)	94.8%
	Genetics	349	351	2	100.5%	699	729	31	104.4%
Cancer & Blood Services Total		**12,659**	**11,444**	**(1,215)**	**90.4%**	**24,945**	**23,707**	**(1,239)**	**95.0%**
Cardiovascular Services		**15,812**	**12,982**	**(2,830)**	**82.1%**	**29,192**	**26,025**	**(3,167)**	**89.2%**
Children's Health	Child Health Community Services	3,299	2,638	(662)	79.9%	6,599	4,844	(1,755)	73.4%
	Child Health Medical	6,833	5,129	(1,704)	75.1%	13,342	11,203	(2,139)	84.0%
	Child Health Surgical	10,892	9,455	(1,437)	86.8%	21,527	20,065	(1,461)	93.2%
Children's Health Total		**21,025**	**17,221**	**(3,803)**	**81.9%**	**41,468**	**36,112**	**(5,356)**	**87.1%**
Clinical Support Services		**4,077**	**3,640**	**(437)**	**89.3%**	**8,155**	**7,762**	**(393)**	**95.2%**
DHB Funds		**10,032**	**9,435**	**(598)**	**94.0%**	**19,813**	**19,833**	**20**	**100.1%**
Perioperative Services		**18**	**3**	**(15)**	**16.2%**	**35**	**12**	**(24)**	**33.2%**
Public Health Services		**155**	**155**	**0**	**100.0%**	**310**	**310**	**0**	**100.0%**
Support Services		**102**	**102**	**0**	**100.0%**	**205**	**205**	**0**	**100.0%**
Women's Health Total		**9,369**	**7,784**	**(1,585)**	**83.1%**	**18,132**	**16,970**	**(1,163)**	**93.6%**
Grand Total		**127,406**	**110,437**	**(16,969)**	**86.7%**	**248,372**	**232,941**	**(15,431)**	**93.8%**

