AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Hospital Advisory Committee Meeting

Wednesday, 18 March 2020

1:30pm

A+ Trust Room
Clinical Education Centre
Level 5
Auckland City Hospital
Grafton

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Published 13 March 2020

Agenda
Hospital Advisory Committee
18 March 2020

Venue: A+ Trust Room, Clinical Education Centre
Level 5, Auckland City Hospital, Grafton

Time: 1.30pm

Committee Members	**Auckland DHB Executive Leadership**	
William (Tama) Davis (Chair)	Ailsa Claire	Chief Executive Officer
Jo Agnew (Deputy Chair)	Karen Bartholomew	Acting Director of Health Outcomes – ADHB/WDHB Margaret
Michelle Atkinson	Dotchin	Chief Nursing Officer
Zoe Brownlie	Joanne Gibbs	Director Provider Services
Peter Davis	Dame Naida Glavish	Chief Advisor Tikanga – ADHB/WDHB
Fiona Lai	Dr Debbie Holdsworth	Director of Funding – ADHB/WDHB
Bernie O'Donnell	Mel Dooney	Acting Chief People Officer
Michael Quirke	Riki Nia Nia	General Manager Māori Health
Pat Snedden (Board Chair) ex officio	Rosalie Percival	Chief Financial Officer
	Meg Poutasi	Chief of Strategy
	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
	Auckland DHB Senior Staff	
	Dr Vanessa Beavis	Director Perioperative Services
	Dr Nigel Robertson	Interim Director Perioperative Services
	Dr John Beca	Director Surgical, Child Health
	Jo Brown	Funding and Development Manager Hospitals
	Ian Costello	Director of Clinical Support Services
	Suzanne Corcoran	Director Participation and Insight
	Dr Kalra Lalit	Acting Director Community & Long Term Conditions
	Rachel Lorimer	Director Communications
	Mr Arend Merrie	Director Surgical Services
	Duncan Bliss	Associate Director Surgical and Perioperative Services
	Kieron Millar	Acting General Manager Commercial Services
	Auxilia Nyangoni	Deputy Chief Financial Officer
	Alex Pimm	Director Patient Management Services
	Anna Schofield	Director Mental Health and Addictions
	Dr Michael Shepherd	Director Medical, Children's Health
	Dr Barry Snow	Director Adult Medical
	Dee Hackett	General Manager Adult Medical
	Dr Robert Sherwin	Director Women's Health
	Dr Michael Stewart	Director of Cardiovascular
	Joanne Bos	Acting General Manager of Cardiovascular
	Dr Richard Sullivan	Director Cancer and Blood
	Emma Maddren	General Manager Children's Health
	Deirdre Maxwell	General Manager Cancer and Blood
	Deborah Pittman	Director Midwifery Women's Health
	Mark O'Carroll	Clinical Lead for Heart and Lung Transplant
	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

1.30pm	**1.**	**Karakia**
		Attendance and Apologies
		Members:
		Senior Staff: Sue Waters, 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?
1.35pm	**3.**	**Confirmation of Minutes 12 February 2020**
	4.	**Action Points**
1:40pm	**5.**	**PERFORMANCE REPORTS**
	5.1	Provider Arm Operational Performance – Executive Summary
	5.2	Provider Arm Scorecard
	5.3	Cancer & Blood Services
	5.4	Cardiovascular Services
	5.5	Clinical Support Services
	5.6	Perioperative Services
	5.7	Pacific Health Services
	5.8	Surgical Services
	5.9	Women's Health Directorate
	5.10	Provider Arm Financial Performance Report
2.25pm	**6.**	**RESOLUTION TO EXCLUDE THE PUBLIC**

Next Meeting:	Wednesday, 22 April 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
William (Tama) Davis (Chair)	1	
Joanne Agnew (Deputy Chair)	1	
Michelle Atkinson	1	
Doug Armstrong	1	nm
Bernie O'Donnell	1	
Michael Quirke	1	
Peter Davis	1	
Zoe Brownlie	1	
Ian Ward	1	nm
Fiona Lai	1	
Pat Snedden	x	

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

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 Contracting Role – Shea Pita and Associates Chargenet, Director & CEO – Partner	25.02.2020
Zoe BROWNLIE	Director - Belong Director - GenderTick Partner – CAYAD, Auckland Council Committee Member – RockEnrol Steering Committee	24.02.2020
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 Pharmacist – Auckland DHB Member – PSA Union Puketapapa Local Board Member – Auckland Council Member – NZ Hospital Pharmacists' Association	10.12.2019
Bernie O'DONNELL	Manager – Manukau Urban Maori Authority Chair – Board of Trustees – Waatea School Deputy Chair – Marae Trustees – Nga Whare Waatea marae Executive Member – Secretary – Te Whakaruruhau o Nga Reo Iriangi Maori Director – Maori Media Network Te Matawai Funding Panel – Te Pae Motuhake o Te Reo Tukutuku	11.12.2019
Michael QUIRKE	Chief Operating Officer – Mercy Radiology Group Convenor and Chairperson – Child Poverty Action Group	12.12.2019
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 Chair Mana Whenua Working Group – Auckland Council Te Kete Rukuruku Board Member – Freemans Bay School Board Member – District Maori Leadership Board Iwi Affiliations – Ngati Whatua, Ngati Haua and Ngati Tuwharetoa	12.12.2019

Minutes
Hospital Advisory Committee Meeting
12 February 2020

Minutes of the Hospital Advisory Committee meeting held on Wednesday, 12 February 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 (Interim Chair)	Mel Dooney	Chief People Officer
Jo Agnew	Margaret Dotchin	Chief Nursing Officer
Michelle Atkinson	Mark Edwards	Chief Quality, Safety and Risk Officer
Doug Armstrong	Joanne Gibbs	Director Provider Services
Zoe Brownlie	Meg Poutasi	Chief of Strategy, Participation and Improvement
Peter Davis	Dr Margaret Wilsher	Chief Medical Officer
Fiona Lai	**Auckland DHB Senior Staff Present**	
Bernie O'Donnell		
Michael Quirke	Dr John Beca	Director Surgical, Child Health
Ian Ward	Duncan Bliss	General Manager, Surgical and Perioperative
	Ian Costello	Director Clinical Support
	Dr Lalit Kalra	Acting Director Community and Long Term Conditions
	Kimmo Karsikas-Genet	Personal Assistant
	Kieron Millar	General Manager, Commercial Services
	Riki Nia Nia	General Manager, Māori Health Services
	Alex Pimm	Director, Patient Management Services
	Anna Schofield	Director, Mental Health and Addictions
	Dr Michael Shepherd	Director Medical, Child Health
	Marlene Skelton	Committee Secretary
	Dr Barry Snow	Director Adult Medical
	Dr Michael Stewart	Director Cardiovascular Services
	Dr Richard Sullivan	Director Cancer and Blood
	David Vial	Operational Finance and Planning Manager
	(Other staff members who attend for a particular item are named at the start of the minute for that item)	

1. APOLOGIES

That the apologies of the Board Chair, Pat Snedden be received.

That the apologies of Executive Leadership Team members Ailsa Claire, Chief Executive Officer, Rosalie Percival, Chief Financial Officer, Sue Waters, Chief Health Professions Officer and Shayne Tong, Chief Digital Officer be received.

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.

Tama Davis requested the following change to be made to his interest register: Ngati

Whatua representative on Emerge Aotearoa, to be added.

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

3. CONFIRMATION OF MINUTES 27 November 2019 (Pages 8 - 17)

That the minutes of the Hospital Advisory Committee for 27 November 2019 be received.

4. ACTION POINTS (Page 18)

All action points were either complete or in progress. Site visits were to be incorporated as part of the Board induction programme.

5. PERFORMANCE REPORTS (Pages 19 - 101)

5.1 Provider Arm Operational Performance – Executive Summary (Pages 19 - 23)

[Secretarial Note: Items 5.1 and 5.2 were considered as one item]

Jo Gibbs, Director Provider Services asked the report be taken as read providing additional information to support that outlined on pages 19-23 of the agenda. Advising as follows:

- It has been exceptionally busy period for both adults and children including our Mental Health Services. All staff continue to show extraordinary skills coping with increased demand.
- The sonographer strike action is to be a prolonged one. Bargaining is continuing in good faith and contingency plans are working well. No incidents have been reported of elevated risk. Results from facilitation meetings and any recommendations will be reported in more detailed at the next board meeting.
- The Prime Ministers announcement in relation to PICU funding for additional capacity was very good news and should place Auckland DHB in a good position in relation to critical care response.

The following points were covered in the discussion:

- Doug Armstrong wanted to know about the cost implications, patient inconvenience and risk related to the strike action. Jo Gibbs replied that taken into consideration the important work that sonographers do, no doubt a significant risk exists in regards to increased waiting times and demand especially, within the Cardiology pathway. Metro Auckland DHBs are working together on this and some work has been done by each of the DHBs in regards to strike costs and impact. Jo Agnew added that the real risk was that the longer patients waited for a scan the more likely that they were to see their diseases worsen.
- Margaret Dotchin gave a brief overview on the response to the novel corona virus. The Northern Region had stood up an Incident Management Response Team along with a coordinated incident management structure. The team were working closely with the Ministry of Health and to the Ministry's case definition. The DHB are

supporting action that is being taken at NZ borders with provision of clinical staff and expertise, and are sharing information.

Testing has been established at Auckland DHB LabPlus and Auckland DHB is supporting the Ministry of Health in the quarantine of the people evacuated from the Wuhan region. So far there have been no reported cases in New Zealand.

Margaret Wilsher advised that even though the incidents seem to be flattening out in China, there was still a need to be prepared and robust planning put in place. The epidemiology of the virus was that it was a respiratory illness Approximately 15% will have a severe reaction requiring hospitalisation. In China the mortality rate had been reported at 2%. To date there had only been two deaths outside of China.

The discussion on the novel coronavirus continued to cover communication and the importance of consistent messaging. As there have been reported incidents of xenophobia in the media it is important that Auckland DHB's own messaging is built on the value of respect which has also been enforced by Ailsa Claire in her communications.

- Peter Davis enquired about the definition of the all-day operating list. Jo Gibbs replied that historically there had been a changeover of service speciality teams at mid-day. It was determined that it would be more efficient to operate one speciality team for the full day, this is now being considered. However, as this has a knock on impact on outpatients and diagnostic services, it has taken time to achieve.
- Members were provided with clarification on the Auckland DHB Provider efficiency metrics especially the DOSA rate and % Day Surgery Rate. It was advised that while the rates were reasonable there were still more opportunities to make improvements.
- Ian Ward had a question on the Cardiac bypass surgery waiting list targets to actual. He was advised that the target is Ministry set and may not exceed 115. These targets were set 15 years ago and may be worthy of some review given new treatment technologies.

Resolution: Moved Michelle Atkinson/ Seconded Jo Agnew

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

5.2 Provider Arm Scorecard (Pages 24 - 25)

[Secretarial Note: See 5.1 for discussion points.]

5.3 Adult Medical Directorate (Pages 26 - 32)

Dr Barry Snow, Director Adult Medical asked the report taken as read and gave a brief overview of the Adult Medical Directorate including the services and departments that made up the directorate.

Barry highlighted points from the Q2 actions reported on page 27 of the agenda:

- Building consent had been granted for the new renal community building Kererū. This is very exciting as it brings the dialysis units closer to clients' homes and community.
- The construction of ward 51 is under way and will enable a new model of stroke care to be offered.
- There is a plan to start the bowel screening programme by the end of the year. However the current obstacles of not achieving routine outcomes will need to be investigated and understood first before this can take place.
- General Medicine was seeing similarly high numbers of patients as the rest of the hospital. There had previously been 4 wards and now there were 6. A pod system was being investigated as an option for new model of care in general medicine.

The following points were covered in discussion:

- Bernie O'Donnell asked about the accessibility of the new renal building for Māori and Pacific patients commenting that there had been a southward drift in where patients were residing. Barry Snow advised that even though the project was 10 years old this is still where the most people reside that require dialysis. The population in was still largely Māori and Pacific.
- Michael Quirke wanted to know more about the colonoscopy routine targets and what the history and context behind the drop was. Barry Snow replied that the service has always managed the urgent cases. The situation has deteriorated over the last year partly due to internal systemic problems and issues, but there has been a significant growth in referrals which were most likely a heightened awareness and community response to the bowel screening programme.

5.4 Child Health Directorate (Pages 33 - 49)

Dr John Beca, Director Surgical, Child Health asked the report to be taken as read after giving an introduction on the unique role of the Starship Hospital locally, regionally and nationally including the challenges the situation creates in terms of mix of work and some services being national tertiary providers.

There are ongoing difficulties and pressures in achieving sustainable and resilient teams, constant competition in terms of workforce, funding that has not been recognised and the challenges associated with teams that work around the country.

John Beca raised drew attention to the Q3 actions on pages 34-38 of the agenda:

- The piloting of patient focused booking
- A new pain service model to improve support for children with acute and chronic pain
- Plastics surgery with a focus on the more complicated cases

The following points were covered in discussion:

- Michelle Atkinson drew attention to page 46 of the agenda and the cessation of funding for the Rheumatic fever prevention programme.
- Zoe Brownlie drew attention to the adverse results for our young children recently highlighted in the new State of the Nation report and wanted to know how our work would fit into the bigger picture of family violence and children. John Beca highlighted the existence of Puawaitahi and the fact that a five year strategic plan on this issue had been drafted which would soon be brought to HAC. There is also internal work done in terms of raising staff awareness detecting violence towards children.
- Tama Davis wanted assurance that inter agency collaboration was in place to reduce the uplift of children and was advised that this was a goal around engaging effectively with Māori and was referred to page 41 of the agenda. Training had been developed by the Māori team on engaging effectively with Māori and Pacific patients and whānau. Tama Davis emphasised that it was vital that both Māori and Pacific Health Services be part of developing the teaching modules for staff.
- Jo Agnew wanted to know the number of Māori nursing staff required to be in compliance. Margaret Dotchin, Chief Nursing Officer advised the hospital required approximately a further 200 Māori nurses. Meg Poutasi, Chief of Strategy commented that this provided another layer of complexity as most figures shown were regional but Auckland DHB was a tertiary hospital and this needed to be kept in mind when looking specifically at numbers related to Māori patients and staff.

5.5 Community and Long Term Conditions Directorate (Pages 50 - 58)

Dr Lalit Kalra, Director Community and Long Term Conditions provided a brief outline of the services covered by the Directorate. He then raised the following points from the report advising that there had been:

- Good work done on implementation of best practice towards reducing capacity pressures in the hospital.
- More focus on the community health as well as better engagement with the people.

The following points were covered in the discussion:

- Michelle Atkinson congratulated the team on reductions on presentations at the Emergency Department.
- Bernie O'Donnell asked what was being done in relation to reducing the high non-attendance rates for Māori and Pacific Peoples at the diabetes clinics as these groups also had the higher prevalence of diabetes.

  Dr Lalit Kalra advised that the health coaching model works well in supporting Pacific communities; identifying what was wrong and providing education not just to the patient but also to the family. The Service was also looking at the possibilities around joined up clinics covering a number of specialties, which would encourage better

attendance. The key is going out to the community not expecting people to always come to us.

5.6 Commercial Services (Pages 59 - 65)

Kieron Millar, General Manager Commercial Services advised that the purpose of Commercial Services was to manage non-clinical contracts for the organisation the major ones being linen and laundry. The service also administered car-parking motor vehicle fleet, shuttle bus, property leases and power.

Kieron Millar asked his report to be taken as read while highlighting the following points:

- There has been year to date OPEX savings of $1 M and CAPEX savings of $1.57M
- Recently a survey for all employees was undertaken in relation to travel patterns with a goal of reducing dependency on private vehicles. A report is due to be published at soon.

The following points were covered in the discussion:

- Michael Quirke wanted to know more about the repurposing of single use instruments. Kieran Millar replied that the service was conducting a trial looking at ways to either repurpose instruments or to reuse parts rather than disposing of them. Once the trial is completed a report will be brought back to HAC.

5.7 Māori Health Services (Pages 67 - 73)

Riki Nia Nia, General Manager Māori Health Services acknowledged the new board, Māori board members and Tama Williams as the chair. Riki advised that the service consisted of three parts; Tikanga under the guidance of Dame Naida Glavish, Māori Health Gains under the management of Shayne Wijohn and Māori Health Services and Development under the management of Riki himself. All looked to Dame Naida Glavish for overall leadership.

Riki gave an overview of the Service highlighting the following items:

- 25 new Māori nurses were welcomed this morning; 18 coming to work at Auckland DHB and four in Starship.
- A goal via training programmes was to support staff in order to eliminate racism and achieve health equity for Māori.
- The Māori Health Service itself needs to be reviewed. The Service operates across 5 hospitals, 20,000 Māori come through the service and it is not possible for a staff of 12 people to take care of all Māori patients and whānau.

The following points were covered in the discussion:

- Tama Davis wanted to know if the cultural competence training was also available for Board Members. Riki Nia Nia advised that a training programme had been developed for the Board at Waitemata DHB and similar could be offered at Auckland DHB.
- Bernie O'Donnell commented that it was a challenge to service the wider need of the community and a challenge to reduce the numbers when the Māori Health Service

was not currently designated as a regional one.

- Meg Poutasi clarified that equity and Te Tiriti o Waitangi were two different things and being invested in separately.
- Zoe Brownlie acknowledged her use of the Āke Āke application commenting that it was brilliant and very helpful.

Resolution: Moved Jo Agnew/ Seconded Michelle Atkinson

That the Hospital Advisory Committee:

1. **Receives the Māori Health Services report for February 2020.**
2. **Notes the status and progress of Māori Health Services at Auckland DHB.**
3. **Recommends that a training program be developed for Auckland DHB Board Members on cultural competence and offered as part of the induction programme.**

5.8 Mental Health and Addictions Directorate (Pages 71 - 82)

Anna Schofield, Director Mental Health and Addictions gave a brief overview of the Directorate and services advising that it offered acute, regional and super-regional services and that there were increasing challenges in offering these services as need had increased dramatically in the last three years.

The Service attempts to work in an integrated way with partners and as a result of the Mental Health inquiry were looking at early intervention initiatives and how to build capacity so that people can easily move through the system so that the right service can be offered in the right place.

Anna highlighted some key points within her report:

- There has been steadily increasing demand especially for acute services which has led to challenges for the acute teams. Remedies are in place and there is an ongoing focus on acute adult flow work.
- Māhere Angamua, a plan for better mental health, wellbeing and equity, will be the vision for the longer term for the Directorate and its services. One of the priority areas is suicide prevention (Zero Suicide Initiative).

The following points were covered in the discussion:

- Jo Agnew complimented the service for the great work done on discharges with face-to-face contact within 7 days of discharge which is at 100%.
- Michelle Atkinson wanted to raise the section 76 as an issue and the national discussion linked to that as well as the slow increase.

5.9 Patient Management Services (Pages 83 - 90)

Alex Pimm, Director Patient Management Services gave an introduction to the Services which includes a diverse range of both clinical and non-clinical services at both sites.