2) Total Discharges for the YTD (2 Months to August 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%
DHB Funds Total		283	297	285	298	4.6%	212	218	74.4%	73.2%
Surgical Services	Gen Surg, Trauma,	3,387	3,029	3,659	3,218	(12.1%)	2,019	1,740	55.2%	54.1%
	N Surg, Oral, ORL, Transpl, Uro	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 (2 Months to August 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		**234**	**204**	**(29)**	**1,295**	**1,133**	**(162)**	**87.5%**	**20**	**3**	**(17)**	**111**	**15**	**(96)**	**13.8%**	**254**	**207**	**(47)**	**1,407**	**1,148**	**(258)**	**81.6%**
Adult Medical Services	AED, APU, DCCM, Air Ambulance	684	704	20	3,795	3,905	111	102.9%	0	0	0	0	0	0	0.0%	684	704	20	3,795	3,905	111	102.9%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	3,822	3,378	(444)	21,193	18,733	(2,460)	88.4%	6	0	(6)	33	0	(33)	0.0%	3,828	3,378	(450)	21,226	18,733	(2,493)	88.3%
Adult Medical Services Total		**4,506**	**4,082**	**(424)**	**24,988**	**22,638**	**(2,349)**	**90.6%**	**6**	**0**	**(6)**	**33**	**0**	**(33)**	**0.0%**	**4,512**	**4,082**	**(430)**	**25,021**	**22,638**	**(2,382)**	**90.5%**
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	1,691	1,727	36	9,375	9,574	199	102.1%	1,328	1,138	(190)	7,362	6,310	(1,052)	85.7%	3,018	2,864	(154)	16,738	15,884	(853)	94.9%
	N Surg, Oral, ORL, Transpl, Uro	1,716	1,782	67	9,513	9,883	370	103.9%	1,350	1,217	(133)	7,484	6,747	(737)	90.2%	3,065	2,999	(66)	16,997	16,631	(366)	97.8%
	Orthopaedics Adult	1,076	1,086	9	5,969	6,020	51	100.8%	673	493	(179)	3,731	2,736	(995)	73.3%	1,749	1,579	(170)	9,701	8,756	(945)	90.3%
Surgical Services Total		**4,483**	**4,594**	**112**	**24,858**	**25,477**	**619**	**102.5%**	**3,350**	**2,848**	**(502)**	**18,578**	**15,794**	**(2,784)**	**85.0%**	**7,833**	**7,443**	**(390)**	**43,435**	**41,271**	**(2,164)**	**95.0%**
Cancer & Blood Services		**1,120**	**987**	**(133)**	**6,210**	**5,473**	**(737)**	**88.1%**	**0**	**0**	**0**	**0**	**0**	**0**	**0.0%**	**1,120**	**987**	**(133)**	**6,210**	**5,473**	**(737)**	**88.1%**
Cardiovascular Services		**2,905**	**2,739**	**(166)**	**16,107**	**15,187**	**(920)**	**94.3%**	**1,785**	**1,397**	**(388)**	**9,897**	**7,747**	**(2,150)**	**78.3%**	**4,689**	**4,136**	**(554)**	**26,004**	**22,934**	**(3,070)**	**88.2%**
Children's Health	Child Health Community	682	365	(317)	3,784	2,025	(1,758)	53.5%	0	0	0	0	0	0	0.0%	682	365	(317)	3,784	2,025	(1,758)	53.5%
	Child Health Medical	1,507	1,215	(292)	8,357	6,739	(1,618)	80.6%	10	4	(6)	58	22	(36)	38.5%	1,518	1,219	(298)	8,415	6,761	(1,654)	80.3%
	Child Health Surgical	1,778	1,670	(108)	9,858	9,259	(599)	93.9%	1,349	1,184	(165)	7,480	6,567	(913)	87.8%	3,127	2,854	(273)	17,338	15,825	(1,513)	91.3%
Children's Health Total		**3,967**	**3,250**	**(717)**	**21,998**	**18,023**	**(3,976)**	**81.9%**	**1,359**	**1,188**	**(171)**	**7,538**	**6,589**	**(949)**	**87.4%**	**5,326**	**4,438**	**(888)**	**29,537**	**24,612**	**(4,925)**	**83.3%**
Women's Health Services		**1,961**	**1,728**	**(233)**	**10,875**	**9,581**	**(1,293)**	**88.1%**	**403**	**411**	**8**	**2,237**	**2,281**	**44**	**102.0%**	**2,364**	**2,139**	**(225)**	**13,111**	**11,862**	**(1,250)**	**90.5%**
DHB Funds		**45**	**0**	**(45)**	**250**	**0**	**(250)**	**0.0%**	**341**	**328**	**(13)**	**1,890**	**1,817**	**(73)**	**96.1%**	**386**	**328**	**(58)**	**2,139**	**1,817**	**(322)**	**84.9%**
Grand Total		**19,220**	**17,585**	**(1,635)**	**106,581**	**97,513**	**(9,068)**	**91.5%**	**7,264**	**6,175**	**(1,089)**	**40,283**	**34,242**	**(6,041)**	**85.0%**	**26,485**	**23,760**	**(2,725)**	**146,864**	**131,755**	**(15,109)**	**89.7%**
Excludes caseweight Provision																						

The impact of Covid-19 continues to affect overall performance, with activity dropping again due to the August lockdown. In addition, the flow on benefit of the first lockdown of the lighter flu season has continued to mean reduced demand in some areas, particularly paediatric emergency department and general paediatrics, but also in general medicine and adult respiratory services. Overall discharges are 11% lower than the same period last year. However, both the average WIES and the length of stay are up on last year.