Alex Pimm asked the report be taken as read and highlighted the following points:

- There had been very high hospital occupancy for the period with unprecedented growth and demand. It had been almost at the level of winter 2018 which is really concerning coming into winter 2020 and there was a view that beds could not be flexed down going into 2021.
- In the coming weeks and months all Directorates will be working together to achieve a robust winter plan which will then be shared.
- The "To Thrive" programme which is aimed at lower paid members of staff for personal and professional development has been successful. Further collaboration will take place with the organisational development team to develop an internship programme to allow staff to try out different roles without their leaving current ones as well offering assistance with CV development and practise at job interviews.

The following point was covered in the discussion:

- Tama Davis was advised that a small number, 12, had been assisted so far through the internships and the rollout was designed to be slow but steady as the programme was a very resource hungry one. Tama was advised that Auckland DHB is not a minimum wage employer and supports its staff to attain a living wage by meeting certain thresh holds. Staff can join Auckland DHB with no experience and work through a staged qualification to improve their financial position.

5.10 Provider Arm Financial Performance Report (Pages 91 - 101)

David Vial, Operational Finance and Planning Manager asked the report be taken as read.

There were no questions.

Resolution: Moved Michelle Atkinson / Seconded Zoe Brownlie

That the Provider Arm performance reports for the month of December 2019 be received.

Carried

6. RESOLUTION TO EXCLUDE THE PUBLIC (Pages 102 - 104)

Resolution: Moved Jo Agnew / Seconded Michelle Atkinson

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.

Carried

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. 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 27 November 2019	**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 Critical Care Strategy	**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]
5.2 Organ Donation New Zealand Transition Paper	**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]

6.1 Auckland Cardiology Electrophysiology Services 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]
6.2 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]
6.3 Ophthalmology Department 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 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	**Commercial Activities** **Information contained in this report is related to commercial activities and**	That the public conduct of the whole or the relevant part of the meeting would

Safety Service Report	**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.	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]

The meeting closed at 5:30pm

Signed as a true and correct record of the Hospital Advisory Committee meeting held on Wednesday 12 February 2020

Chair: _____ Date: _____

Tama Davis

Action Points from Previous Hospital Advisory Committee Meetings

As at Wednesday, 12 February 2020

Meeting and Item	Detail of Action	Designated to	Action by
16 October 2019 Item 5.4	**Inpatients with Social Complexity – Deep Dive** That a deep dive be provided to the new Board on "inpatients with social complexity."	Jo Gibbs	Item revised due to new focus for the Committee COMPLETED

Provider Arm Operational Performance – Executive Summary

Recommendation

5.1

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

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

Glossary

Acronym/term	Definition
GSU	Greenlane Surgical Unit
MIT	Medical Imaging Therapists
MoH	Ministry of Health

1. Executive Summary

The Executive Team highlight the following performance themes for the March 2020 Hospital Advisory Committee Meeting:

- The daily focus on patient flow continues, with overall hospital occupancy remaining high.
- Workforce and recruitment issues continue to be a challenge in a number of specialty areas, notably Midwifery, Radiology (Medical Imaging Technicians) and Mental Health.
- The full impact on in-patient hospital services from the COVID-19 virus is yet to be realised.

2. Progress/Achievements/Activity

- The target was not met by the Adult Emergency Departments during January 2020 (80.42%). During February, investment has been made (as per budget) for the commencement of the POD model. Some improvements in the AED waiting times is expected (although overall flow will not be impacted by this investment).
- Currently, overall year to date hospital midnight occupancy is running approximately 3.1 per cent above previous years.
- It is likely that winter will see unprecedented levels of demand on hospital and community services in Auckland. Whilst Auckland DHB has plans in place to respond to the forecasted demand, it is likely that the hospital will maintain high rates of occupancy throughout the winter period. Planning is underway given the additional likely impact of COVID-19
- Performance against the MRI target of 95% of referrals completed within six weeks has 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%. The department currently has a significant number of Medical Imaging Therapist vacancies which is starting to significantly impact capacity. The majority of new recruits (within the last 6 months) are recent graduates who require a further six months post-graduate training to be able to perform MRIs. Locum Medical Imaging Therapists (MITs) are being sought to support the increased demand. MRI continues to be a

critical service, in spite of a pro-active recruitment plan, no further appointments have been made over the last 2 months.

- Performance against the Ministry of Health (MoH) CT indicator of 95% of out-patients completed within six weeks has improved to 85.5% in February 2020 compared to 68.6% in January 2020. CT demand continues to grow at 8% per year.
- Whilst there is an internal Ultrasound target (95%) we are mindful of the importance of patient access to service and safe waitlist management. Performance against this target has improved to 48.4% of out-patients scanned within 6 weeks at the end of February 2020 compared to 42% in January 2020. Under performance against MoH targets is reflective of the strike action over the last 3 months for both the MIT and Sonography workforce. Recovery from the MIT strikes will likely take 3-4months. The sonography strike action continues and performance against targets may deteriorate further until these are completed.
- The critical care strategy has been signed off by Board. A governance group will be set up to oversee the workstreams and to implement the strategy.
- The Radiation Oncology Service (within the Regional Cancer and Blood Service) has experienced a sustained increase in patient demand since mid-2018. This is due to the 3% sustained population growth of First Specialist Appointments translating into a 6% growth for radiation treatments. This was causing concern about the increased wait times for patients to receive radiation treatment, where this had not been a problem previously. The Auckland DHB Executive Leadership Team, with the Board's endorsement and oversight, sanctioned the recruitment of 7 additional radiation therapy staff to provide capacity for 2 additional late shifts. In the meantime, patient treatments were being outsourced to a private provider. From 17 February 2020 we have been able to commence this increased in-house provision and cease outsourcing. This is a great outcome for patients and the service.
- Work is underway, jointly with the Planning & Funding team to submit the business case to the Ministry of Health, for commencement of Bowel Screening during 2020, as per the National Program.

Transplants

Solid Organ Transplant Volumes

From Coding (based on discharge date once coded)

By Month	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20
Heart	1	0	4	1	2	0	1
Lung	3	1	3	1	2	6	0
Liver	4	5	5	4	6	6	4
Total Nat Funded	**8**	**6**	**12**	**6**	**10**	**12**	**5**
Renal	10	10	12	8	16	13	8
Total	**18**	**16**	**24**	**14**	**26**	**25**	**13**

Year to Date	14/15 YTD	15/16 YTD	16/17 YTD	17/18 YTD	18/19 YTD	19/20 YTD
Heart	7	6	5	17	14	9
Lung	7	13	10	14	24	16
Liver	27	27	30	36	31	34
Total Nat Funded	**41**	**46**	**45**	**67**	**69**	**59**
Renal	44	54	65	74	77	77
Total	**85**	**100**	**110**	**141**	**146**	**136**

Full Year	14/15 Full Year	15/16 Full Year	16/17 Full Year	17/18 Full Year	18/19 Full Year	19/20 Contract
Heart	12	12	13	21	22	
Lung	17	19	18	18	32	
Liver	46	52	54	51	52	
Total Nat Funded	**75**	**83**	**85**	**90**	**106**	**115**
Renal	78	95	119	115	119	
Total	**153**	**178**	**204**	**205**	**225**	

- There has been no change to the clinical FTE for transplant services position for the current financial year and planning has started for the 2020/21 financial year. The year to date organ transplant volumes are slightly below the 2018/19 volumes and this has mitigated any clinical risk associated with non-approval of clinical FTE requests for the current financial year.
- The Australian and New Zealand Paired Kidney Exchange continues to operate successfully.

Planned Care

The first two work streams which focused on: 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, are now largely complete. Two additional areas of focus are now underway:

- Improvement of preadmission processes
- Progressing all day operation lists

The preadmission work stream has six areas of work to progress over coming months:

  - Data visibility and production planning to understand who needs to be seen when by service
  - Increasing the pool of GSU-suitable patients
  - Equity and day of surgery cancellations
  - Patient preadmission communications
  - Optimising current capacity
  - Redesign Model of care

The all day operating lists work has progressed with:

- most Senior Medical Officer meetings attended by the improvement team to socialise the plans.
- Beginning to design new schedules and identify changes at a surgeon by surgeon level
- Discussing with ASMS to understand consultation required
- Ophthalmology will begin to introduce 4 hour mornings first then introduce afternoons on a volunteer basis to start with

Building for the Future Programme

- The Programme and Tranche 1 cases have been approved by the Board and will be presented for further regional and CIC endorsement for Crown funding.
- Procurement of the Tranche 1 design team continues whilst the design group is mobilised.
- The Government has announced $25m funding for the expansion of the Paediatric Intensive Care Unit; a priority for Tranche 2.
- Construction and operational readiness of ward 51 continues with the ward expected to open in September 2020. A scope variation to provide some further fully equipped bed spaces to mitigate the risk of demand exceeding capacity during winter 2020, (funded by programme contingency), is undergoing endorsement for Board and Ministry approval.

Auckland DHB - Provider

HAC report for January 2020

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

Safety

Metric			Actual	Target	Previous
Number of reported incidents		PR083	1,422		1,383
Number of reported adverse events causing harm (SAC 1&2)		PR084	8	Lower	9
Central line associated bacteraemia rate per 1,000 central line days		PR087	R/U	<=1	R/U
Healthcare-associated Staphylococcus aureus bacteraemia per 1,000 bed days		PR088	0.39	<=0.25	0.2
Healthcare-associated bloodstream infections per 1,000 bed days - Adult		PR089	2.31	<=1.6	2.05
Healthcare-associated bloodstream infections per 1,000 bed days - Child		PR090	3.88	<=2.4	2.93
Falls with major harm per 1,000 bed days		PR095	0.03	<=0.09	0
Nosocomial pressure injury point prevalence (% of in-patients)		PR097	3.75%		1.79%
Rate of HO-CDI per 10,000 bed days (ACH)	*	PR143	2.54	<=4	2.67
Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)		PR185	2.03%		2.02%
% Hand hygiene compliance		PR195	85.69%	>=80%	84.62%
Unviewed/unsigned Histology/Cytology results >= 90 days		PR290	267	Lower	240

Patient-centred

Metric			Actual	Target	Previous
% DNA rate for outpatient appointments - All Ethnicities		PR056	9.83%	<=9%	9.56%
% DNA rate for outpatient appointments - Māori		PR057	21.34%	<=9%	19.04%
% DNA rate for outpatient appointments - Pacific		PR058	19.9%	<=9%	19.91%
% Very good and excellent ratings for overall inpatient experience	#	PR154	84.46%	>=90%	86.27%
Number of CBU Outliers - Adult		PR173	705	<=300	559
% Patients cared for in a mixed gender room at midday - Adult		PR175	27.31%	Lower	21.97%
Breastfeeding rate on discharge excluding NICU admissions	#	PR099	77.96%	>=75%	76.75%
% hospitalised smokers offered advice and support to quit		PR129	96.11%	>=95%	96.34%

Timeliness

Metric			Actual	Target	Previous
(MOH-01) % AED patients with ED stay < 6 hours		PR013	80.42%	>=95%	84.83%
(MOH-01) % CED patients with ED stay < 6 hours		PR016	95.09%	>=95%	92.24%
% of inpatients on Reablement Services Wait List for 2 calendar days or less		PR023	92%	>=80%	99.29%
(ESPI-2) Patients waiting longer than 4 months for their FSA		PR038	2.65%	Lower	1.71%
(ESPI-5) Patients given a commitment to treatment but not treated within 4 months		PR039	10.99%	Lower	8.95%
Cardiac bypass surgery waiting list		PR042	54	<=115	74

% Accepted referrals for elective coronary angiography treated within 3 months	PR043	95.89%	>=90%	96.86%
% Urgent diagnostic colonoscopy compliance	PR044	97.26%	>=90%	96.49%
% Non-urgent diagnostic colonoscopy compliance	PR045	33.01%	>=70%	40.25%
% Outpatients and community referred MRI completed < 6 weeks	PR046	34.78%	>=95%	35.84%
% Outpatients and community referred CT completed < 6 weeks	PR047	68.65%	>=95%	89.55%
31/62 day target - % of non-surgical patients seen within the 62 day target	PR181	94.92%	>=90%	93.62%
31/62 day target - % of surgical patients seen within the 62 day target	PR182	100%	>=90%	100%
62 day target - % of patients treated within the 62 day target	PR184	97.3%	>=90%	96.25%
% Chemotherapy patients (Med Onc and Haem) attending FSA within 2 weeks of referral	PR508	57.06%	100%	74.57%
% Radiation oncology patients attending FSA within 2 weeks of referral	PR509	29.82%	100%	39.49%

Effectiveness

Metric		Actual	Target	Previous
28 Day Readmission Rate - Total	# PR078	10.57%	<=6%	10.77%
Mental Health - 28 Day Readmission Rate (KPI Discharges) to Te Whetu Tawera	# PR119	6.25%	<=10%	5.88%

Efficiency

Metric		Actual	Target	Previous
HT2 Elective discharges cumulative variance from target	PR035	0.92	>=1	0.92
Elective day of surgery admission (DOSA) rate	PR048	65.61%	>=68%	71.36%
% Day Surgery Rate	PR052	58.01%	>=70%	50.32%
Inhouse Elective WIES through theatre - per day	# PR053	115.33	>=99	137.25
Average LOS for WIES funded discharges (days)	PR074	2.78	<=3	2.86
Mental Health Average LOS (KPI Discharges) - Te Whetu Tawera	PR120	26.1	<=21	37

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

Amber	Variance from target not significant enough to report as non-compliant. This includes percentages/rates within 1% of target, or volumes within 1 value from target.
#	Actual is the latest available result prior to January 2020
*	Quarterly
	PR143 (Quarterly) Actual result is for the period ending December 2019. Previous period result is for period ending September 2019.
R/U	Result Unavailable
	Central line associated bacteraemia rate per 1,000 central line days Results Unavailable

Cancer and Blood Directorate

Speaker: Richard Sullivan, Director

Service Overview

Cancer is a major health issue for New Zealanders. One in three New Zealanders will have some experience of cancer, either personally or through a relative or friend. Cancer is the country's leading cause of death (29.8%) and a major cause of hospitalisation.

The Auckland DHB Cancer and Blood Service provide active and supportive cancer care to the 1.5 million population of the greater Auckland region. This is currently achieved by seeing approximately 5,000 new patients a year and 46,000 patients in follow-up or on treatment assessment appointments.

The Cancer and Blood Directorate is led by:

Director:	Richard Sullivan
General Manager:	Deirdre Maxwell
Director of Nursing:	Brenda McKay
Director of Allied Health:	Cheryl Orange
Finance Manager:	Dheven Covenden
Human Resources Manager:	Andrew Arnold

Directorate Priorities for 2019/20

In 2019/20 our Directorate will contribute to the delivery of the Provider Arm work programmes. In addition to this we will also focus on the following Directorate priorities:

1. Equity considerations
2. Improved patient experience
3. Health and wellbeing of our people
4. Research and innovation
5. Cancer and blood information system
6. Service improvements including Cancer Nursing Strategy
7. Prudent operational and financial management

Glossary

Acronym/term	Definition
LDO	Local Delivery of Oncology
NRICS	Northern Region Integrated Cancer Service
OH&S	Occupational Health and Safety
SCD	Service Clinical Director

Q3 Actions – 90 day plan

1. Equity considerations

Our Directorate is working with Auckland DHB, Regional and National processes to explore how we can best address the gap in health outcomes for Māori patients. A workplan is currently underway which will be presented to the DHB Executive Leadership Team for approval.

2. Improved patient experience

Waiting Room Upgrade: Work will commence at the end of February 2020 using charity funding to redevelop our main waiting area in Building 8. This area sees approximately 300 patients with their whānau daily, and houses the pharmacy pickup area. We will later bring in artwork that is consistent with the new Māori name of our Regional Service 'Te Pūriri O Te Ora'. Upgrade work will take place during weekends and should be completed within 4 weeks.

Brachytherapy bunker development: Concept plans are in progress and we continue to work with the anaesthetic and theatre teams towards finalising the business case. This will enable better utilisation of theatre capacity, linac capacity, and improve patient experience as a result of not having to seek treatment in different areas across the hospital.

Cancer and Blood space requirements and mitigation options: More broadly we are working through Building 8 space requirements linked to increasing demand growth for all Cancer and Blood services. For example medical oncology chemotherapy provision (with associated clinic visits) has increased 15% 2018-2020. Our Local Delivery of Oncology (LDO) delivers chemotherapy at local DHBs as this is the right thing to do for patients/whānau, and assists to decant activity off the Auckland Hospital site. This is integrally linked to the approval processes and speed with which we can implement LDO – with extension to the full delivery of breast cancer cytotoxic mediations at both Counties and Waitematā DHBs approved by the Northern Region Integrated Cancer Service (NRICS) in February 2020, and implementation planning underway with this full service commencing July 2020. The provision of echos at local DHBs will also be included in this initiative.

3. Health and wellbeing of our people

We are working to progress employee engagement action planning with all groups of staff, where plans are being implemented with the majority of teams. We are also working on the implementation of Care Capacity and Demand Management. This is currently being implemented as a change management process in Ward 64 where nursing staffing numbers have been augmented and improved flexible rostering has moved away from a minority of staff working on fixed shifts leading to a fairer arrangement for the majority of nursing staff. Current concerns relate to increasing the skill mix on the ward, which is being addressed with support from senior nursing staff.

4. Research and innovation

The Integrated Cancer Service work spans business case generation for both the cancer precinct rebuild (Buildings 7, 8, 9 and 13), and the regional electronic protocol and prescribing system. Current activity includes the refinement of the drafted 10-year Radiation Therapy Regional Plan (final version to be completed by March 2020). Additionally, following agreement by the Programme Board, the planned development of a draft model of care (medical oncology, radiation oncology, haematology and research) has been redefined into the Better Business Case Methodology,

focussing on the development of the case for change, and strategic assessment by June 2020 as a means to articulate the need for a rebuild from a facility and clinical perspective. This will provide the foundation for completing the business case for Auckland DHB cancer and blood facility rebuild during 2020.

Our Research Service has been restructured to support more efficient and effective operation, with linked activity across Early Phase and Late Phase areas. The Early Phase Trials Centre, in conjunction with the University of Auckland, is sourcing increasing numbers of international trials. External funding is supporting the fixed term employment of Research Fellows. Current activity is also focused on the interrogation of finances to ensure sustainable/growth provision.

5. Cancer and Blood information system

This regional work continues, progressing regional healthAlliance process regarding funding for the Regional Oncology Electronic System – note that this is consistent with the Regional Long Term Investment Plan. This system will support consistency regarding cancer and blood protocols and prescriptions to ensure the same standard of care is provided across the region. Seed funding for business case development and implementation planning has been approved through the Regional Information Systems Strategic Plan process, to be released in February 2020. Business case submission through this process is expected in September 2020. Investment logic mapping has been completed, and work is underway with healthAlliance to source the appropriate staff to develop the business case.

6. Service improvements including Cancer Nursing Strategy

In this quarter the two areas of focus of our Cancer Nursing Strategy in order to advance the capability for the evolving needs of LDO are Develop our Workforce and New Models of Care.

Within Ward 64, the new roster utilises Care Capacity and Demand Management data to appropriately allocate staffing numbers and skill where required over the 24 hour period – this staffing and roster change process is now complete excepting a 0.6 FTE vacancy, but not all staff have on-boarded yet. This provides the ability to better roster within accepted guidelines for staff wellbeing. The recently appointed Nurse Educator and the newly developed Clinical Coach position will be integral to implementation of our team building and training programme. This programme will expand the skills and knowledge of the new team, provide them with a structured career progression and provide a positive base for the coming year.

Further improvements explore the success of a recent Greenbelt project which showed demonstrable reduction in the 'did not attend' rate for first specialist appointment for Māori and Pacific patients, based within the breast tumour stream. Work is underway with our Faster Cancer Treatment and Psycho-oncology teams, along with the Patient Administration Service team, with support/agreement from Provider Directors. We are translating the attributes of this work to other tumour streams, with initial commencement across gynaecology, skin and lung cancer. The intent is to roll this work across all tumour streams.

7. Prudent operational and financial management

Ongoing work within the directorate is underway to manage financial and operational pressures.

We operate monthly service meetings with Service Clinical Directors (SCDs) and senior directorate leadership team members to provide detailed understanding and management of financial, human

resource and other issues. Linked with this, monthly key performance indicator meetings are held with SCDs, the Director and General Manager.

We also operate weekly standing meetings with wider directorate leadership members to understand and monitor service issues, aligned with Management Operating System meetings.

A further piece of work pertains to linking Medirota administration process with DHB-wide systems such as Workforce Central. This work ensures consistent administration practices regarding leave approval as an example.

Scorecard

Auckland DHB - Cancer & Blood Services

HAC report for January 2020

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

Safety

Metric		Actual	Target	Previous
Medication errors with major harm	PR215	0	Lower	0
Nosocomial pressure injury point prevalence (% of in-patients)	PR097	0%		0%
Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	PR185	0%		0%
Number of falls with major harm	PR199	1	Lower	0
Number of reported adverse events causing harm (SAC 1&2)	PR084	1	Lower	0
Unviewed/unsigned Histology/Cytology results >=30 days	PR596	0	Lower	0
% Hand hygiene compliance	PR195	90.29%	>=80%	83.1%

Patient-centred

Metric		Actual	Target	Previous
% Patients cared for in a mixed gender room at midday - Adult	PR175	19.05%	Lower	13.67%
% hospitalised smokers offered advice and support to quit	PR129	100%	>=95%	100%
% DNA rate for outpatient appointments - Māori	PR057	11.55%	<=9%	12.16%
% DNA rate for outpatient appointments - Pacific	PR058	6.8%	<=9%	10.04%
% DNA rate for outpatient appointments - All Ethnicities	PR056	4.8%	<=9%	5.02%
% DNA rate for outpatient appointments - Deprivation Scale Q5	PR338	6.09%	<=9%	8.66%
% Very good and excellent ratings for overall inpatient experience	# PR154	75%	>=90%	62.5%
% Very good and excellent ratings for overall outpatient experience	# PR179	91.3%	>=90%	91.8%
% Very good and excellent ratings for coordination of care after discharge	# PR493	66.7%	>=90%	57.1%
% Response rate to ADHB patient experience inpatient survey	# PR315	16%	>=25%	11%
Number of CBU Outliers - Adult	PR173	54	<=300	52

Timeliness				
Metric		**Actual**	**Target**	**Previous**
31/62 day target - % of non-surgical patients seen within the 62 day target	*PR181*	**94.92%**	>=90%	93.62%
31/62 day target - % of surgical patients seen within the 62 day target	*PR182*	**100%**	>=90%	100%
62 day target - % of patients treated within the 62 day target	*PR184*	**97.3%**	>=90%	96.25%
BMT Autologous Waitlist - Patients currently waiting > 6 weeks	*PR186*	2	Lower	0
% Cancer patients receiving radiation/chemo therapy treatment within 4 weeks of DTT	*PR070*	**83.06%**	100%	90.19%
% Chemotherapy patients (Med Onc and Haem) attending FSA within 4 weeks of referral	*PR059*	**92.14%**	100%	95.3%
% Chemotherapy patients (Med Onc and Haem) attending FSA within 2 weeks of referral	*PR508*	**57.06%**	100%	74.57%
% Radiation oncology patients attending FSA within 2 weeks of referral	*PR509*	**29.82%**	100%	39.49%
% Radiation oncology patients attending FSA within 4 weeks of referral	*PR064*	**55.48%**	100%	85.52%
% Patients from Referral to FSA within 7 days	*PR180*	13.22%	TBC	17.49%

Effectiveness				
Metric		**Actual**	**Target**	**Previous**
28 Day Readmission Rate - Māori	# *PR079*	**20%**	<=6%	62.5%
28 Day Readmission Rate - Pacific	# *PR080*	**44.44%**	<=6%	19.23%
28 Day Readmission Rate - Total	# *PR078*	25.86%	TBC	24.23%
28 Day Readmission Rate - Deprivation Scale Q5	# *PR322*	**31.71%**	<=6%	30.23%

Efficiency				
Metric		**Actual**	**Target**	**Previous**
% Day Surgery Rate	*PR052*	**0%**	>=70%	0%
Average LOS for WIES funded discharges (days) - Acute	*PR219*	4.39	TBC	4
Average LOS for WIES funded discharges (days) - Elective	*PR220*	8.4		0

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

#	Actual is the latest available result prior to January 2020

Scorecard Commentary

- Hand hygiene for Jan is 86%.
- There was One Sac 2 event which was a fall in Motutapu ward in January 2020, this was also recorded as the adverse event. This patient went to DCCM with concussion and a laceration on his forehead.

- Brief Advice for smokers is at 100%.
- We continue to monitor the readmission rate of Māori and Pacific Island patients, noting that the numbers of patients this pertains to is small. Our Cancer Psychological and Social Support Service is available to assist people should they require it.

Key achievements in the month

- We are working with Nuclear Medicine on the production of a DHB business case for the delivery of a national Peptide Receptor Radionuclide Therapy service for patients with neuro-endocrine tumours. The Ministry of Health has recently commenced paying for treatment at the Peter MacCullum Centre (Melbourne) while this work is progressed.
- We have developed the next extension of the Local Delivery of Oncology initiative, where this will deliver breast cancer chemotherapy to the full cohort of patients/whānau. This paper has been approved by NRICS (February 2020) with implementation planning underway for commencement July 2020.
- We thank Facilities and Development for their work to bring the second new lift into service within Building 8, while continuing work on the replacement of a third critical lift in the radiation treatment area. This upgrade work has substantially reduced the pressures on patients/whanau and staff to manage frequent lift entrapments and breakdowns.
- We are working with the Emergency Management Team to establish a pipeline for School of Public Health graduates, utilising the skills within our Faster Cancer Treatment team.

Areas off track and remedial plans

- Achieving Financial Savings: We continue to institute greater directorate leadership oversight to ensure robust process and management. We have processes to understand and manage instances where budgets are not met, for example increased use of pharmaceutical cancer treatments as a consequence of increased demand; and to explore reasons where revenue is not achieved, for example changes in inpatient revenue year on year. This activity will flow into annual planning processes.
- A continued demand increase within Radiation Oncology has seen a sustained increase in referrals to first specialist appointment (6% per annum 2015-2019), with a flow through increase in radiation therapy treatments required. These determinants of radiation therapy demand are linked to additional referral sources such as acutes and on-treatment reviews. We have employed additional radiation therapy staff to run 2 additional late shifts commencing late February 2020, and have ceased the outsourcing arrangement with a private provider accordingly. Recruitment has resulted in a total of 19 additional staff hires to also support the provision of annual leave and to manage the high on-going turnover rate within this workforce. A retention allowance is being applied to assist with stability. This process is managed through Oversight Review, with DHB senior leadership providing advice and direction.

Key issues and initiatives identified in coming months

- The physical clinic and daystay capacity within Building 8 is causing pressures within radiation oncology, haematology, research and medical oncology. Our medical oncology (chemotherapy) unit is being challenged with increasing numbers of patients requiring treatment. This is despite the LDO work providing a decant of volumes to local DHBs. We are modelling this activity and have been managing this using an Oversight Review process within Cancer and Blood. We are currently auditing the use of clinic rooms to ensure appropriate utilisation, and will install 3 additional chemotherapy chairs within our Acutes department (adjacent to the infusion centre).
- Equity focus within Cancer and Blood Directorate: We are engaged with the NRICS process to understand institutional racism awareness processes, and additionally how we can best employ regional planning processes regarding the development of models of care. Our intent is to develop substantive engagement/change management processes to result in improved decision-making and outcomes. We have engaged a staff member to assist, and are engaged with Dame Naida Glavish and Māori Health staff to progress.
- From a Health and Safety perspective, our new Occupational Health & Safety Advisor has been appointed and has delivered a deep-dive exercise with the directorate committee. Patient falls has been determined as a priority area. Meantime we remain well below the DHB average in lost time due to injury frequency rate. There are 12 key DHB Occupational Health and Safety (OH&S) risk categories with eight being applicable to the directorate: manual tasks; remote work; vehicles/driving; contractor management, fatigue management; hazardous substances; violence/aggression; and biological hazards. OH&S guidance will be followed to record and manage these identified risks in alignment with DHB process. The objective will be educational and to establish OH&S routine around identifying and implementing mitigating actions.

Financial Results

STATEMENT OF FINANCIAL PERFORMANCE
Cancer & Blood Services

Reporting Date Jan-20

($000s)	MONTH			YEAR TO DATE (7 months ending Jan-20)		
	Actual	Budget	Variance	Actual	Budget	Variance
REVENUE						
Government and Crown Agency	1,223	1,227	(4) U	9,771	8,589	1,182 F
Funder to Provider Revenue	12,092	10,312	1,780 F	77,560	73,139	4,421 F
Other Income	38	72	(33) U	502	501	1 F
Total Revenue	**13,353**	**11,610**	**1,743 F**	**87,832**	**82,229**	**5,603 F**
EXPENDITURE						
Personnel						
Personnel Costs	4,248	3,823	(425) U	28,047	28,012	(35) U
Outsourced Personnel	45	52	7 F	292	363	71 F
Outsourced Clinical Services	446	272	(174) U	3,523	2,243	(1,280) U
Clinical Supplies	5,440	4,596	(843) U	37,417	32,607	(4,810) U
Infrastructure & Non-Clinical Supplies	132	193	61 F	1,116	1,229	113 F
Total Expenditure	**10,312**	**8,937**	**(1,375) U**	**70,394**	**64,454**	**(5,940) U**
Contribution	**3,042**	**2,673**	**368 F**	**17,438**	**17,775**	**(337) U**
Allocations	846	735	(111) U	5,630	5,491	(139) U
NET RESULT	**2,196**	**1,938**	**258 F**	**11,807**	**12,284**	**(476) U**

Paid FTE

	MONTH (FTE)			YEAR TO DATE (FTE) (7 months ending Jan-20)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	78.9	73.1	(5.8) U	77.4	73.1	(4.3) U
Nursing	161.2	158.3	(2.9) U	157.7	158.3	0.6 F
Allied Health	102.7	117.8	15.1 F	95.8	117.8	22.0 F
Support	2.4	1.0	(1.4) U	2.1	1.0	(1.1) U
Management/Administration	55.8	53.9	(1.9) U	56.1	53.9	(2.3) U
Total excluding outsourced FTEs	**401.0**	**404.1**	**3.1 F**	**389.1**	**404.1**	**15.0 F**
Total Outsourced Services	2.2	1.3	(0.8) U	3.2	1.3	(1.9) U
Total including outsourced FTEs	**403.1**	**405.4**	**2.3 F**	**392.3**	**405.4**	**13.1 F**

Financial Commentary

The result for the year to date January 2020 is an unfavourable variance of $476k.

Volumes: Overall volumes are 100.2 % of contract.

Note: The Haemophilia Service is included in the Cancer and Blood Directorate. Haemophilia is a demand driven service and is reimbursed by the National Haemophilia Management Group (NHMG) for blood product usage and nursing costs. However, the demand for blood products is quite variable and often results in significant variances in the monthly blood product usage, and the corresponding revenue reimbursement. This sometimes distorts the Cancer and Blood result but is mainly bottom line neutral.

Key drivers of the unfavourable variances are

Total Revenue - $5,603k favourable. This is mainly due to:

- Funder to Provider revenue $4,421k F driven by the Pharmaceutical Cancer Treatments (PCTs) wash up and Medical Oncology volume performance (washed up monthly in arrears).
- Haemophilia blood product reimbursement - demand driven and offset by higher blood product costs.

Total Expenditure (including allocations) - $6,027k unfavourable. This is primarily due to:

- Personnel costs including Outsourced Personnel $36k favourable - primarily due to:
  - Medical Personnel costs $824k U – this is mainly due to increased volumes in Medical Oncology, an unbudgeted Haematology RMO (research funded role offset by additional revenue), and the unachieved SMO vacancy savings target.
  - Allied Health vacancies $1,072k F mainly radiation therapists and physicists vacancies (mostly offset by Auckland Radiation Oncology (ARO) outsourced costs).
- Outsourced clinical services $1,280k unfavourable – mainly due to:
  - The outsourcing of radiotherapy delivered at ARO $1,016K U (offset by the radiation therapists vacancies).
  - Local Delivery of Oncology (LDO) costs $255k U.
- Clinical supplies $4,810k unfavourable – this is due to:
  - Pharmaceuticals $3,195k U - driven by the PCT drug overspend (mostly offset by the funder to provider revenue wash up).
  - Haemophilia blood products $1,375k U - demand driven and offset by additional revenue.

FTE – 13.1 FTE favourable, mainly Allied Health vacancies.

Cardiovascular Services Directorate

Speaker: Michael Stewart, Director

Service Overview

The Cardiovascular Directorate comprises Cardiology, Cardiothoracic Surgery, Vascular Surgery and the Cardiothoracic and Vascular Intensive Care Unit delivering services to both our local population and the greater Northern Region. Our team also delivers the National Heart and Lung Transplant Service on behalf of the New Zealand population. Our other national services are Organ Donation New Zealand.

The Cardiovascular Services Directorate is led by:

Director:	Michael Stewart
General Manager:	Joanne Bos
Director of Nursing:	Joanne Wright
Director of Allied Health:	Kristine Nicol
Director of Primary Care:	Jim Kriechbaum

Directorate Priorities for 2019/20

In 2019/20 our Directorate will contribute to the delivery of the six Provider Arm work programmes. In addition to this we will also focus on the following Directorate priorities:

1. Enhancing Quality Frameworks and Risk management to drive safer and more effective care
2. Equity: Improve access and health outcomes for our Māori and Pacific population
3. Managing demand and delivering equitable and timely care across all Cardiovascular pathways
4. Our people: Enabling a culturally diverse workforce to deliver quality healthcare and providing professional development opportunities for all staff in a safe work environment
5. Being well led: Growing capability and accountability within the directorate leadership team
6. Improve revenue position and reduce cost

Glossary

Acronym/term	Definition
CTSU	Cardiothoracic Surgical Unit
CVICU	Cardiothoracic and Vascular Intensive Care Unit
DNA	Did not attract
DOSA	Day of same admission
EP	Electrophysiology
ESPI	Elective Services Patient Flow Indicator
NZBS	New Zealand Blood Service
ODNZ	Organ Donation New Zealand
SMO	Senior Medical Officer
TAVI	Transcatheter Aortic Valve Implantation

Q3 Actions – 90 day plan

1. Enhancing Quality Frameworks and Risk management to drive safer and more effective care

Our risk register is presented at regular leadership forums and is used as a tool to understand and mitigate immediate risks and issues. We continue to work with our teams to update the risk register and to identify controls to be implemented against the risks to develop a culture within the directorate of staff at all levels undertaking risk assessments and using that to inform immediate and future planning.

The audit schedule implemented in Cardiothoracic and Vascular Intensive Care Unit (CVICU) to improve bedside compliance with equipment checking guidelines is now embedded and reported monthly.

The Cardiovascular Directorate led the development of a Pressure Injury Website which is now live and revision of the current pressure Injury care plan for the organisation. A trial of the revised Pressure Injury Assessment and Care Plan was undertaken during October and November and feedback from that trial has now been incorporated into the new form, which is now ready for further assessment.

The Cardiovascular Directorate has also taken the lead in developing a Post-Operative Assessment and Care Plan for delirium to support patients with post-operative delirium. A draft care plan is currently being trialled in two wards and the trial is expected to be completed by the end of February. The intention, once the form has been revised and finalised, is to roll this out to rest of organisation where appropriate.

An organisational project is underway to develop a framework for staff support after serious unanticipated patient events. Recent feedback provided by ADHB staff is that current processes do not consistently support staff at times when there is an unexpected patient event. A pilot has commenced of a defusing / briefing tool and the Cardiovascular Directorate will be included in this pilot phase from January 2020.

In the last 2 years attendance at early cardiac rehabilitation nurse post-discharge follow-up clinics has increased along with patient complexity. There is now medical supervision allocated to these clinics to allow for active management of patients. Early and intensive engagement with patients is associated with higher uptake of cardiac rehabilitation programs and improved adherence to medication and the introduction of these clinics have resulted in a change in practice with routine doctor follow up clinics are no longer scheduled. Data on outcomes for these patients is continuously reviewed to monitor adherence to medication and rehabilitation programmes.

2. Equity: Improve access and health outcomes for our Māori and Pacific population

The Greenbelt project on reducing the number of Māori patient Did not attracts (DNAs) at the Heart Failure clinic has identified a number of key reasons for DNAs and work is now underway to identify improvement initiatives to deliver improvement. The initial focus is on improved cultural support for Māori through the introduction of a cultural navigator role. In addition, there is now a focus on ensuring information about patients in the heart failure clinic is maintained accurately and a new Post-DNA telephone system has been implemented.

Cardiac surgery has been focussing on preadmission and new ways of working to remove barriers to admission for cardiac surgery. We continue to identify areas within our pathway that make

navigation through to surgery difficult. Early contact with patients and whānau and regular contact throughout has been key, including working with patients who have needed more input or care prior to being wait listed. This has resulted in improvement in the success of moving patients from being suspended on the waitlist through preadmission, surgery and discharge. The Nurse Specialist leading this has engaged with cultural support teams across the regions to prepare patients preoperatively and ensure they have the necessary support in place on discharge. The Nurse Specialist has recently been appointed permanently to the part time role of Thoracic Nurse Specialist and has commenced implementation of similar processes within the thoracic pathway.

Following a review of Northland DHB processes for repatriation for Northland DHB patients post cardiac catheterization, improvements to streamline pathway have been introduced, with particular focus on ensuring better planning before arrival to ensure can always be discharged on the same or following day. These are being monitored to determine if any further changes or additional resources are required.

3. Managing demand and delivering equitable and timely care across all Cardiovascular pathways

CVICU/Cardiac Services

Thoracic preadmission clinics are now operating fortnightly to identify potential Day of Surgery Admission (DOSA) patients and improve preparation of patients. There is currently no space for DOSA patients on Level 4 or capacity in the Transition Lounge, therefore Ward 42 utilises a procedure room two - three days per week to prepare thoracic DOSA patients for theatre. If this is successful a dedicated patient bay on Ward 42 for thoracic and vascular DOSA patients will be considered.