Acute Services

- Acute medical discharges are down by 12%, with average WIES and ALOS being 2% lower than the same period last year.
- Acute surgical discharges are also down by 8% compared to the same period last year, but the average WIES is 7% higher and the ALOS is 12% higher. This is due to big increases in average WIES in General Surgery and Adult Neurosurgery which means that overall total WIES is only 3% lower than the same period last year.
- Obstetric numbers have dropped significantly again with overall discharges being 15% lower than the same period last year, and actual birth numbers being 12% lower and 4.5% lower than the same period in 2018/19. The average WIES is slightly higher for normal births than the same period last year. Newborn numbers are 16% lower than the same period last year, with a 3% drop in average WIES and a 7% drop in LOS.

Elective Services

The effect of the second lockdown on elective services was less extreme than the first lockdown. Year to date elective services are 85% of contract (down from 92% in July). July discharges were 7% higher than the same month last year, but August dropped 17% lower than August last year reflecting the lockdown (compared to the first lockdown when elective discharges dropped by nearly 50%). Average WIES is 3% lower than the same period last year and ALOS is down by over 6%.

4) Non-DRG Activity (ALL DHBs)

		Aug-2020				YTD (2 months ending Aug-20)			
		$000s				$000s			
Directorate	**Service**	**Cont**	**Act**	**Var**	**Prog %**	**Cont**	**Act**	**Var**	**Prog %**
Adult Community & LTC	Ambulatory Services	918	975	57	106.2%	1,836	2,055	219	111.9%
	Community Services	2,072	2,003	(69)	96.7%	4,145	4,229	84	102.0%
	Diabetes	592	632	40	106.8%	1,184	1,309	125	110.6%
	Palliative Care	39	39	0	100.0%	78	78	0	100.0%
	Reablement Services	2,157	2,200	44	102.0%	4,323	4,473	150	103.5%
	Sexual Health	354	486	132	137.5%	707	1,082	374	152.9%
Adult Community & LTC Total		**6,132**	**6,336**	**204**	**103.3%**	**12,273**	**13,226**	**952**	**107.8%**
Adult Medical Services	AED, APU, DCCM, Air Ambulance	868	719	(149)	82.9%	1,696	1,491	(204)	87.9%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	4,615	4,538	(76)	98.3%	9,240	9,398	159	101.7%
Adult Medical Services Total		**5,483**	**5,258**	**(225)**	**95.9%**	**10,935**	**10,890**	**(45)**	**99.6%**
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	2,795	2,589	(207)	92.6%	5,590	5,390	(200)	96.4%
	N Surg, Oral, ORL, Transpl, Uro	3,344	2,892	(452)	86.5%	6,688	6,291	(396)	94.1%
	Orthopaedics Adult	384	528	144	137.4%	769	1,153	384	149.9%
Surgical Services Total		**6,523**	**6,008**	**(515)**	**92.1%**	**13,047**	**12,834**	**(213)**	**98.4%**
Cancer & Blood Services	Cancer & Blood Services	9,018	8,397	(622)	93.1%	18,036	17,504	(532)	97.1%
	Genetics	349	351	2	100.5%	699	729	31	104.4%
Cancer & Blood Services Total		**9,368**	**8,748**	**(620)**	**93.4%**	**18,735**	**18,234**	**(501)**	**97.3%**
Cardiovascular Services		**1,594**	**1,398**	**(196)**	**87.7%**	**3,188**	**3,091**	**(96)**	**97.0%**
Children's Health	Child Health Community Services	1,408	1,347	(61)	95.7%	2,815	2,818	3	100.1%
	Child Health Medical	2,464	2,118	(346)	86.0%	4,927	4,442	(485)	90.1%
	Child Health Surgical	2,094	1,982	(112)	94.6%	4,189	4,240	51	101.2%
Children's Health Total		**5,966**	**5,447**	**(519)**	**91.3%**	**11,931**	**11,500**	**(431)**	**96.4%**
Clinical Support Services		**4,077**	**3,640**	**(437)**	**89.3%**	**8,155**	**7,762**	**(393)**	**95.2%**
DHB Funds		**8,837**	**8,979**	**142**	**101.6%**	**17,674**	**18,016**	**342**	**101.9%**
Perioperative Services		**18**	**3**	**(15)**	**16.2%**	**35**	**12**	**(24)**	**33.2%**
Public Health Services		**155**	**155**	**0**	**100.0%**	**310**	**310**	**0**	**100.0%**
Support Services		**102**	**102**	**0**	**100.0%**	**205**	**205**	**0**	**100.0%**
Women's Health Total		**2,511**	**2,302**	**(208)**	**91.7%**	**5,021**	**5,108**	**87**	**101.7%**
Grand Total		**50,764**	**48,375**	**(2,389)**	**95.3%**	**101,508**	**101,186**	**(322)**	**99.7%**