Improvements to cardiac surgical pathway to enable optimisation of the CVICU capacity are progressing well and planning is well underway to commence a pilot of pathway changes to reduce the time to extubation post routine cardiac surgery in CVICU to meet best practice guidelines and enable a reduction in the ratio of nursing care required for these patients. As well as identifying and mitigating key barriers to extubation and increasing the available senior nursing support for bedside nurses, an assistant nurse co-ordinator has been appointed to support nurses to manage this new pathway.

Following the introduction of early blood rounds and x-rays to ensure all clinical tests have been completed in preparation for early discharge, there has been marked increase in the number of patients transferred from CVICU to ward 42 prior to 11am. Nursing staff have also engaged with the Adult Congenital Cardia Heart Disease (ACHD) service which utilises beds on ward 42 to streamline communication and discharging processes and to remove delays to discharge for these patients.

Cardiology

For appropriate patients, Transcatheter Aortic Valve Implantation (TAVI) are now being performed in CIU without anaesthetic support. This greatly reduces case time and frees up operating room capacity. Overall TAVI volumes continue to increase with the 15 being performed in December, which is higher than any previous month. January volumes were low (8). However, Senior Medical Officer (SMO) availability during January was also very low. We expect volumes to be sustained at around 15 per month over the coming months.

Cardiology has a number of initiatives underway to improve throughput in the Cardiac Cath Lab and ensure the most appropriate pathways are being developed for patients, particularly around DOSA procedures. A 6-month pilot to extend post-operative day to 21:00 to increase the day stay volumes for Electrophysiology (EP) and angiography patients started in January 2020. It was agreed a pilot for 6 months was appropriate to ensure day stay pathways are utilised well. This will require a change in clinical practise and the service would like to see this adopted and embedded before any future FTE is requested to support this model long term. A review will be undertaken after 3 months and if successful, planning will commence to operationalise this approach.

The new cardiac investigation unit (CIU) schedule to improve throughput and deliver a further 2- 4 procedures per week has commenced. This will undergo continuous review and refinement over the next few months to maximise the benefits.

The reasons for late start times in CIU are now being recorded in the theatre management system and this data will be being presented at the weekly MOS meetings from early 2020. The intention is to resolve issues that are causing late session starts, reducing risk of procedure cancellations due to insufficient time. Obtaining the data required to inform this initiative has been challenging as the theatre management system is very old and not configured well for CIU and we are exploring alternative data sources.

Regional planning is continuing for the transition of catheter lab services to Northland DHB and Counties Manukau Health as their new facilities come on stream. A paper was completed that outlines the stranded costs for Auckland DHB and implications of volume to these DHBs based on their indicative time frames for repatriation of angiography (Northland DHB) and ICD/pacemaker (Counties Manukau Health) volumes and this has been presented regional forums for review. Planning is now focussed on mitigating the impact of the identified stranded costs.

A paper was presented to the Regional Cardiology Network that proposes repatriation of Herceptin ECHOs to the patient's DHB of domicile. This was accepted in principle and will be implemented by the regional Local Delivery of Oncology working group with a planned implementation date of 1 July 2020.

Vascular Surgery

The Vascular service is working on initiatives to reduce the need to admit patients overnight pre and post-procedure. This includes adopting the Diabetes Management Protocol for Type 1 and 2 Diabetes patients, updating the pre-hydration guideline for renal protection so this can be safely delivered as a day case and investigating alternative accommodation for patients from Northland that could be offered as alternatives to a hospital bed. Accommodation alternatives will ensure that there is no impact to equity of access for these patients as a result of move to more day case procedures.

Vascular Outpatients follow ups are currently under review. Senior nurses, with input from primary health commenced a six-month pilot of the SOS system in February for a cohort of vascular patients. Assuming this is successful, we anticipate being able to extend this service to other vascular patients following the end of the pilot. The nursing team is also working with the performance improvement team to investigate alternatives to the traditional face to face appointments for follow up assessments and this is progressing well.

Following a recent resignation, the service began interviewing for a replacement SMO at the end of October 2019. Recruitment has been successful and a new SMO will commence with the service early March 2020. A locum SMO that was secured to assist with outpatient workload through January and February 2020 was unfortunately unable to work in January but has provided some outpatient clinics in February.

A paper has been drafted for presentation to ELT and the regional executive forum that outlines the opportunity, options and risks for a regional service and this is will be presented for review in March.

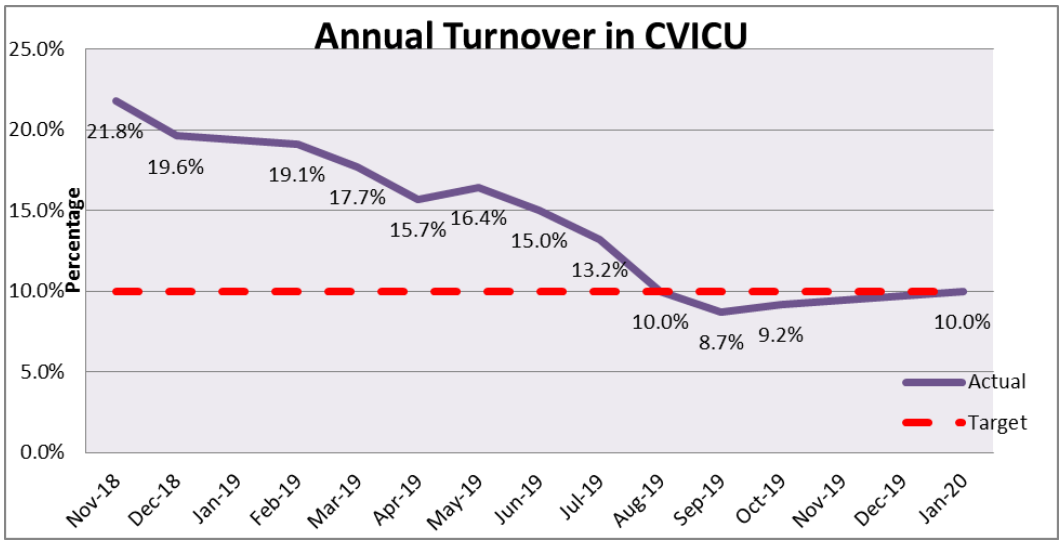
4. Our people: Enabling a culturally diverse workforce to deliver quality healthcare and providing professional development opportunities for all staff in a safe work environment

Nurse Unit Managers and Charge Nurses continue to work closely with Māori and Pacific nursing professional leads to identify talent on entry to nursing practice. Focus has been applied to increasing the Māori nursing workforce and this has resulted in increased numbers of nurses who identify as Māori (see table below). The same approach is now being applied to the Pacific nursing workforce. The Cardiovascular Directorate held a Māori Nurse's Hui on 14 February 2020 aimed at enhancing networks supporting Māori nurses in professional and personal development. The hui was attended by 14 nurses. There will be a follow up session in a few weeks' time and then regular quarterly huis.

The table below illustrates the increase in Māori Senior Nurses and Staff nurses from 2017 to present and the target for 2025.

	2017 Actual	2019 YTD	2025 Target
Senior nurses	1	4	5
Registered Nurses	8	17	23
TOTAL	**9**	**21**	**28**

CVICU has continued to reduce nursing staff turnover over the past quarter, with most recent turnover data showing CVICU is meeting organisational targets (see graph below). This reduction in staff turnover has positively benefited the nursing skill mix in CVICU. The staff engagement survey work is ongoing and there are action plans targeting three main areas, which are predominately implemented;



- safe staffing levels, ensuring appropriate senior support
- appreciation and wellbeing
- equipment and storage, enabling improved workflow and easy access to equipment

There has been a successful campaign to increase the opportunities for CVICU nursing staff to access funding to enable them to complete postgraduate Intensive Care qualifications from the University of Auckland, with 9 students from CVICU currently undertaking this study. This is a 5% increase on our total number of nurses with these qualifications. We are expecting that we will be offering 10 students the opportunity to study in 2020.

The CVICU nursing team have re-established an active peer support group for staff who are currently engaged in wellbeing activities and social events for the team and the CVICU nurses are represented at the Directorate Wellbeing group. Regular resilience sessions and team forums are continuing and a partnership with a massage school has been established so staff can now be offered a regular free 10-minute massage. There is a team day planned in April.

5. Being well led: Growing capability and accountability within the directorate leadership team

Staff continue to enrol in the Management Development programme (MDP) learning modules and 68 modules have now been completed. Leading our Values and Role and Responsibility of being a Manager are the most popular modules and all other modules have been completed by some staff or are in progress. We will continue to encourage participation in this programme.

New Service Clinical Directors for Cardiothoracic Surgical Unit (CTSU) and Cardiology have been appointed and a 3-month transition period has commenced.

Clinical services are holding monthly MOS meetings, led by Service Clinical Directors, to review service KPIs and performance and to identify barriers and risks. The directorate also holds monthly finance meetings that are attended by all SCDs, Operations Directors, Senior Nurses and Finance team to review operational and financial performance across Directorate to ensure some peer challenge and support.

The Assistant Coordinator Registered Nurse role introduced to support the Clinical Nurse Coordinator with managing patient flow in CVICU is now embedded. It is now planned that this is extended into the afternoon to provide additional support and ensure plans are in place for the new pathway for earlier extubation for routine cardiac surgery patients across the evening and night shifts. As total patient numbers increase, this role is also seen as a step towards the evolution into 2 pods within CVICU to meet College of Intensivists guidelines for accreditation in 2020.

6. Improve revenue position and reduce cost

Please refer to the financial results section.

Scorecard

Auckland DHB - Cardiovascular Services

HAC report for January 2020

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

Safety

Metric		Actual	Target	Previous
Medication errors with major harm	PR215	0	Lower	0
Nosocomial pressure injury point prevalence (% of in-patients)	PR097	8.3%		11.5%
Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	PR185	2.4%		2.4%
Number of falls with major harm	PR199	0	Lower	0
Number of reported adverse events causing harm (SAC 1&2)	PR084	0	Lower	0
Unviewed/unsigned Histology/Cytology results >=30 days	PR596	6	Lower	13
% Hand hygiene compliance	PR195	86.68%	>=80%	85.86%
Central line associated bacteraemia rate per 1,000 central line days	PR087	2.18	<=1	0

Patient-centred

Metric		Actual	Target	Previous
% Patients cared for in a mixed gender room at midday - Adult	PR175	17.74%	Lower	15.31%
% hospitalised smokers offered advice and support to quit	PR129	96.33%	>=95%	94.74%
% DNA rate for outpatient appointments - Māori	PR057	28.43%	TBC	24%
% DNA rate for outpatient appointments - Pacific	PR058	16.13%	TBC	20.38%
% DNA rate for outpatient appointments - All Ethnicities	PR056	11.78%	TBC	10.98%
% DNA rate for outpatient appointments - Deprivation Scale Q5	PR338	16.94%	<=9%	17.57%
% Very good and excellent ratings for overall inpatient experience	# PR154	92.3%	>=90%	93.5%
% Very good and excellent ratings for overall outpatient experience	# PR179	90.6%	>=90%	90.4%
% Very good and excellent ratings for coordination of care after discharge	# PR493	71.4%	>=90%	54.3%
% Response rate to ADHB patient experience inpatient survey	# PR315	29%	>=25%	25%
Number of CBU Outliers - Adult	PR173	70	<=300	57

Timeliness

Metric		Actual	Target	Previous
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Māori	PR323	15	Lower	11
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Pacific	PR324	17	Lower	17
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Total	PR327	134	Lower	116
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Deprivation Scale Q5	PR326	30	Lower	26
Cardiac bypass surgery waiting list	PR042	53	<=115	72
% Accepted referrals for elective coronary angiography treated within 3 months	PR043	95.89%	>=90%	96.86%

Vascular surgical waitlist - longest waiting patient (days)	PR235	149	<=150	119
Outpatient wait time for chest pain clinic patients (% compliant against 42 day target)	PR236	48.08%	>=70%	60%

Effectiveness

Metric		Actual	Target	Previous
28 Day Readmission Rate - Māori	# PR079	26.32%	<=6%	20.69%
28 Day Readmission Rate - Pacific	# PR080	14.71%	<=6%	16.67%
28 Day Readmission Rate - Total	# PR078	15.34%	TBC	12.14%
28 Day Readmission Rate - Deprivation Scale Q5	# PR322	16.13%	<=6%	17.81%

Efficiency

Metric		Actual	Target	Previous
Elective day of surgery admission (DOSA) rate	PR048	12.94%	TBC	19.05%
% Day Surgery Rate	PR052	14.81%	TBC	17.98%
Average LOS for WIES funded discharges (days) - Acute	PR219	4.71		5.8
Average LOS for WIES funded discharges (days) - Elective	PR220	3.64		2.12
HT2 Elective discharges cumulative variance from target	PR035	1.05	>=1	1.04
Inhouse Elective WIES through theatre - per day	# PR053	15.43	TBC	23.32
% Adjusted Session Theatre Utilisation	PR198	81.2%	>=85%	82.2%
% Theatre Cancellations	PR218	10.27%	TBC	13.16%

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

#	Actual is the latest available result prior to January 2020

Scorecard Commentary

- There were no Severity Assessment Code 1 or 2 events reported for January for the Cardiovascular Directorate.
- There were no falls with harm reported during January.
- There were no medication errors resulting in harm. There are concerns related to available support via pharmacy and in errors in discharge prescriptions in particular and the associated risk is included on the directorate risk register.
- There was one complaint received in January and February. This has been resolved with the family.

- There were two Grade 2 pressure injury reported in January.
- The Cardiology wait list numbers as at 24 February were as follows:
    - Interventional: 100 patients on the waiting list.
    - Device: 76 patients on the waiting list.
    - Electrophysiology (EP): 242 patients are on the waiting list. This waitlist continues to be very high. There are 138 patients waiting over 120 days as at 24 February 2020 and the waiting time for the longest waiting patient is 305 days. Initiatives to improve productivity and waitlist management are outlined above.
- The Cardiology service had six Elective Services Patient Flow Indicator (ESPI) 2 breaches in January as a result of SMO unavailability during the sonographer strike.
- The cardiac eligible bypass surgery list continues to be below target. The service three ESPI 5 breaches in February due to very high acute demand. The service performed 2 lung and 4 heart transplants in December and January.
- The Vascular service had 81 ESPI 2 breaches for February as a result of an SMO vacancy. A locum was engaged to temporarily fill this vacancy but unfortunately due to an accident, was not able to work in December and January. A replacement SMO is starting in March. The service had no ESPI 5 breaches in January.

Key achievements in the month

- Continued successful development of our Māori workforce particularly in senior nursing positions.
- Commencement of an additional community clinic to provide complex multi-disciplinary care for Māori and Pasifika patients with acute coronary syndrome and Rheumatic fever in the Glen Innes area.
- Commencement of a 6-month pilot of extended hours in Ward 31 to increase the day stay volumes for EP and angiography patient. Senior staff have volunteered to help staff this during pilot phase to ensure this can be done with existing staffing. This started in early January 2020.
- Continuation of consultation planning for transition of Organ Donation NZ to NZ Blood Services, with a formal consultation document to be provided to staff in early March.
- Early blood and X-ray rounds have been introduced on ward 42 to facilitate early patient discharge home and allow early transfer from CVICU to free up CVICU beds. The learning from this initiative is now being transferred across the Directorate.
- A full time permanent SMO has been successfully recruited into the Vascular Service and to commence in early March 2020.
- Commencement of new Charge Cardiac Sonographer (December 2019), and appointments made to all vacancies and will be in these roles by June 2020.
- Cardiology and CTSU services have both consistently delivered to PVS contract levels over the past three months, which represents an improvement over the first quarter.

- The Cardiac Monitoring Governance group was the winner of the Clinical Excellence Award at the Health Excellence Awards for their work to improve cardiac monitoring for adult patients at Auckland DHB. The aim of this project was to reduce waste - time, resources, and utilisation as well as to ensure the right patients are being monitored in the right way, in the right place, by the right staff and at the right time
- The Patients at Risk (PAR) team were winners of the Living our Values Health Excellence award based on the high regard they are held in by the medical and nursing teams for their ability to communicate well and their skill in liaising patient care.
- Appointment into the SCD roles for Cardiology and CTSU.
- Endorsement from the Regional Cardiac Network for transition of ECHOs for women from other northern region DHBs taking Herceptin to their DHB of domicile.

Areas off track and remedial plans

- The Regional EP waitlist continues to grow and the number of patients waiting longer than 120 days has increased over the last period as has the longest waiting time. The new updated Cardiology Investigation Unit (CIU) schedule is now in place and is being regular reviewed and revised and an EP SMO returned from maternity leave in December. There is risk that if the increase in productivity expected from the new CIU schedule does not eventuate and we will not meet the volumes indicated in our recovery plan. Alternative options including outsourcing are being explored to determine the availability, costs and benefits of these in case internal capacity is not sufficient to deliver the required volumes.
- The service continues to be challenged in meeting PVS volumes and the revenue position reflects a year to date result is $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 ECHO service continues to be stretched with challenges in recruiting and retention of the sonography workforce. However, all vacancies are now filled with all appointees expected to be in place by June. As a result of these capacity constraints, the ECHO waitlist is growing and this was exacerbated by the recent industrial action. Locums have been providing cover in the outpatient setting to enable some mitigation of the impact of the recent industrial action and will continue to support recovery following the recent withdrawal of this action.
- The Vascular service is not delivering the required PVS contract volumes and had a high number of ESPI 2 breaches in January (81). Whilst it is expected that there will be a similar number of ESPI 2 breaches in March, with the commencement of a new SMO in March, breaches are expected to reduce significantly from April. The additional SMO will also improve productivity and ensure some recovery of the PVS contract position. A locum SMO will deliver 1 – 2 outpatient clinics per week for the next six months to assist with the recovery.

Key issues and initiatives identified in coming months

- Review the pilot for extended hours in Ward 31 to increase the day stay volumes for EP and angiography patients which commenced in early January 2020.
- Ongoing improvement work across the service, including prevention of cancellations, consistent on-time starts in CIU, rapid discharge and transfer pathways, review of long stay patients, continuous review and refinement of the CIU schedule and increasing DOSA volumes.
- Development and implementation of a revised Cardiology roster in consultation with all cardiology SMOs to optimise delivery of patient care whilst safe guarding the staff from the demands of an increasing workload.
- Development and implementation of the new EP database, due to be implemented in March 2020 to improve audit and quality outcomes for EP patients.
- Stabilisation of the ECHO service and orientation of new staff to deliver improvement plans
- In collaboration with MOH, Organ Donation New Zealand (ODNZ) and New Zealand Blood Service (NZBS) commence the consultation process with staff for the transition of ODNZ to NZBS on 1 July 2020
- Continue to focus on increasing revenue and reducing costs to improve the financial position
- Appointment of the SCD roles for Cardiology and CTSU.
- Planning for transition of ECHOs for women from other northern region DHBs taking Herceptin to their DHB of domicile.