As expected the second lockdown also had an impact on outpatient activity. The August performance was 95% of contract compared to July at 101%. The main affected services were Cancer & Blood and Adult Surgical services, both of which had a drop of $500k in performance to contract compared to July.

Care Navigation Progress Update

Recommendation

That the Hospital Advisory Committee:

1. **Receives the Care Navigation Progress Update for October 2020.**
2. **Notes the first three months of the care navigation team's progress within planned care.**
3. **Notes the insight into the approach, challenges and successes for the Kaiārahi Nāhi rōpū and the Pacific Care Navigation Service to date.**

Prepared by: Meg Poutasi, Chief of Strategy
Rawiri McKree Jansen, Clinical Director at National Hauora Coalition
Andrew Jones Improvement Programme Manager
Endorsed by: Ailsa Claire (Chief Executive)

1. Background

The causes of health inequity are complex and often begin prior to patients entering the planned care pathway. Not all causes are within the control of the health sector, to reduce the impacts of health inequity we need targeted equity interventions at various points in the planned care pathway. A sustained approach to response solutions will assist with the process.[1]

The first step was to examine our existing data in our planned care activities. We delivered an Equity Sprint (Planned Care Value Stream) with the Cardiovascular, Child Health, Surgical and Women's Health Directorates in October 2019. This included data analysis of the pathway, and patient experience evidence. The sprint revealed disparities for Māori and Pacific peoples in accessing planned care across the organisation both quantitatively and from reported patient and whānau experiences.

As Auckland DHB re-started planned care after Covid-19 restrictions, our objective was to focus on equity. Evidence suggests that in times of resource constraint, inequities will develop as services are prioritised and redirected. Auckland DHB decided to interrogate our data and consider options to intervene effectively in a first phase reset, noting that existing inequities in the planned care pathway are not inevitable and are modifiable.

Active case management, and a dedicated focus on the patient and whānau pathway by clinical staff allows patients to progress through the planned care pathway. It is also a method that allows us to:

1. gather data (quantitative and narrative) to understand where Auckland DHB's processes need to change to ensure equitable and timely care is provided;
2. provides greater visibility of barriers in the pathway for both Māori patients and Pacific patients; and
3. improves the experience of patients and families.

Through the experiences of those currently on the surgical wait list, alternative approaches to the management of referrals both from primary care and within secondary/tertiary care have been

[1] Andrew Connelly, paper on Equity Adjustment, National Planned Care Sector Advisory Group (May 2020).

identified. This work will be informed and support the "Access to Community Diagnostics pilot" currently under development (ADHB May 2020).

In the medium term, the objective will be to provide this type of case management from referral in primary care through the pathway. The expectation is that there will be reduced time from referral to FSA and more significantly reduced time from FSA to surgical intervention, particularly for those requiring additional diagnostic or clinical input.

2. Care Navigation Process

The Kaiārahi Nāhi rōpū and the Pacific Care Navigation services consist of 10 FTE each, with a team leader and nine Clinical Nurse Specialists. Six CNS are focused on adult surgical services, while three are focused on paediatric services. The adult teams were established in July 2020, while the paediatric service has been in place since 14 September 2020.

The process is in place for 6 months and then an evaluation will take place. Funding is secure for 6 months.