Financial Results

STATEMENT OF FINANCIAL PERFORMANCE

Cardiovascular Services

Reporting Date Jan-20

($000s)	MONTH			YEAR TO DATE (7 months ending Jan-20)		
	Actual	Budget	Variance	Actual	Budget	Variance
REVENUE						
Government and Crown Agency	151	194	(42) U	1,264	1,355	(91) U
Funder to Provider Revenue	11,518	11,531	(14) U	87,992	91,700	(3,708) U
Other Income	564	998	(435) U	4,654	6,989	(2,335) U
Total Revenue	**12,233**	**12,723**	**(491) U**	**93,911**	**100,044**	**(6,134) U**
EXPENDITURE						
Personnel						
Personnel Costs	6,857	6,363	(494) U	46,451	46,447	(4) U
Outsourced Personnel	46	52	6 F	343	362	19 F
Outsourced Clinical Services	40	233	193 F	1,522	1,629	107 F
Clinical Supplies	2,877	2,951	74 F	22,934	23,211	277 F
Infrastructure & Non-Clinical Supplies	188	204	16 F	1,402	1,316	(86) U
Total Expenditure	**10,007**	**9,802**	**(205) U**	**72,651**	**72,964**	**313 F**
Contribution	**2,225**	**2,921**	**(696) U**	**21,259**	**27,080**	**(5,821) U**
Allocations	956	1,184	228 F	8,359	9,047	689 F
NET RESULT	**1,269**	**1,737**	**(468) U**	**12,901**	**18,033**	**(5,132) U**

Paid FTE

	MONTH (FTE)			YEAR TO DATE (FTE) (7 months ending Jan-20)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	93.5	101.6	8.1 F	97.6	101.6	4.0 F
Nursing	367.3	360.8	(6.5) U	368.5	361.1	(7.4) U
Allied Health	66.9	69.0	2.1 F	65.9	69.0	3.0 F
Support	2.7	2.7	0.0 F	2.7	2.7	0.0 F
Management/Administration	32.2	33.7	1.5 F	32.7	33.7	1.0 F
Total excluding outsourced FTEs	**562.5**	**567.7**	**5.2 F**	**567.4**	**568.1**	**0.6 F**
Total Outsourced Services	1.9	1.7	(0.1) U	2.3	1.7	(0.6) U
Total including outsourced FTEs	**564.4**	**569.5**	**5.1 F**	**569.8**	**569.8**	**0.0 F**

Comments on Major Financial Variances

The January year to date result is $5,132k U – driven by unfavourable Revenue, offset by favourable Outsourcing, Personnel and Clinical Supply costs.

Year to date inpatient Weighted Inlier Equivalent Separation is 95% of budget with Cardiology at 96%, Cardio-thoracic at 98% and Vascular at 81% of budget.

FTE Employed/Contracted is on budget.

Revenue

Overall revenue variance is $6,134k U – this relates to volumes at below planned levels. Approximately 90 cardiology cases were lost in October due to strikes plus eight days lost in November due to the commissioning of the new EP Lab, approximating $700k of lost revenue.

Cardiology and CTSU services have both been consistently delivering at PVS contract levels over the past three months, which represents an improvement over the first quarter. Vascular still has some way to go but will be bolstered by the filling of an SMO vacancy from March.

Expenditure

Total Expenditure (including Allocations) for year to date January is $1,002k F, this is mainly due to:

- Personnel and Outsourced personnel costs being net $15k F; with the cost/FTE being on budget.
- Outsourced Clinical is favourable $107k. CTSU cases have been outsourced due to capacity issues at Auckland City Hospital in July in relation to referrals from Waikato and Capital & Coast DHBs. We have managed to steadily pull this initially unfavourable position back to its now favourable position.
- Clinical Supplies is $277k F. The main drivers are:
    - Blood costs are still high ($429k U or 119% budget, although only 9% higher than last year to date) – the organisational review has not yet commenced.
    - There is currently an effective $277k savings requirement year to date ($475k full year) built into the budget, associated with budgeted CTSU volume increase.
    - We continue to work on opportunities in the procurement space reviewing graft and stent usage and engaging Health Alliance to negotiate rebates with suppliers. There have been a number of procurement initiatives implemented through the 18 19 year which will continue to be monitored through 19 20 in addition to on-going negotiations.
- Infrastructure & Non-Clinical Supplies is $86k U relating to Doubtful Debt provision and Internal Allocations are $689k F associated with lower vascular volumes.

In summary, there are a number of improvement projects running across the directorate that, whilst focused on quality outcomes, patient experience, and improved utilisation and patient flow – will have the indirect benefit of improving productivity and effectiveness of spend. These projects are on-going and will support service delivery and financial management through 19/20.

Clinical Support Directorate

Speaker: Ian Costello, Director

Service Overview

The Clinical Support Directorate is comprised of the following service delivery groups: Patient Services Centre (Administration, Contact Centre and Interpreter services), Allied Health Services (including Physiotherapy, Occupational Therapy, Speech Language Therapy, Social Work and Dietetics), Radiology, Laboratory (including community Anatomical Pathology services, Gynaecological Cytology), Clinical Engineering and Pharmacy.

The Clinical Support Directorate is led by:

Director:	Ian Costello
General Manager:	Kelly Teague
General Manager (Labs and Pathology)	Daniel Hunt
Director of Nursing:	Jane Lees
Director of Allied Health:	Moses Benjamin
Director of Primary Care:	Barnett Bond
Human Resource Manager:	Andrea Long
Finance Manager:	Leanne Gatman

Directorate Priorities for 2019/20

In 2019/20 our Directorate will contribute to the delivery of the six Provider Arm work programmes. In addition to this we will also focus on the following Directorate priorities:

1. **Integrated strategic service planning:** Continue implementation of the agreed strategies for Pathology and Laboratory Medicine Services and Pharmacy and Medicines Management. In addition, to developing service strategies for Radiology, Clinical Engineering, Patient Administration, Contact Centre and Allied Health (AH) working in collaboration with other Directorates to deliver agreed priorities aligned to Auckland DHB strategy.
2. **Capacity and demand management:** Develop workforce and capacity plans, business models and recruitment and retention strategies for all our services that support quality, efficiency, diversity, Directorates and organisational priorities and enable planning and delivery of required activity.
3. **Health and wellbeing of our people:** Develop and implement a systematic process to establish and budget for staffing Full-time Equivalent, staff and skill mix, to ensure the provision of timely, appropriate and safe services using Trendcare and CCDM methodology where appropriate. Each of our services has an engaged and empowered workforce that reflects Auckland DHB values and that our people are equipped and supported to lead and be successful.
4. **Improved patient experience:** Patients experience a service and environment that meets their quality and cultural expectations.
5. **Service quality and improvement:** Further develop the Quality and Safety Excellence Programme across the Directorate, building on work already in place to ensure quality and

safety excellence is embedded across all our services. To develop indicators and measure and improve patient-centred outcomes and clinical safety.

6. **Operational/financial management:** Achieve a sustainable financial position which supports best clinical practice. An agreed strategy for managing significant key equipment replacement and facilities constraints is developed and implemented.

7. **Research and collaboration networks:** Clinical networks established for all our services. Our services have agreed research strategies aligned to strategic priorities. Further develop collaborations with the University of Auckland, in Pharmacy, Pathology and Laboratory Medicine Services and Radiology. To develop further collaborations with Auckland University of Technology and other potential partners to deliver improvement in quality, outcomes, training, research and joint ventures.

Glossary

Acronym/term	Definition
AH	Allied Health
CCDM	Care Capacity Demand Management
MoH	Ministry of Health
MIT	Medical Imaging Therapist

Q3 Actions – 90 day plan

Priority	Action Plan
1	• Finalise the Radiology MRI Strategy and align with Strategic Programmes of work • Implement the agreed Auckland DHB/WDHB IR service • Implement Robotics Automation within CRO for a number of services
2	• Develop our workforce, capacity plans, recruitment and retention strategy and business model for Phlebotomy, Physiotherapy, Occupational Health and Clinical Engineering. • Develop and agree outsourcing strategies for MRI Radiology • Strategic approach to recruitment, retention and workforce diversity
3	• Embed the employment survey results within each service • Establish staff well-being groups within Labs • Develop and agree on People and Engagement plans • Identify key roles and succession plans, Clinical Engineering a priority • Embed strategies for increasing Māori and Pacific workforce • Implement a new graduate programme for nursing workforce strategic direction in Radiology
4	• Implement automated telephone messages in Māori • Finalise options for measuring patient experience in AH, Pharmacy, Radiology, Phlebotomy and Labs • Develop options for supporting whānau in bereavement care
5	• Automate quality measures where possible • Develop capacity and demand reports for Radiology, Laboratories and Pharmacy • Embed access and utilisation of Telephone Interpreting • Finalise quality, safety, equity and outcome metrics with services and begin reporting

	• Finalise patient experience and equity measures and begin reporting • Ensure Care Capacity Demand Management (CCDM) is fully implemented in Allied Health
6	• Identify revenue, savings targets and capital expenditure strategies for all our services. Sustained and effective financial management across financial years with balanced cost/revenue emphasis • Identify revenue, savings targets and capital expenditure strategies for 2020/21 • Model the impact of IR being a stand alone service under Radiology • Develop and agree the high cost capital strategy, management and asset planning
7.	• Develop clinical networks in Pathology and Laboratory and Radiology. Further embed and develop academic partnerships • Expansion of Medicines and Pharmacy Academic Practice Unit to include Schools of Medicine and Nursing

Scorecard

Auckland DHB - Clinical Support Services

HAC report for January 2020

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

Safety

Metric		Actual	Target	Previous
Medication errors with major harm	*PR215*	0	Lower	0
Number of reported adverse events causing harm (SAC 1&2)	*PR084*	0	Lower	0
Unviewed/unsigned Histology/Cytology results >=30 days	*PR596*	1	Lower	0

Timeliness

Metric		Actual	Target	Previous
% Outpatients and community referred MRI completed < 6 weeks	*PR046*	**34.78%**	>=95%	35.84%
% Outpatients and community referred CT completed < 6 weeks	*PR047*	**68.65%**	>=95%	89.55%
% Outpatients and community referred US completed < 6 weeks	*PR229*	**42%**	>=95%	55.6%

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

Service Commentary

1.0 Radiology

Performance against Ministry of Health (MoH) targets has been significantly impacted by industrial action over the last 5 months. Recovery from the strikes will take 3-4 months depending on demand.

Greater integration into other Directorates production planning work and pathway mapping to ensure appropriate modelling of the impact and dependencies of Radiology continues. A suite of reports developed with BI to support this is being developed.

A service review of the Interventional Radiology service is underway, including review of facilities, development of capacity and demand modelling, introduction of a quality and safety framework, financial modelling and horizon scanning for future developments. A joint collaboration with WDHB has been agreed and 3 additional Interventional Radiologists, have been appointed who will work across both DHBs and commence in post from mid-February 2020.

1.1 MRI

Overall performance against the MRI target of 95% of referrals completed within six weeks has deteriorated in January 2020 to 34.8% compared to 35.8% in December 2019.

Cardiac MRI:

Cardiac Adult MRI is showing 72.2% compliance for month end January compared with 82.2% at month end December 2019. The number of adult cardiac patients waiting longer than 42 days is 1 at month end January 2020, no significant change from 0 at month end December 2019, with the total on the waiting list increasing from 27 in December 2019 to 39 in January 2020.

Cardiac Paediatric MRI is showing 50% compliance as at the end of January 2020 compared with 33.3% at month end December 2019. The number of paediatric cardiac patients waiting longer than 42 days remains constant at 12 as at the end of January 2020 compared with 11 at the end December 2019. The total on the waiting list is unchanged at 17.

Non-Cardiac MRI:

The number of MRI Medical Imaging Therapist (MIT) vacancies still remains an issue. Despite on-going and pro-active recruitment, no further appointments have been made in December or January. Outsourcing above the budgeted normal outsourcing volume has commenced. At month end January 2020 we had managed to outsource an additional 238 patients, including 43 paediatric patients. Further increases in outsourcing volumes are being considered.

Adult MRI was at 33.6% compliance in January 2020 compared with 36.5% at month end December 2019 against the MoH target. The number of adult patients waiting longer than 42 days is 781 as at the end of January 2020, decreased from 796 as at the end December 2019 with the total waiting decreasing from 1347 in December to 1226 in January 2020.

Paediatric MRI is showing 33.0% compliance at the end of January 2020 which has improved from 22.3% at the end of December 2019. The number of paediatric patients waiting longer than 42 days has decreased from 137 at the end of December 2019 to 104 at the end of January 2020 with the total waiting list at 163 patients.

1.2 CT:

Performance against the MoH indicator of 95% of out-patients completed within six weeks has deteriorated to 67.1% compliance at the end of January 2020 compared with 89.7% at the end of December 2019. This deterioration against performance has been the result of the recovery form industrial action combined with the holiday period. Weekly reporting for Adult CT shows no significant issues, however we remain non-compliant with the MoH monthly reporting target.

The number of adult CT patients waiting longer than 42 days was 0 as at the end January 2020 which has decreased from 9 as at the end of December 2019 with the total waiting decreasing from 220 at month end December to 123 at month end January 2020.

Paediatric CT is showing 87.7% compliance as at the end of January 2020 compared with 86.8% at the end of December 2019. The number of paediatric patients waiting longer than 42 days was 2 at the end of January 2020, relatively unchanged from 0 at the end of December 2019. The total waiting list also remains stable at 12 patients at the end of January 2020 compared with 16 at the end of December 2019.

1.3 Ultrasound:

Whilst there is an internal target (95%) we are mindful of the importance of patient access to service and safe waitlist management. Performance against the target has deteriorated due to the sonographer industrial action combined with the holiday period. Adult US performance has deteriorated to 40.0% compliance at the end of January 2020 compared with 55.1% at the end of December 2019.The number of adult USS patients waiting longer than 42 days has increased from 661 at the end of December 2019 to 693 at the end of January 2020 with the total waiting decreasing from 1477 at the end of December 2019 to 1152 in January 2020.

Paediatric USS is showing 66.7% compliance at the end of January 2020 compared with 83.8% at the end of December 2019.The number of Paediatric USS patients waiting longer than 42 days has decreased from 7 at the end of December 2019 to 2 at the end of January 2020 with the total waiting also decreasing from 57 at the end of December 2019 to 34 at the end of January 2020.

2.0 Pathology and Laboratory Medicine:

The number of un-viewed/unsigned Histology/Cytology results for January 2020 was 1. These tests have been ordered by the Perinatal Pathologists and then viewed and closed by the same Pathologist in the Delphic Laboratory System. This metric requires that the result is also signed out in Éclair. This process has been review with the Pathologist where an additional step in the process is required to sign-out the result.

At the end of January 2020, 76% of LabPlus small biopsies were reported within 5 days compared to 69% in December 2019. 81% of large specimens were reported within 10 days compared to 98% in December 2019. The target is 80% for both categories. The service continues to operate with a 1.6 FTE Pathologist vacancy and is utilising locum sessions to cover this gap. The service continues to review its constraints through the laboratory and reporting processes to ensure these levels of performance are sustained going forward. This will be evaluated as part of this work to build resilience within the service which will include managing the growing demand from transplant services, MDMs and expanded requirements for immune-histology testing.

APS (Community Anatomical Pathology) is meeting service KPIs inconsistently. The January result for 5 day histology turnaround time was 48% against a target of 80%. Demand is exceeding capacity more frequently due to continued growth in community histology samples (6% pa for the last 3 years). There has been a significant increase in demand over the last 2 months. The laboratory turnaround times for preparing and processing the tissue is on target, however a shortage of Pathologist capacity has delayed reporting times. The service is prioritising and reporting all urgent specimens within specified turnaround times and is meeting the 10 day target KPI more consistently. A detailed service and KPI review is being prepared for review at the Regional APS Review Meeting.

With the recent appointment of a Clinical Lead in Diagnostic Genetics the department is preparing an approach for developing a wider strategy for genomics. This work will require collaboration between, cancer and blood, genetics, the university, the MoH and the laboratory.

The laboratory is now able to offer the COVID-19 test. Winter capacity planning will be vital this year if the laboratory is be required to deliver both COVID-19 and rapid influenza testing.

The LabPlus histology cutup room upgrade project will be concluded in March. The project is projected to deliver within budget and will significantly improve space constraints and the management of formalin levels.

3.0 Patient Services Centre

The Patient Services Centre is developing policies and processes to ensure a consistent approach to patient management processes, booking, and data management and reporting within an overarching governance framework. The Patient Access, Booking and Choice policy and associated scorecards for each clinical service have been launched. We are actively working on increasing diversity within our booking and scheduling team.

The Contact Centre strategy aims to enable patients and whānau to speak in the language of their choice. The first phase of this is to record our automated phone messages in Māori and increase Māori language capability within the telephonist workforce. The Contact Centre software performance is now more stable following the stabilization project. The project has now moved in to the improvement phase.

Telephone Interpreting (TINT) has been re-launched in December 2019. Each directorate is responsible for implementing and managing this process and this has been going well with some services reaching 40%. Weekly progress reports are being circulated to each directorate. The Tele-health platform provides opportunities for further embedding alternative methods of accessing interpreting services.

4.0 Allied Health

Services are being reviewed through engagement with clinical services across the Directorates, including scoping requirements for 7 day service provision and evolving scopes of practices associated with evolving models of care. Utilisation of available resources, capacity and prioritisation is being reviewed to ensure resources are being deployed based on patient need and organizational priorities.

The referral process to community allied health services continues to improve, with increasing numbers of direct referrals supporting more timely discharge and in-patient flow.

Short term loan equipment management system is being reviewed to improve access, utilisation and minimise wastage or loss of equipment. Opportunities for regional and multi-sector collaboration are being explored in Physiotherapy and Social Work.

Approaches to recruitment and retention are being reviewed to reduce vacancies and turnover in some key pressure areas, building on work done in Physiotherapy.

5.0 Clinical Engineering

Demand for 3D printing services is increasing and a review of processes, systems, governance and oversight is underway, with a report to be presented to the Senior Leadership team in March.

Clinical Engineering continues to support the Equipment and asset management strategy. Succession planning strategy will be a key objective this year with a number of key staff indicating they will be retiring in the next 2-3years.

6.0 Pharmacy

Options for managing Medicines Reconciliation capacity and demand continue to be explored through a Greenbelt project.

Two automated medication cabinets (Pyxis®) have now been installed and are operational after completion of the education/training and implementation plan. They are located in the Pharmacy After Hours Cupboard and Starship respectively and provide easier and more timely access to medicines across adult services and Starship while providing greater ability to risk manage and track medication use.

The steering group established to explore the options for relocating PAPU to Greenlane Clinical Centre (GCC) continues to work through the necessary planning and change management processes in line with FIRP timelines. Additional work streams under the steering group have also been established to address particular parts of the change management process.

The Retail Pharmacy strategy continues to take steps towards a health and well-being approach and away from retail sales. Upskilling pharmacy staff in providing advice on how non-drug treatments, including Rongoā rākau (plant or tree-based medicinal remedies), may interact with prescribed medication is a key element of the strategy.

The prescription reception and medicine management support point in Oncology Day Unit (The Pharmacy Hub) has been implemented and the three phase pilot has been completed, with report pending. Patient, whānau and Cancer & Blood staff feedback has been outstanding noting increased service quality and support for patients and staff. Opportunities to provide a similar approach for additional medication services are starting to be explored in conjunction with Starship.