The initial focus for the services has been Māori patients and Pacific patients currently on the surgical waitlist, with a particular focus on patients who are have clinically urgent surgery, long waiting patients and those who have been deferred for clinical and non-clinical reasons.

The Kaiārahi Nāhi rōpū has developed an approach of engagement that focuses on Whanaungatanga (establishing and maintaining relationships), Manaakitanga (Caring for and respecting everyone's mana), Kotahitanga (working in unity) and Rangatiratanga (enabling self-determination) as well as Te Whare Tapu Whā.

The Pacific Care Navigation service is utilising talanoa (open free flowing conversation) and the Fonefale model that considers the physical, spiritual, mental and cultural aspects of health, all underpinned by a connection to family and community.

Engagement has occurred over the phone, but face to face meetings at home, marae, church or within the hospital facilities are central to the approach. In establishing trust and understanding through open, free flowing conversations the navigators are able to identify what are the priorities for a patient and their whānau, facilitate the resolution of barriers and highlight system level change required.

3. Issues Identified

A wide range of patient level and systems level issues have been identified. Below are a range of the issues identified. For more details, see appendix.

- The way that we communicate with Pacific people can create barriers to their understanding, limiting their ability to make informed decisions and prepare for surgery
- Poor patient experience due to lack of Whānaungatanga or Manaakitanga
- The access, booking and choice policy requires review to ensure it delivers on its objectives
- Review of the suspend list business rules
- Consideration of the priority levels between services that can cause delay in treatment

- Patient feels their voice is not being heard by service providers
- Navigators are able to make contact with people when other parts of the system have been unable
- The surgical booking process is often driven by the needs of system and/or is not person centred
- Inconsistent clinical eligibility criteria for surgery is a barrier to access, which the system is not picking up early enough in the pathway and in some cases not supporting people to overcome
- Access to and or cost of transport is a barrier to accessing services
- Patient and or family have lost trust in the health system
- Patient is unable or unwilling to take time of work to attend and recover from surgery
- Patients are placed on the suspend list they often do not receive regular pro-active follow up or are not supported to overcome the issue that is causing the suspension

4. Feedback on Service

Feedback to date has been resoundingly positive and supportive of the approach and its benefits to patients and their families. A number of highlights are:

Reported by patient: Delighted that she had been contacted by the navigation service. If they [Pacific Care Navigator] hadn't been in touch, she wouldn't have had surgery and wouldn't know what was happening. There was a disconnect between her GP and the surgical service in regards to the surgery plan and what was required for her to be prepared for surgery.

Reported by surgeon: The patient told me the navigator team had been great and she was delighted with the support offered. The support organised for transport was invaluable….told me she felt the best she had done for a long time and her walking had improved. …… appreciated the text messages and reassuring contact you had continued with her throughout the time before her surgery. Your [Kaiārahi Nāhi] support and care has enabled her to be in the best possible condition prior to this major surgery and allowed the best chance at recovery.

5. Insights from the Teams

Today PEC will hear insights from the teams. Dawson Ward and Pauline Fakalata will be presenting. Additional reporting on outcomes will be provided as the evaluation frameworks are confirmed in October 2020.

Patient and Whānau Voice – Patient and Whānau-Centred Care Council

Recommendation

That the Hospital Advisory Committee receives the report.

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

Glossary

Acronym/term	Definition
HQSC	Health Quality and Safety Commission
PWCC	Patient and Whānau-Centred Care Council
QSM	Quality and Safety Marker

1. Executive Summary

The Auckland DHB Patient and Whānau Centred Care Council exists to support Auckland DHB to accelerate its journey towards becoming a patient centred-care organisation. Membership is seven consumer (Patient and Whānau) advisors including representatives of Māori, disability, long term conditions and Pacific communities, and seven senior or executive Auckland DHB staff, supported by the Māori Patient and Whānau Experience Lead. The Council was established in September 2018 and is currently focused on an annualised strategic work programme. This financial year's objectives are to oversee a new Health Quality and Safety Commission consumer engagement initiative, to implement a communications plan, and to support Auckland DHB to achieve optimal consumer engagement with a focus on Māori patient and whānau experience.