7.0 Complaints

There were 5 complaints received in January 2020 compared to 3 in December 2019. All the complaints relate to difficulty in contacting services and lack of communication. A complaints database has recently been developed to enable a view across the Directorate of trends to inform further education and training and to enable oversight of progress against specific actions resulting from complaints.

8.0 Quality and Safety

The Directorate Quality and Safe Care Governance Group continues to provide oversight of service quality and clinical safety.

Standardisation of the quality scorecards was an identified quality priority for the Directorate and these were completed in the final quarter of 2019. Each service of the Directorate represented on the Clinical Quality and Safe Care Forum now has in place a scorecard measuring all six quality domains (as appropriate for each service) with identified metrics, targets and triggers. The metrics have been devised in consultation with Performance Improvement, Business Intelligence, Quality and Safety and Māori and Pacific General Managers. These standardized Quality Scorecards are reported monthly to the Directorate Leadership Team through the Directorate Clinical Quality and Safe Care Forum.

Service level quality meetings continue to take place on a monthly basis with the Allied Health Director and Director of the Directorate. This structure allows time for more in depth and detailed risk reviews, quality oversight and incident management specific to each service.

We also have a Quality Dashboard for the Directorate which is reviewed once a month by the Senior Leadership Team and also by the directorate Quality and Safe Care Forum.

Preparation for the recent Certification Audit has also been a focus across the Directorate, overseen by the Directorate Quality and Safe Care Governance Forum. Review, update or preparation of service specific documents including but not limited to Board Policies, Scorecards, A3 Business/Strategic Plans and Business Continuity Plans have been prioritised for delivery in February.

Work is continuing with the Patient Engagement team to develop a framework to capture patient feedback for the services in the Directorate through the Qualtrix system.

The Directorate Health and Safety Committee continue to have oversight of Health and Safety issues in the Directorate. Each department has developed a hazard register which in turn escalates to the Directorate register.

With the introduction of the Hazardous Substances Regulations late in 2017 there is now a requirement that all laboratories who previously followed the Exempt Code of Practice Section 33 HSNO meet the requirements of Part 18 of the regulations. An audit has been undertaken across LabPlus and Anatomical Pathology, Mt Wellington and a corrective action plan has been developed. Progress against this plan is monitored at a laboratory level and through the Directorate's Health and Safety Governance Committee.

9.0 Incidents

Medication Incidents

There were 9 medication incidents reported in January 2020 relating to Pharmacy omissions/delays, incorrect quantity and documentation issues. There was no harm to patients.

Falls

There were 4 falls reported in January 2020, involving patients mobilising.

Incidents

There were no Severity Assessment Codes reported in January 2020.

10.0 Our People

10.1 Wellness & Compliance:

LabPlus as part of their wellness programme have been looking at where they can 'give back'. The musically gifted amongst them also formed a band and on Christmas day they played at the Auckland City Mission.

Since August we have seen a steady decrease in the number of sick days taken and in December reached our target. With events such as the MIT & on-going Sonographer strikes and the work completed by the forensics team during the Whakaari/White Island eruption our overtime hours continue to fluctuate, this however does remain below the peaks of 2017/2018. We still have pockets of staff taking less than 10 days of leave in a year and our focus with them to tackle this is with a health and safety focus.

We continue to focus on the importance of MDP module's, the highest completion is for the modules developing our people, leading our values and the role of a Manager. There is a continued increase in the percentages of staff with systemised performance conversations in KIOSK, we are aware there are instances of Managers and Employees having these conversations they just aren't being recorded. We will continue to educate the Directorate on the importance of using KIOSK as the vast majority of our staff have daily access to a computer.

10.2 Retention and Culture:

Greater focus is being placed on equity of health outcomes within the Directorate. Hiring Managers are positively engaged with interviewing Māori and Pacific candidates with suitable skill sets. Under the Rangitahi programme representatives from a variety of teams across the service attended the Auckland Girls Careers Fair in November to help them understand the variety of careers they could consider with us. Similar teams also attended the To Thrive Careers Fair to showcase their areas and help people understand the potential pathways and opportunities open to them. Over the 2019/2020 summer break we had 3 Rangitahi Cadets in our social work and physiotherapy teams.

Following the Whakaari/White Island eruption our forensic team lead by Simon Stables were actively involved in assisting the coroner and the police with body identification and post mortems. During this incredibly difficult time this team came together to do everything they could to ensure the deceased could be returned to their whānau as soon as possible. Their work was recognised by the Australian Consul-General who visited the DHB in January to thank the staff personally.

We were pleased to hear that two of our LabPlus AUT students, Sahil Mani and Krupa Lumbhani were awarded most outstanding students in their year.

Following a dip in attendance at Navigate in Q1 we focused on increasing this and have seen a significant improvement in staff attending within 2 months of commencing employment. Educating teams as to what happens on this day and how integral it is as part of on-boarding is on-going.

Key achievements in the month

- Three Interventional Radiologists (x1 for Auckland DHB and x2 for WDHB) have been appointed and the Auckland DHB/WDHB Interventional Radiology Service has a go live date of the end of March 2020
- Telephone interpreting uptake increasing
- Lease renewal secured for APS Mount Wellington service
- A MoU outlining a change to a full 'FTE service model' for the delivery of clinical trials to C&B Research was finalised. The recruitment of 2 additional (C&B Research funded) clinical trials posts has commenced this month with a clear vision for service and quality improvements this resource will be able to deliver
- The Auckland DHB laboratory is now able to offer the COVID-19 test

Areas off track and remedial plans

- LabPlus small biopsy turnaround times process under review
- Adult and paediatric imaging waiting lists

Key issues and initiatives identified in coming months

- Continue to improve the process for patients receiving their appointment letters
- Continue with implementation of the Interpreter Improvement Project
- The Health Information Team have arranged a deep dive session to review the regional risks in relation to RIS/PACS systems being out of date and no longer supported by the vendor at the end of this year
- Radiology waiting list recovery plan following industrial action
- Preparation for IANZ inspections in Laboratories (February) and Radiology (March)
- Continue to develop our Māori and Pacific employee recruitment and retention strategy
- Continue with engagement and values workshops in all services
- Part 18 hazardous substance audit across Laboratories

Financial Results

STATEMENT OF FINANCIAL PERFORMANCE
Clinical Support Services

Reporting Date Jan-20

($000s)	MONTH			YEAR TO DATE (7 months ending Jan-20)		
	Actual	Budget	Variance	Actual	Budget	Variance
REVENUE						
Government and Crown Agency	1,870	1,606	264 F	11,914	11,114	800 F
Funder to Provider Revenue	3,890	3,639	250 F	26,706	26,140	566 F
Other Income	3,351	3,141	210 F	23,500	21,985	1,515 F
Total Revenue	**9,110**	**8,386**	**724 F**	**62,121**	**59,239**	**2,881 F**
EXPENDITURE						
Personnel						
Personnel Costs	11,445	11,420	(25) U	81,536	84,410	2,874 F
Outsourced Personnel	138	30	(108) U	910	209	(701) U
Outsourced Clinical Services	979	699	(279) U	6,516	4,850	(1,666) U
Clinical Supplies	3,985	4,125	140 F	29,848	29,637	(211) U
Infrastructure & Non-Clinical Supplies	2,640	2,325	(314) U	16,878	15,969	(910) U
Total Expenditure	**19,186**	**18,599**	**(587) U**	**135,688**	**135,075**	**(613) U**
Contribution	**(10,076)**	**(10,213)**	**137 F**	**(73,567)**	**(75,836)**	**2,269 F**
Allocations	(8,702)	(8,785)	(84) U	(66,064)	(66,276)	(212) U
NET RESULT	**(1,374)**	**(1,427)**	**53 F**	**(7,503)**	**(9,559)**	**2,057 F**

Paid FTE

	MONTH (FTE)			YEAR TO DATE (FTE) (7 months ending Jan-20)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	152.9	153.9	1.1 F	152.1	153.9	1.9 F
Nursing	28.4	33.9	5.5 F	27.9	33.9	6.0 F
Allied Health	888.0	889.7	1.7 F	874.9	889.0	14.1 F
Support	0.2	0.0	(0.2) U	0.1	0.0	(0.1) U
Management/Administration	269.8	270.1	0.3 F	268.8	270.1	1.3 F
Total excluding outsourced FTEs	**1,339.2**	**1,347.6**	**8.4 F**	**1,323.8**	**1,346.9**	**23.1 F**
Total :Outsourced Services	17.7	2.1	(15.6) U	19.0	2.1	(16.9) U
Total including outsourced FTEs	**1,356.9**	**1,349.7**	**(7.2) U**	**1,342.8**	**1,349.0**	**6.2 F**

Comments on major financial variances

January YTD result is $2,057K F. The key drivers of this result are;

1. Personnel costs including outsourced were $2,173K F to budget. This is due to vacancies across the directorate but predominately in Radiology and Laboratories. A number of vacancies in Laboratories are due to the delay in the roll out of the National Bowel screening (FIT Laboratory) contract.
2. Outsourced Clinical Services were $1,666K U. $889K was due to outsourced MRI scans in Radiology. This is partly offset by savings in MIT's. $417K was due to the send away of lab tests predominately in Diagnostic Genetics. A review of the service has been undertaken with the first steps being to bring some of this work in house. $110K is due to additional outsourcing from Anatomical Pathology to cover vacant positions.

3. Infrastructure and Non Clinical Supplies were $ 910K U. Retail Pharmacy cost of goods sold is $749 K U and is offset by revenue.
4. Revenue is $2,881K F. $1,344K relates to Pharmacy and is offset by costs of goods sold and clinical supplies. $236K is in Labs and is driven by volume and price. Funder to provider revenue was $566K F due to volumes being above contract.

Perioperative Directorate

Speaker: Vanessa Beavis, Director

Service Overview

The Perioperative Directorate provides services for all patients who need anaesthesia care and operating room facilities. All surgical specialties in Auckland DHB use our services. Patients needing anaesthesia in non-operating room environments are also cared for by our teams. There are five suites of operating rooms on two campuses, and includes five (or more) all day preadmission clinics every weekday. We provide 24/7 acute pain services for the whole hospital. We also assist other services with line placement and other interventions when high level technical skills are needed.

The Perioperative Directorate is led by:

Director:	Vanessa Beavis
General Manager:	Duncan Bliss
Director of Nursing:	Leigh Anderson
Director of Allied Health:	Kristine Nicol

Directorate Priorities for 2019/20

In 2019/20 our Directorate will contribute to the delivery of the six Provider Arm work programmes. In addition to this we will also focus on the following Directorate priorities:

1. Safe and quality services
2. Equity
3. Health and wellbeing of our people
4. Efficient and effective clinical care
5. Service size to meet growth in demand
6. Financial sustainability

Glossary

Acronym/term	Definition
GSU	Greenlane Surgical Unit
OR	Operating Room
SAC	Severity Assessment Code
TDOC	Traceability Documentation

Q3 Actions – 90 day plan

1. Safe and quality services

Activity	Progress
Implementation of Single Instrument Tracking briefing	**Single Instrument Tracking System:** • All Neuro instruments have now been marked with a 2D bar code. This will allow scanning and traceability to the individual item. Work has begun on marking ophthalmology instruments. • The (required) Traceability Documentation (TDOC- BI) feature has been turned on. • At present the technical ability to track instruments is in place. Additional hardware will be required to ensure scanning volumes are met. • Additional software modules as detailed in the business case will be purchased and installed once the core stability of the system is proven to achieve the full benefits outlined in the business case. • The washers are being programmed to heat the water locally. This will avoid the silver tarnishing and disrupting the 2D mark.

2. Equity

Activity	Progress
Working with our partners to make our workplace attractive and supportive for Māori and Pasifika staff	Following a directorate Māori Workforce Hui held last year the following objectives are set in place towards making our work place attractive to the Māori and Pasifika staff and ultimately our patients. • A symbol of the wairua that greets Māori into the theatre suite • A team of cultural advocates in our directorate • Adapt our advertising and recruiting to appeal to a diverse population • Investigate the option of transport offered to enable patients to get to their appointments • Māori pronunciation lessons as part of in-service sessions

3. Health and wellbeing of our people

Activity	Progress
Operating Room (OR) Model of care tracking OR staffing vacancies vs FTE	• Retaining Anaesthetic Technicians and Nurses and being able attract and source staff has been the key focus • The UK recruitment drive held in August 2019 has given us 16 new AT recruits and 5 OR Nurses. Another recruitment drive has been scheduled for April 2020

	with the hope of filling up the 10 vacancies for Anaesthetic Technicians • The service bonus has definitely made a difference in staff turnover for the Anaesthetic Technicians. We have had not resignations since end of 2019. Face to face exit interviews have been requested recently by some specific Managers across the service to provide commentary for analysis to understand turnover and improve retention for all staff

4. Efficient and effective clinical care

Activity	Progress
Acute index time to OR from booking reporting available	• A heavy acute load and maintaining the elective throughput is finely balanced. We achieved 77.27% against a target of 90% • The Surgical Integrated Operations Centre (SIOC) has been set up and is proving helpful in creating the visibility needed to achieve appropriately booked lists. Work continues on ensuring that all elective lists are used and filled. Management of the disruption caused by a big acute load and transplants continues

5. Service size to meet growth in demand

Activity	Progress
Building for the future strategic programme timelines	• The Building for the Future group has continued to meet with outlined plans endorsed by the group for 2 additional OR's, new endoscopy and infusion facility

6. Financial sustainability

Activity	Progress
Appropriate fleet replacement program Management of consumables Management of vacancies	• See financial report

Scorecard

Auckland DHB - Perioperative Services

HAC report for January 2020

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

Safety

Metric		Actual	Target	Previous
Medication errors with major harm	*PR215*	0	Lower	0
Number of reported adverse events causing harm (SAC 1&2)	*PR084*	0	Lower	0
% Hand hygiene compliance	*PR195*	**78.82%**	>=80%	76.8%
Wrong site surgery	*PR255*	0	Lower	0

Patient-centred

Metric		Actual	Target	Previous
Number of complaints received	*PR085*	0		1
Number of compliments received	*PR336*	0		0

Timeliness

Metric		Actual	Target	Previous
% Cases with unintended ICU / other area stay	*PR258*	**0.44%**	<=3%	0.39%
% CSSD incidents	*PR260*	**3.91%**	<=2%	3.26%
% Acute index operation within acuity guidelines	*PR254*	**77.27%**	>=90%	82.05%

Effectiveness

Metric		Actual	Target	Previous
% 30 day mortality rate for surgical events	*PR259*	**0.25%**	<=2%	0.48%
% Patients with Hypothermia in PACU	*PR271*	**2.68%**	<=1%	2.35%
% Patients with PONV in PACU	*PR272*	**1.87%**	<=5%	2.31%

Efficiency

Metric		Actual	Target	Previous
% Elective sessions planned vs actual	*PR261*	**92.85%**	>=97%	93.6%
% Adjusted theatre utilisation - All suites (except CIU)	*PR262*	**83.83%**	>=85%	85.45%

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

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

Scorecard Commentary

- There were 3 medication incidents reported for January 2020. Each department holds a monthly quality meeting where all incidents are reviewed and investigated. This is monitored by a directorate quality meeting where any recurring trends are reviewed and action plans agreed as necessary.
- Hand hygiene compliance is good overall. There is a focus on targeting the poorer performing groups this month.
- There was 1 complaint received for Perioperative services for January 2020.
- One perioperative Severity Assessment Code (SAC) 1 and no SAC 2 incident was reported in the three months from 1 November to 31 January 2020, although we are supporting other directorates as required.
- Recommendations from previous Root Cause Analysis have been implemented. Formal auditing of the surgical safety check list has recommenced this quarter, with good rates of engagement and compliance.
- Central Sterile Supply Department incidents are up due to production pressure as a result of vacancies. Recruitment is underway.

Key achievements in the month

- A Māori Workforce Hui was held on Friday 29 November 2019 at Manawanui Marae where all Māori staff within the directorate were invited to attend that resulted in the following outputs.
    - A symbol of the Wairua that greets Māori into the theatre suite
    - A team of cultural advocates in our directorate
    - Adapt our advertising and recruiting to appeal to a diverse population
    - Investigate the option of transport offered to enable patients to get to their appointments Māori pronunciation support at in-service sessions
- Level 8 Perioperative participated in the first trans-Tasman kidney transplant exchange program around late October 2019.
- The annual Golden Laryngoscope running race was held on Wednesday 4 December 2019 and was won by Level 8, Perioperative Services. The best women's team was from Middlemore Hospital and the best dressed team was "Team CREW" from Level 9, Perioperative Services. Lots of fun was had by all.

Areas off track and remedial plans

- E4P has not yet been put into production. We are working with the Health information and technology team and Health Alliance on this. The business case for stage 2 has been written where the major benefits will be achieved.

Key issues and initiatives identified in coming months

- Anaesthetic Technician training and staffing shortfall has significantly improved. As of February 2020, the directorate has 10 vacancies, this includes the new positions and two levels being

fully staffed (i.e. Level 4 and Starship). To ensure a sustainable workforce is maintained following measures are being worked upon:

  - Auckland DHB currently has 30 trainees. 6 of these started in February 2020
  - Another recruitment drive has been scheduled for April 2020 with the hope of filling up the 10 vacancies
  - Retention of staff: We are happy with how this is tracking. The service bonus seems to have definitely made a difference in staff turnover. Presently we have had not resignations since end of 2019. We have had one 0.4 FTE retire and one staff return from maternity leave
  - Our workforce seems to be happy and stable

- Some formal performance improvement team resource has been assigned to perioperative services to assist with pre-admission programme project. There are a number of outputs this work will achieve:
  - Improved visibility of patients waiting for preadmission for surgical bookers
  - Improved production planning and understanding of the capacity required to preadmit sufficient patients to meet T-7+1 milestones
  - Improved utilisation of preadmission clinic slots
  - Improved coordination of Level 8 and Greenlane Surgical Unit (GSU) (as initial areas of focus) preadmission grids and processes
  - Improved scrum processes for picking up released/available GSU preadmission clinic capacity
  - Improved quality and timing of communication with patients, including utilisation of different communication channels, simplification of information and better accessibility for patients
  - Improved experience of preadmission clinics for patient
  - Better use of our patients time in minimising unnecessary additional outpatient appointments where assessment can be provide in a single visit or through alternative modes of delivery
  - Better understanding and utilisation of GSU criteria within the triage process

Financial Results

(All Perioperative results are reported exclusive of the Starship Operating Suite which is now managed under Child Health).