2. Background

Patient-centred care can be described as "health care designed around the preferences and needs of people who access health services". Patient-centred care is health care that is respectful of, and responsive to, the preferences, needs and values of patients and consumers. The widely accepted dimensions of patient-centred care are respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of whānau and carers, and access to care.

Research demonstrates that patient-centred care improves patient care experience and creates public value for services. When health professionals, managers, patients, whānau and carers work in partnership, the quality and safety of health care rises, costs decrease, provider satisfaction increases, and patient care experience improves.

Key to becoming a patient-centred care organisation is effective consumer engagement, which is a process to enable patients and whānau to communicate with the organisation about their preferences and needs, and to have those well understood and responded to effectively by Auckland DHB.

The two legislative documents that underpin consumer engagement in New Zealand are the Code of Health and Disability Services Consumers' Rights and the Treaty of Waitangi. Right 1 of the Code encapsulates the Treaty with respect to Māori.

The Code of Health and Disability Services Consumers' Rights states that consumer rights need to be recognised in the following ways: respect, information, choice, equity, dignity, effective communication, support and full involvement.

The New Zealand Public Health and Disability Act (2000) upholds the Treaty of Waitangi and the need to provide mechanisms to enable Māori to contribute to decision-making and participate in the delivery of health and disability support services, which are at the heart of consumer engagement.

National, regional and local plans also set the context for Auckland DHB to design services together with the people who use them to better understand what they need, and how to achieve health equity.

The 'New Zealand Health Strategy: Future Direction 2016-2026 - All New Zealanders live well, stay well, get well' sets out five strategic themes for the nation's health system and they are focused on the pursuit of equitable health outcomes and the recognition and respect of the principles of the Treaty of Waitangi with more support for Māori given their poorer health outcomes. Other populations who have poorer health and social outcomes are pacific peoples, peoples with disabilities and mental health conditions and they are also a focus of this strategy.

The Health Quality and Safety Commission (HQSC) recommends all DHBs establish a consumer council as one mechanism through which consumers can participate in how health and disability services are delivered in different communities. In this way, consumer representatives can provide feedback on current services and tell providers what is really important to them.

In September 2018, Auckland DHB held the first meeting of its consumer council 'The Patient and Whānau-Centred Care Council' (PWCCC). Early work focused on agreeing a patient-centred care framework and the role of the PWCCC in putting the framework in to action through a benefits mapping process. Last financial year the PWCCC had input into Auckland DHB strategic projects such as the Hospital Administration Replacement Project, Patient Experience Survey re-design, the draft People Plan, and Kōrero Mai. During that period, the Director of Patient Experience position was disestablished, the Māori Patient and Whānau Experience Lead role commenced and assumed the secretariat function for the PWCCC. During the initial response to the COVID-19 pandemic the senior and executive staff members paused their involvement the Patient and Whānau Advisors continued planning towards strengthening the PWCCC communications and developed recruitment, orientation and training material.

This financial year the Minister of Health's Letter of Expectations to all DHB Board Chairs specified strengthening service user/consumer representative councils. Auckland DHB's 2020/2021 Annual Plan activities include that the PWCCC: develop and implement a communications plan; oversee the new consumer engagement Quality and Safety Marker; and produce a resource for the Auckland

DHB workforce to support optimal consumer engagement across the organisation with a focus on Māori patient and whānau experience.

The communications plan aims to ensure stakeholders know how and why to engage with the PWCCC. This work will enable a second project, overseeing the newest HQSC Quality and Safety Marker (QSM) for consumer engagement. The QSM requires Auckland DHB and all other DHBs to collect and report examples of consumer engagement in the design and delivery of health services. The third priority activity for PWCCC this financial year builds upon the first two to create an education resource designed to support Auckland DHB staff to carry out optimal consumer engagement with a focus on Māori patient and whānau experience.