STATEMENT OF FINANCIAL PERFORMANCE

Perioperative Services Excluding SSOR

Reporting Date **Jan 20**

($000s)	**MONTH**			**YEAR TO DATE**		
	Actual	**Budget**	**Variance**	**Actual**	**Budget**	**Variance**
REVENUE						
Government and Crown Agency	154	172	(17) U	1,093	1,202	(109) U
Funder to Provider Revenue	36	17	19 F	114	125	(11) U
Other Income	27	17	10 F	167	118	49 F
Total Revenue	**217**	**206**	**12 F**	**1,373**	**1,445**	**(71) U**
EXPENDITURE						
Personnel Costs	8,267	7,704	(563) U	55,785	56,185	399 F
Outsourced Costs	88	70	(18) U	564	490	(74) U
Clinical Supplies	3,185	3,029	(156) U	24,220	23,447	(772) U
Infrastructure	134	162	28 F	1,240	1,048	(192) U
Total Expenditure	**11,674**	**10,966**	**(709) U**	**81,809**	**81,170**	**(640) U**
Contribution	**(11,457)**	**(10,760)**	**(697) U**	**(80,436)**	**(79,725)**	**(711) U**
Allocations	17	10	(8) U	110	82	(28) U
NET RESULT	**(11,474)**	**(10,770)**	**(705) U**	**(80,545)**	**(79,806)**	**(739) U**

Paid FTE

	MONTH (FTE)			**YEAR TO DATE**		
	Actual	**Budget**	**Variance**	**Actual**	**Budget**	**Variance**
Medical	147.8	144.4	(3.4) U	139.3	145.5	6.2 F
Nursing	396.8	417.9	21.1 F	393.1	417.9	24.8 F
Allied Health	95.1	110.6	15.5 F	91.3	110.6	19.3 F
Support	105.7	115.3	9.6 F	110.7	115.3	4.7 F
Management/Administration	23.7	23.2	(0.5) U	23.3	23.2	(0.1) U
Other - Savings	0.0	-9.5	(9.5) U	0.0	-9.5	(9.5) U
Total excluding outsourced FTEs	**769.1**	**801.9**	**33 F**	**757.6**	**803.0**	**45 F**
Total :Outsourced Services	5.2	0.0	(5.2) U	5.3	0.0	(5.3) U
Total including outsourced FTEs	**774.2**	**801.9**	**28 F**	**762.9**	**803.0**	**40 F**

Comments on major financial variances

Volumes

Table 1:

Perioperative Theatres (Excl SSOR)	Year to date				
	Actual	Budget	Variance to budget	Prior year Actual	Variance year on year
Minutes	2,135,547	2,114,574	101.0%	2,065,808	103.4%
Cases	22,378	22,428	99.8%	22,073	101.4%
Cost per minute	$ 37.72	$ 37.74	99.9%	$ 36.64	102.9%
Average minutes per case	95.4	94.3	101.2%	93.6	102.0%
Median minutes per case	63.0	64.0	98.4%	64.0	98.4%

Year to Date

The result is $739K U unfavourable for the year to date.

Production is slightly ahead of plan YTD in minutes 101% and cases are slightly behind at 99.8%. This indicates that although fewer cases have been completed, they have been more complex. Average minutes per case are over budget 101.2%.

Revenue

- Government and Crown Agency revenue is $109K unfavourable due to lower than expected clinical training funding.

Expenditure

- Personnel costs are $399K F with the main drivers being vacancy across all professional groups, partially offset by;
    - overtime and SMO additional duties
    - Annual leave accrued is higher than taken.
- Outsourced Personnel $74K U high use of Anaesthetic Technicians to cover vacancy offset by lower cost of Medical Personnel.
- Clinical supplies spend $772K U YTD with the main drivers of cost being Laparoscopic Equipment $260K U and Treatment Disposables $501K U that include:
    - Catheters $86K U.
    - Dressings $55K U.
    - Staples & Accessories $165K U.
    - Patient Consumables $73K U.

The actual cost per minute (Table 1) YTD is $37.72 against a budget of $37.74. The higher than budgeted production minutes have driven a favourable cost per minute result despite total costs being higher than budget.

Table 2 below demonstrates the cost per minute for all theatres across Auckland DHB provider. Including Starship OR's, results in an overall theatre cost of $36.26 per minute against a budget of $36.38.

Table 2

All Theatres (Incl SSOR)	Year to date				
	Actual	Budget	Variance to budget	Prior year Actual	Variance year on year
Minutes	**2,593,839**	**2,575,723**	**100.7%**	**2,517,438**	**103.0%**
Cases	**28,223**	**28,697**	**98.3%**	**28,166**	**100.2%**
Cost per minute	**$ 36.26**	**$ 36.34**	**99.8%**	**$ 35.12**	**103.2%**
Average minutes per case	**91.9**	**89.8**	**102.4%**	**89.4**	**102.8%**
Median minutes per case	**61.0**	**60.0**	**101.7%**	**60.0**	**101.7%**

Pacific Health Directorate

Speaker: Bruce Levi

Service Overview

To partner with the Directorates, Pasefika staff, patients and their families and communities in realising their goals and aspirations for their holistic health.

General Manager:	Pulotu Bruce Levi
Director of Nursing:	Abel Smith
Operations Manager:	Penina Felise - Mackay
Projects Manager:	Tuliana Guthrie
Matua:	Mahe Uliuli Ha'unga (recently deceased)
Executive Assistant:	Josilina Silimaka

Directorate Priorities for 2019/20

In 2019/20 we will focus on the following Directorate priorities:

1. Cultural Competency Training: Pacific Best Practice, Kapasa framework, Cultural Excellence.
2. Workforce Pipeline: Health Science Academies: Building Maintaining and Sustaining Outcomes. PALT data.
3. Supporting high needs Pacific families in inpatient settings.
4. Leadership Support and advisory

Highlights

Pacific Strategy

National Strategy: Ola Manuia Pacific Health Action Plan 2020-2025, the refreshed National Pacific Health Strategy is out for consult. The draft Plan was developed incorporating government and ministry health priorities, Pacific people's current health status/needs and the impact of the social determinants of health. An Equity lens was applied across it, using a co-design approach (with the community and sector) and built on the achievements of the previous Pacific action plan - Ala Mo'ui: Pathway to Pacific Health and Well-being 2014-2018.

The three high level outcomes are organised as follow:

- Outcome 1 (actions to support individuals, promote healthy lifestyle and make healthy choices in the community)
- Outcome 2 (actions to improve health services and have a more responsive health system)
- Outcome 3 (actions that address the environment and upstream determinants of health, specifically health in-equities)

Equity actions were prioritised using feedback and recommendations (themes) gathered from the sector and community talanoa engagement sessions (co-design). These action areas are what Pacific say is their lived experience of 'health inequity'. The finalisation of the strategy will be in two weeks with Assoc Health Minister Jenny Salesa.

Health Science Academy Evaluation

Synergia Consultancy was brought on to evaluate the Auckland Regional Health Science Academies programme. The evaluation objectives included 1) describing the service delivery, 2) understand the benefits and experiences of key stakeholders involved 3) Identify ideas for improvements to the programme including considerations for future rollout of the programme. 300 students and staff contributed with their feedback through group talanoa, survey and fono.

Pacific Health Science Academy Programme Delivery.

This regional programme is a strategic initiative to build the Maaori and Pacific health workforce across the metro-Auckland to reflect the demography of the community it serves. This growing programme across 7 schools Alfriston College, De La Salle College, Onehunga High School, Auckland Girls Grammar, Tangaroa College, James Cook High School provides students with pastoral support, extra tutoring in sciences, career exposure and development opportunities

Stakeholder experiences

The students valued the study support and higher grades and reported an increased motivation to pursue health careers. The students also reported increased confidence and leadership skills. They also reported valued the higher learning with other Pacific students and gained friendships and contacts beyond school.

The schools reported having a belief in the purpose of HAS and wanting to “break the cycle”. They reported stronger relationships with students, they valued the sharing with other schools and saw increasing Pacific students uptake of science. They also reported a huge pride of the HSA.

The aiga appreciated the low demands on them and the opportunities for their children. They reported improved relationships with the schools, improved health and education literacy and siblings were inspired to study health.

What works:

1. Well defined HSA: Strong focus on science achievement.
2. Passionate Directors/tutors have caring relationships with students
3. School Support
4. Culturally aware teachers
5. Past students are inspiring
6. Studying as a group of Pacific students
7. Career exposure influences students
8. Camps and activities help develop confidence and networks
9. Programme team and professionals bring a Pacific presence to the school

Improvements and future considerations:

- Better coordination and planning
- More small scale and broader range of career exposure

- Student tracking Fit for purpose reporting
- Review team structure and resources.

Future direction:

- Develop long-term strategy and funding
- Regional DHB driver role
- School Selection (6 more schools)
- System view of workforce pipeline

Pacific new graduate nurses

The Pacific NETP/NESP Feb Intake started their NETP/NESP programme on 10 February and they have now completed their initial orientation programme. There were a total of 15 Pacific NETP/NESP nurses at Auckland DHB and 6 at Waitemata DHB. Overall we had offered more employment to Pacific graduates however we were not matched to a lot of them and they preferenced other DHBs. This issue is being further looked into to see how we can improve our appeal to Pacific graduates. One of the major issues we continually face is the short supply within the Auckland region and although we have continued to look outside of our locality, the issue of them moving up to Auckland and living in our areas/locality is a problem due to accommodation and high living costs.

Our Pacific New Graduate Feb 2020 Fono was held Wednesday 12 February. This combined Auckland DHB and Waitematā DHB NETP/NESP Fono was hosted by Auckland DHB NDU (Augustina Reid and Tuliana Guthrie and the Pacific Team). Outlined is the summary report of the day and programme documented by Pacific Nurse Educator Augustina Reid:

Auckland DHB utilizes the Pacific People support fund to enhance the likelihood of the Pacific workforce successfully completing Ministry of Health-funded training programmes by providing Pacific Peoples support that is culturally competent and technically relevant to the training programme. It provides trainees with access to mentoring, cultural supervision and cultural development activities that enhance the personal, cultural and professional self.

Cultural Development Day 12 Feb, 2020 (*hosted by ADHB for ADHB & WDHB trainees)*

Number of trainees that attended cultural development day	- 18 ADHB (15 NETP/NESP trainees & 3 Post grad trainees) - 6 WDHB (6 NETP trainees) & additional 3 IndoFijian nurses new graduates
Other attendees ADHB & WDHB	- ADHB/WDHB Pacific health team - Pacific nurse leaders - Pacific nursing staff - Mentors and supervisors - Cultural consultant - ADHB Executive leadership team - Community members

Cultural development day inclusive of cultural identity "Tagata Pasifika" who we are today, Pasifika people and communities, networking, Pacific perspective enhancing practice, indigenous knowledge, Pacific cultural frameworks, career planning, mentoring, Pacific health, Pacific health workforce and Pacific health systems. ***Picture captured of the nurse cohort and staff in support below:***	- Cultural consultant 'Nurse Matua': Matafanua Hilda Faa'salele

PALT Pacific Alliance Leadership Team

Pacifc Nurse director Abel Smith co-facilitated 2020 PALT half day workshop on 20 February at Ko-Awatea. This workshop was well attended by representatives from Auckland DHB, Counties Manukau DHB and Waitematā DHB. The aim of the workshop was to discuss and finalise a Pacific Workforce Strategy document. Following on from the workshop Pacific nurse director will be working with Pacific equity Director Anna Redican Kolose to formulate a draft document to be circulated to members of PALT for further discussion and endorsement. It is envisaged that this document will be ready for circulation and action by 1 April 2020 (new financial year period).

Cultural Competency Programmes: Kapasa

- Collaborate with Auckland DHB Organisation Development (OD) Team to deliver on the Healthy Workplace plan for Pacific. This entailed an initial meeting on 11 Feb 2020 with a follow up meeting with Pacific staff on 24 March 2020.
- Collaborate with Auckland DHB Organisation Development Team (OD) on Kapasa programme.

Matua Mahe Uliuli Ha'unga RIP

A Memorial Service was held 20 Feb 2020 in honour of our much loved Matua and Cultural Navigator of Tautai Fakataha (Pacific Health, Auckland DHB and Waitematā DHB) - Mahe Uliuli Haunga. He was buried Auckland Anniversary 2020.

Mahe also ran a Tongan Radio language on Mondays disseminating important health messages to the Tongan community. Matua Mahe was our first endorsed Matua and had a huge heart and made a huge impact on our hospital and community. He was instrumental in coining the team name "Tautai Fakataha" *Leading together*. He epitomised that for the service.

Pacific Health Scorecard Dec 2019

Health Targets - Auckland DHB

	Pacific	Target		Trend		Non-Pacific/Non-Māori
Shorter Waits in ED	**84%**	95%	🔴		▲	*(86%)*
Faster cancer treatment (62 days)	**100%**	90%	🟢		--	*(96%)*
Better help for smokers to quit - primary care	**87%**	90%	🔵		▼	*(84%)*
Increased immunisation (8-month old)	**92%**	95%	🔵		--	*(98%)*
Raising Healthy kids	**100%**	95%	🟢		--	*(100%)*

Access- Auckland DHB

	Pacific	Target		Trend		Non-Pacific/Non-Māori
Cervical Screening	**59%**	80%	🔴		▲	*(63%)*
Breast screening	**74%**	70%	🟢		--	*(64%)*
b. MH Access Rates 0-19 years	*2.9%*					*(3.3%)*
b. MH Access Rates 20-64 years	*5.2%*					*(3.3%)*
b. AOD Access Rate 20-64 years	*2.2%*					*(0.9%)*
k. POAC Referrals	*732*	*307*	🟢			
k. Well Child core contact within first year - % of enrolled	*56%*	*90%*	🔴			*(79%)*
Oral health - % utilisation by 2 years	**57%**	80%	🔴		▲	*(105%)*
B4 school checks for 4 year olds	**45%**	45%	🟢		▼	*(42%)*
e. **Preventable Hospitalisation**						
Ambulatory Sensitive Hospitalisations (ASH) 0-4	*15,286*	*15,079*	🔵		▲	*(5457)*
Ambulatory Sensitive Hospitalisations (ASH) 45-64	*8,526*	*8,679*	🟢		▲	*(2630)*

Quality - Auckland DHB

	Pacific	Target		Trend		Non-Pacific/Non-Māori
Improving outcomes						
k. More Heart & Diabetes Checks	*92%*	*90%*	🟢		▲	*(93%)*
f. Diabetes management	*48%*	*65%*	🔴		▼	*(65%)*
e. CVD on Triple therapy (dispensed)	*57%*				▲	*(56%)*
c. HBSS clients with Clinical interRAI	*98%*	*95%*	🟢			*(95%)*
Older patients Falls Risk Assessed	**83%**	90%	🟡		▲	*(85%)*
Patient Experience						
Inpatient rated care as very good or excellent	**88%**	90%	🔵		▲	*(86%)*
g. Pacific contacts with cultural service	*65*				▼	

Outcome - Auckland DHB

	Pacific	Target		Trend		Non-Pacific/Non-Māori
Key Topics						
d. Rheumatic fever rates	*16.1*	*≤1.1*	🔴			*(0.2)*
Oral Health - Children caries free at 5yr	**30%**	61%	🔴			*(66%)*
Oral Health - Mean rate DMFT at school yr 8	**0.93**	≤0.65	🔴			*(0.5)*
Exclusive breastfeeding at 3 mths	**49%**	70%	🔴			*(64%)*
Percentage of children who are obese	**21%**					*(3%)*
k. Hospital falls resulting in NOF fracture	*0*	*0*	🟢		--	*(9)*
h. Surgical site infection rate	*10*	*≤0.93*	🔴			*(1.1)*
Mortality						
a. Overall Mortality ASR per 100 000	*650.4*					*(289)*

Managing our Business - Auckland DHB

Workforce	Actual
Pacific management FTE as % of total workforce	**3%**
Pacific clinical FTE as % of total workforce	**4%**
Pacific administrative FTE as % of total workforce	**7%**
Pacific other FTE as % of total workforce	**29%**

How to read

Performance indicators:
- 🟢 Achieved/ On track
- 🟡 Not Achieved but progress made
- 🔵 Substantially Achieved but off target
- 🔴 Not Achieved/ Off track

Trend indicators:
- ▲ Performance ***improved*** compared to previous month
- ▼ Performance ***declined*** compared to previous month
- -- Performance was ***maintained***

Key notes

1. Most **Actuals and targets** are reported for the reported month/quarter (see scorecard header).
2. ***Actuals and targets*** in *grey bold italics* are for the most recent reporting period available where data is missing or delayed.
3. **Trend lines** represent the data available for the latest 12-months period. All trend lines use auto-adjusted scales: the vertical scale is adjusted to the data minimum-maximum range being represented. Small data range may result small variations perceived to be large.

a. 2 yr aggregated data as at Dec 18
b. Nov 19
c. Sep 18
d. Initial cases per year, per 100 000 - Jun 19
e. Sep 19
f. Sep 19 data. Aligns with MACGF indicator; differs from MoH indicator
g. Oct 19
h. Dec 18
k. Jun 19
m. Jul 19

A question?

Contact:
Victoria Child - **Reportingng Analyst, Planning & Health Intelligence Team:** victoria.child@waitematadhb.govt.nz
Planning, Funding and Health Outcomes, Waitematā DHB

Faster Cancer treatment target was met 100% for Dec 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. 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 peoples.

Surgical Services Directorate

Speaker: Arend Merrie, Director

Service Overview

The Surgical Services Directorate is responsible for the provision of secondary and tertiary surgical services for the adult Auckland DHB population, and also provides regional and national services in several specialties. The services in the Directorate are structured into the following portfolios:

- General surgery, Trauma, Transplant and Intestinal Failure
- Otorhinolaryngology, Oral Health and Oromaxillofacial surgery
- Orthopaedics
- Urology and Neurosurgery
- Ophthalmology

The Surgical Services Directorate is led by:

Director:	Arend Merrie
General Manager:	Duncan Bliss
Director of Nursing:	Katie Quinney
Director of Allied Health:	Kristine Nicol
Director of Primary Care:	Kathy McDonald
Human Resources Manager:	Louise Bull
Finance Manager:	Alison West

Directorate Priorities for 2018/19

In 2018/19 our Directorate will contribute to the delivery of the Provider Services strategic programmes. In addition to this we will also focus on the following Directorate priorities:

1. Culture of safety
2. Timely and effective
3. Equitable and inclusive access
4. Efficient and financially sustainable pathways
5. Our people are happy, healthy and high performing

Glossary

Acronym/term	Definition
GSU	Greenlane Surgical Unit
NZNO	New Zealand Nurses Organisation
OR	Operating Room
SAC	Severity Assessment Code

Q3 Actions – 90 day plan

1. Culture of safety

Activity	Progress
Embed the risk module within Datix across our services	• The services have started adding risks to Datix with agreed Directorate review to ensure consistent scoring. • We have had two meetings with the risk team to review and refine our current directorate risks. Our Directorate production meeting includes using the current risk matrix and links with the known risk. • We are working with the risk team to understand themes, gain clarity on risk level alignment and plans in place. With a view to establishing a more robust and sustainable way for the surgical directorate to maintain an acceptable level of oversight. We are looking forward to particular guidance following the recent certification audit. • We are actively promoting the risk management module that is part of the MDP online learning package. • From March 2020, with the change in leadership structure all risks will be reviewed monthly by the 4 Provider Directors at the Surgical and Perioperative Management Group.
Ensure that incidents and risks are continually reviewed and managed within agreed timescales	• Weekly Directorate governance review is now embedded which review outstanding incidents, Severity Assessment Code (SAC) 1 & 2 events and newly added risks. • A recently completed Greenbelt project significantly changed the system reducing time to risk score being assigned across all patient related incidents for the organisation. • Quality meetings are established in many of the services, while these can tend to have predominate nursing focus there is space to integrate with other meetings to spread and connect this work. • The monthly directorate quality meeting continues to be well attended, with good work shared, risk and issues escalated and discussion occurring. • The weekly directorate review and planning meeting, which involves attendance at by a member form the quality team, tracks current open incidents (SAC 1/2 and ARR), allows escalation and has started to include how we track and manage recommendations. • With the interim leadership structure it is agreed that all Interim Surgical Provider Directors will be informed of all SAC 1 & 2 events.