Engaging regularly with members of the Auckland DHB Board through the Hospital Advisory Committee/Provider Equity Committee represents a key opportunity for the PWCCC to build relationships at all levels of the organisation around patient and whanau-centred care. PWCCC will contribute through raising awareness of context and best practice, data driven insights, and will showcase examples around patient and whānau voice at future Health Advisory Committee/Provider Equity Committee meetings.

3. Conclusion

Auckland DHB established a consumer council (the "Patient and Whānau-Centred Care Council") because it is committed to becoming a patient-centred care organisation. The PWCCC membership model brings together seven Patient and Whānau Advisors with seven senior or executive Auckland DHB staff to develop and lead a strategic programme of work. Leveraging national and local health sector plans and expectations, the council's effectiveness and impact are set to strengthen this financial year through implementing a number of key activities outlined in the Annual Plan. An opportunity exists at this time, through building relationships at Board level, to showcase and illustrate patient-centred care best practice and why it is important. PWCCC intends to influence and support the organisation to evolve to become a patient-centred care organisation.

Appendix

Orientation to the Auckland DHB Patient and Whānau-Centred Care Council

Why do we need a Patient and Whānau Centred Care Council?

Patient-centred care is health care that is respectful of, and responsive to, the preferences, needs and values of patients, consumers and their whānau. The dimensions of patient-centred care are respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of whānau and carers, and access to care. Hearing about and understanding patient and whānau needs and preferences helps to uphold the values of the Auckland DHB and Te Tiriti o Waitangi when designing and delivering or improving healthcare services.

The consumer council is a requirement of New Zealand's district health boards by the Ministry of Health to aid in the delivery of world class healthcare which takes into consideration the needs of its consumers.

Vision: What kind of healthcare system do we want to see in the Auckland District Health Board?

We want to see a healthcare system that is proactively responsive to all the needs of our patients, and those they consider whānau.

Purpose: Why do we want to see this kind of healthcare system?

A patient and whānau centric model of healthcare can support improved health outcomes for all who access Auckland DHB services, and improved access for those who have a health need but currently do not engage. Research demonstrates that patient-centred care improves patient care experience. When health professionals, managers, patients, whānau and carers work in partnership, the quality and safety of health care rises, costs decrease, provider satisfaction increases, and patient care experience improves.

Scope: How will we work to assist in the delivery of a world class level of healthcare?

We provide strategic advice to the Executive Leadership Team based on the experience of patients, whānau, and staff to help influence system design to improve quality, safety, and patient experience.

Storytelling – Who are we? What are our goals?

1. Support Auckland DHB to deliver care that matters to patients, whānau and communities
2. Help patient and whānau needs to be heard and well understood (emotional, medical, physical and spiritual)
3. Understand how patient and whānau feedback systematically drives improvements to Auckland DHB services and care
4. Create a work programme that pushes boundaries to create culture change

How do we operate?

- Monthly full council (staff & advisors) meeting
- Working groups to develop ideas (sometimes meeting weekly/fortnightly)
- Communication structure based on communications strategy
- Engage in conversations regarding our healthcare with our community to help better understand the needs of our consumers
- Engage with internal and external stakeholders about the work we are doing and have done
- Seven advisors from the community
- Seven members of the Senior Leadership Team
- Dual chair to be held by one member from each group

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 18 March 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 into Maternal Death – Progress Report	**Privacy of Persons** Information relating to natural person(s) either living or deceased is enclosed in this report. **Legal Professional Privilege** Information contained in this report is subject to legal professional privilege.	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]

5.2 Critical Care Strategy – Update post COVID	**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.	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]
5.3 3 Year Planned Care Update	**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.	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]
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.	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.	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]
7.2 Vulnerable Services Update	**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	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]

	public is enclosed in this report and those measures would be prejudiced by publication at this time.	
7.3 Radiology Waiting Times	**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.	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]