Ensure TrendCare is fully implemented within inpatient services to ensure appropriate response to patient acuity and nursing staffing requirements	• Each surgical portfolio has established regular Trendcare focus groups and we have excellent support from the safe staffing team. • Three wards have completed Full-time Equivalent (FTE) calculations process and have implemented their new rosters. We are experiencing challenges to maintain the rosters in alignment with the anticipated support for any additional requirement for patient attenders. • Variance response management (VRM) and visual indicator scoring (VIS) is established in all wards • A regular directorate New Zealand Nurses Organisation (NZNO) meeting has been established to work with all stakeholders on relevant issues with a focus on safe staffing and short staffing reported incidents. We have seen a decline in the number of NZNO delegates and a charge nurse and a NZNO delegate have taken the lead to engage across the directorate to re-build this core function. • The surgical directorate will be undergoing CDS (Core Data Set) training in April and May and will have an established directorate focus group in alignment with this.

2. Timely and effective

Activity	Progress
Complete seed funding business case for the expansion of operating rooms (ORs) as part of the Building for the Future Programme Board	• The Building for the Future group has continued to meet with outlined plans endorsed by the group for the 2 additional OR's, new endoscopy and infusion facility. The business case was presented and signed off by ADHB Board and will next be presented to treasury. • The Surgical Integrated Operations Committee was established and run from the 13th January 2020 focusing on planning OR sessions 6 weeks in advanced. • The Greenlane Surgical Unit (GSU) optimisation group continues to focus on improved usage and utilisation. The highlights for the last month include: o Renal Transplant lists (eg Tenkhoffs) now occur at GSU o Spinal cord stimulator trials soon to occur o Most LA sessions being used o Process for swapping paeds sessions for adults o Trialling acute arranged lists where unable to fill
Develop medium term plans to utilise all appropriate and available capacity to deliver sustainable high quality	• Agreed outsourcing model in place for Ophthalmology with 2 providers agreed for 2018/19 which delivered 1400 procedures. The contracts

healthcare	have been revised for 19/20 with 1600 procedures planned. • Orthopaedic outsourcing achieved 407 procedures completed in 18/19. A 10% increase of outsourcing has been applied to the 2019/20 target. o Due to the discharge position and large waiting lists in Oral Health – further capacity has been sourced with an external provider which will continue into 2019/20

3. Equitable and inclusive access

Activity	Progress
Develop robust waiting list processes for managing equitable access to elective surgery	• Develop service A3s to include Key Performance Indicators for delivery against Access, Booking and Choice policy. • The Planned Care work stream has a dedicated area of focus on late cancellations for Māori and Pacific patients. • This focus group was formed in January 2020 with initial focus ensuring the service data is correct.
Develop reporting tools which identify our patient population groups	• KPI established and monitored around the reduction of DNA rates for Māori and Pacific patients in Ophthalmology at Waitākere Hospital.
Develop inclusivity plans involving intentional and deliberate targeted recruitment	• Nursing recruitment targeting Māori and Pacific applicants has been built into the Directorate A3 for 19/20 with KPI's set against the ADHB agreed target. • Good progress within nursing recruitment targeting Māori and Pacific applicants.

4. Efficient and financially sustainable pathways

Activity	Progress
Develop the future local and regional strategies for Ophthalmology Services.	• The Regional Ophthalmology Group was paused in October 2019 whilst a regional project lead is appointed in conjunction with the NRA. • Joint appointments continue to be made between ADHB and CMDHB Services.
Implement the findings of the Transplant and regional Head and Neck Cancer reviews	• The Head & Neck Cancer Framework document was approved by the Regional Executive Forum and the Northern Region Integrated Cancer Service Programme Board in December has been shared with the relevant teams and multidisciplinary staff is involved in all areas with the implementation of this framework. • There has been agreement for the H&N sub group recommendations for the allocation of the $900k through Dental Services, Nurse Specialist and MDT Coordination.

	• Hospital Dental Services have been approved to recruit additional resource to meet the patient requirements highlighted in the review.

5. Our people are happy, healthy and high performing

Activity	Progress
Continued recruitment towards a sustainable workforce and understand and address retention issues	• Turnover has been at or below the target of 10% for the 8 months of this calendar year which eases the demand to attract new hires. Opportunities to develop are highlighted in exit information and the desire for more support to professional development a key element of engagement survey feedback that is a directorate priority 2019/20.
Finalise staff engagement plans across the Directorate incorporating a leadership structure	• Directorate level priorities have been developed from the 2018/19 staff survey results. • Team actions are underway across the directorate with nursing leaders taking the lead for each Service. The focus is largely on wellbeing, professional development and tangible actions that make the work environment more efficient or enjoyable. • Regular service meetings with the Directorate Leadership Team at which, amongst other matters, the Service Lead Teams would report back on agreed action plans and achievements are established.
Prepare a communications strategy in preparation of the 2018/19 staff Employee Survey	• A proposed central communications plan has been circulated and from this a draft communications strategy has been prepared. Awareness of results and local team actions is strong within nursing and administration teams. Different channels of communication are needed to reach the medical members of Services.
Embed values, Speak Up and a culture of kindness	• The delivery of values sessions continue across the Directorate with 45% being held across all services in the last 12 months. • The number of incidents of bullying and harassment being reported remains low. A facilitator has been appointed to work with medical staff in General Surgery to address some behavioural issues that have been identified.

Scorecard

Auckland DHB - Surgical Services

HAC report for January 2020

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

Safety

Metric		Actual	Target	Previous
Medication errors with major harm	PR215	0	Lower	0
Nosocomial pressure injury point prevalence (% of in-patients)	PR097	3.2%		0%
Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	PR185	1.5%		1.5%
Number of falls with major harm	PR199	0	Lower	0
Number of reported adverse events causing harm (SAC 1&2)	PR084	0	Lower	0
Unviewed/unsigned Histology/Cytology results >=30 days	PR596	69	Lower	73
% Hand hygiene compliance	PR195	**81.6%**	>=80%	82.07%

Patient-centred

Metric		Actual	Target	Previous
% Patients cared for in a mixed gender room at midday - Adult	PR175	33.32%	TBC	25.32%
% hospitalised smokers offered advice and support to quit	PR129	**98.43%**	>=95%	99.31%
% DNA rate for outpatient appointments - Māori	PR057	**20.54%**	<=9%	17.16%
% DNA rate for outpatient appointments - Pacific	PR058	**20.6%**	<=9%	18.54%
% DNA rate for outpatient appointments - All Ethnicities	PR056	**9.64%**	<=9%	9.67%
% DNA rate for outpatient appointments - Deprivation Scale Q5	PR338	**14.66%**	<=9%	14.96%
% Very good and excellent ratings for overall inpatient experience	# PR154	**80.7%**	>=90%	87.6%
% Very good and excellent ratings for overall outpatient experience	# PR179	**87.7%**	>=90%	88.3%
% Very good and excellent ratings for coordination of care after discharge	# PR493	**62.1%**	>=90%	71.3%
% Response rate to ADHB patient experience inpatient survey	# PR315	**21%**	>=25%	22%
Number of CBU Outliers - Adult	PR173	**250**	<=300	143

Timeliness

Metric		Actual	Target	Previous
31/62 day target - % of non-surgical patients seen within the 62 day target	PR181	**94.92%**	>=90%	93.62%
31/62 day target - % of surgical patients seen within the 62 day target	PR182	**100%**	>=90%	100%
62 day target - % of patients treated within the 62 day target	PR184	**97.3%**	>=90%	96.25%
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Māori	PR329	12	Lower	4
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Pacific	PR330	13	Lower	6
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Total	PR328	98	Lower	57
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Deprivation Scale Q5	PR332	35	Lower	12

(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Māori	PR323	42	Lower	35
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Pacific	PR324	73	Lower	67
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Total	PR327	497	Lower	416
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Deprivation Scale Q5	PR326	113	Lower	99

Effectiveness

Metric		Actual	Target	Previous
28 Day Readmission Rate - Māori	# PR079	11.67%	<=6%	8.39%
28 Day Readmission Rate - Pacific	# PR080	12.27%	<=6%	8.05%
28 Day Readmission Rate - Total	# PR078	11.44%	<=10%	9.75%
28 Day Readmission Rate - Deprivation Scale Q5	# PR322	11.61%	<=6%	9.57%

Efficiency

Metric		Actual	Target	Previous
Elective day of surgery admission (DOSA) rate	PR048	80.75%	>=68%	80.1%
% Day Surgery Rate	PR052	66.56%	>=70%	58.17%
Average LOS for WIES funded discharges (days) - Acute	PR219	3.49	TBC	3.08
Average LOS for WIES funded discharges (days) - Elective	PR220	0.74	TBC	1.25
HT2 Elective discharges cumulative variance from target	PR035	0.97	>=1	0.97
Inhouse Elective WIES through theatre - per day	# PR053	59.69	TBC	78.54

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

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

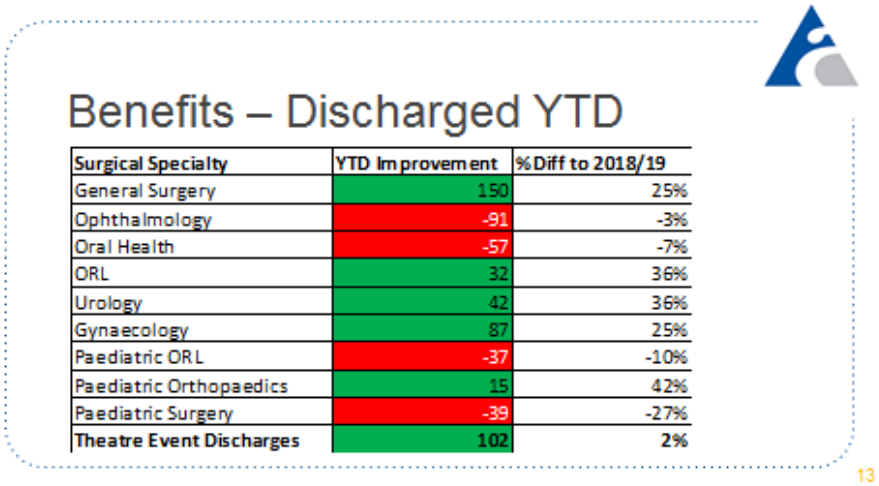
Scorecard Commentary

- SAC 1 and 2 Incidents
  - There have been 0 SAC 1 and 2 incidents for the last 2 months
- There are five open SAX 1/2 incidents. One of these is a SAC 2 fall. We also have two SAC 4 ARR incidents open and under review.
- In addition we are awaiting the decision on one HDC investigation. This is our third recent investigation, final (breach) decisions having been made in Sept 2019 and December 2019.

- DOSA rates remain positive and above 80% which is a reflection of the embedded pathways that exist to bring patients in on the day of surgery.
- There was an increase in Daycase rates through January which is a reflection of high acute volumes and requirement to defer some inpatient work at the ACH site.

Key achievements in the month

- Continued improved OR sessions usage at GSU as part of the Planned Care Work stream.
- Improved discharge volumes at GSU against 18/19 performance
    - This includes a WIES increase of 8% against last year's volumes



Surgical Specialty	YTD Improvement	%Diff to 2018/19
General Surgery	150	25%
Ophthalmology	-91	-3%
Oral Health	-57	-7%
ORL	32	36%
Urology	42	36%
Gynaecology	87	25%
Paediatric ORL	-37	-10%
Paediatric Orthopaedics	15	42%
Paediatric Surgery	-39	-27%
Theatre Event Discharges	**102**	**2%**

- When benchmarked against last years actual performance the Directorate is performing well with delivering:
    - 1016 additional acute discharges in first 7 months
    - 507 increase in elective discharges
    - Total $8.41m additional revenue between months 1-7.

Increase/ (decrease) in delivery Year to Date January 2019 vs January 2020						
	Elective			Total Inpatient		
Service	**Discharges**	**WIES Latest**	**Revenue**	**Discharges**	**WIES Latest**	**Revenue**
General Surgery	167	122.81	640,619	764	664.19	3,464,573
Neurosurgery	16	66.04	344,473	43	139.45	727,424
Ophthalmology	(50)	(17.33)	(90,402)	170	50.50	263,415
Oral & Maxillofacial Surgery	2	5.51	28,755	8	10.34	53,942
Oral Health	82	63.08	329,064	43	41.75	217,768
ORL	140	181.51	946,773	221	313.85	1,637,098
Orthopaedics	60	10.48	54,670	249	358.69	1,871,021
Renal Transplant				(19)	(113.60)	(592,586)
Urology	28	66.68	347,799	(18)	96.93	505,612
Total Internal Delivery	**445**	**498.78**	**2,601,751**	**1,461**	**1,562.10**	**8,148,267**
Ophthalmology O/S	46	23.32	121,653	46	23.32	121,653
Orthopaedics O/S	16	28.16	146,864	16	28.16	146,864
Year on Year Increase / (Decrease	**507**	**550.26**	**2,870,268**	**1,523**	**1,613.58**	**8,416,784**
Note: January WIES/Revenue is only 61% coded, the remaining 39% is estimated						

Summary Net Result

STATEMENT OF FINANCIAL PERFORMANCE
Surgical Services

Reporting Date Jan-20

($000s)	MONTH			YEAR TO DATE (7 months ending Jan-20)		
	Actual	Budget	Variance	Actual	Budget	Variance
REVENUE						
Government and Crown Agency	1,028	663	365 F	5,010	4,644	366 F
Funder to Provider Revenue	23,840	23,268	572 F	177,622	175,723	1,899 F
Other Income	576	430	146 F	3,503	3,013	490 F
Total Revenue	**25,445**	**24,362**	**1,083 F**	**186,135**	**183,381**	**2,755 F**
EXPENDITURE						
Personnel						
Personnel Costs	9,531	8,776	(755) U	67,268	63,789	(3,479) U
Outsourced Personnel	420	321	(99) U	2,657	2,246	(411) U
Outsourced Clinical Services	446	329	(117) U	2,539	2,302	(237) U
Clinical Supplies	2,504	2,533	28 F	19,335	18,900	(434) U
Infrastructure & Non-Clinical Supplies	453	268	(185) U	2,322	1,863	(460) U
Total Expenditure	**13,355**	**12,227**	**(1,129) U**	**94,121**	**89,100**	**(5,021) U**
Contribution	**12,089**	**12,135**	**(46) U**	**92,014**	**94,281**	**(2,266) U**
Allocations	2,586	2,601	15 F	19,556	19,435	(121) U
NET RESULT	**9,503**	**9,534**	**(31) U**	**72,458**	**74,846**	**(2,388) U**

Paid FTE

	MONTH (FTE)			YEAR TO DATE (FTE) (7 months ending Jan-20)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	259.6	237.2	(22.4) U	251.8	236.0	(15.8) U
Nursing	528.3	503.1	(25.2) U	506.1	482.6	(23.5) U
Allied Health	43.4	45.6	2.2 F	44.4	45.6	1.2 F
Support	0.0	0.0	0.0 F	0.0	0.0	(0.0) U
Management/Administration	101.9	105.2	3.3 F	100.8	104.5	3.7 F
Total excluding outsourced FTEs	**933.2**	**891.1**	**(42.1) U**	**903.2**	**868.8**	**(34.4) U**
Total :Outsourced Services	14.4	9.1	(5.3) U	13.7	9.1	(4.6) U
Total including outsourced FTEs	**947.5**	**900.2**	**(47.3) U**	**916.9**	**877.9**	**(39.0) U**

Comment on major financial variances

Surgical Services result is $2,388k U for the year to January 2020.

The key drivers are personnel costs for Medical $1,938k U and in Nursing $1,570k U and clinical supplies $434k U and infrastructure costs $459k U. These costs are partially offset by favourable revenue.

Revenue

Total volumes delivered are 100% of contract for the YTD. Demand for acute services is 105.4% and elective volumes at 93.7% against contract YTD. The revenue adjustment of $1,899k F reflected in the financial result for Funder to Provider revenue, recognizes the over delivery to end of December 2019.

Non-resident revenue is $613k F for the year to date.

Expenditure

The key drivers to the result are:-

- Expenditure including Internal Allocations $5,142k U
- Personnel costs are $3,479k U mainly driven by back pay for Senior Medical Officer relating to job sizing $590k U and the ongoing impact of the remuneration change $312k U and in nursing $1,570k U due to the need for patient attenders to monitor high acuity patients, high occupancy across the hospital as well as high sick leave.
- Clinical supplies $434k U
    - Implants $391k U –Ophthalmology $110k U relating to Ophthalmic Lenses. Neurosurgery $196k U primarily from Neurostimulators, noting several of these procedures are ACC and implant costs are fully reimbursed when the patient event is invoiced.
- Infrastructure costs $459k U - Bad debt write offs and provisions against non-resident billing $190k U due to non-resident billings YTD, offset by Medirota costs of $45k and hosting for HQSC Surgical Site Infection ICT $58k U and cleaning supplies
- Internal Allocations $121k U, driven mainly by interpreters $333k U, noting the first two months of the transition to telephone interpreters is helping to reduce the annual impact. This is offset by favourable MRI $425k F.

Women's Health Directorate

Speaker: Rob Sherwin, Director

Service Overview

The Women's Health portfolio includes all Obstetrics and Gynaecology services. The services in the Directorate are divided into the following six service groups:

- Primary Maternity Services
- Secondary Maternity Services
- Regional Maternity Services
- Secondary Gynaecological Services (including Fertility Services)
- Regional Gynaecology Oncology
- Regional Gynaecology Day Service

The Women's Health Directorate is led by:

Director:	Rob Sherwin
General Manager:	Angela Beaton
Director of Midwifery:	Deborah Pittam
Interim Director of Allied Health:	Claudine Hutchings (Social Work Lead)
Director of Primary Care:	Orna McGinn

Directorate Priorities for 2020/2021

In 2020/21 our Directorate will contribute to the delivery of the Provider Arm work programmes. In addition to this, we will also focus on the following Directorate priorities:

1. Safe and high quality services
2. Better outcomes for our priority populations
3. Learning and responding to patient experiences
4. Workforce capacity and capability that meets the service demand
5. Develop models of care that are patient focused, sustainable and maximise value

Glossary

Acronym/term	Definition
ADMM	Associate Director of Midwifery (Māori Health and Equity)
LARC	Long Acting Reversible Contraceptive
WHS	Women's Health Service
WIES	Weighted Inlier Equivalent Separation
YTD	Year to Date

Priority	Area	Commentary
1	Safe and Quality Services	**Planned activities** Progress against the Women's Health Service (WHS) Health and Safety 2019/20 A3 is on track. The 2020/21 A3 will be developed by the Director and General Manager over Q4. **Datix Reporting**

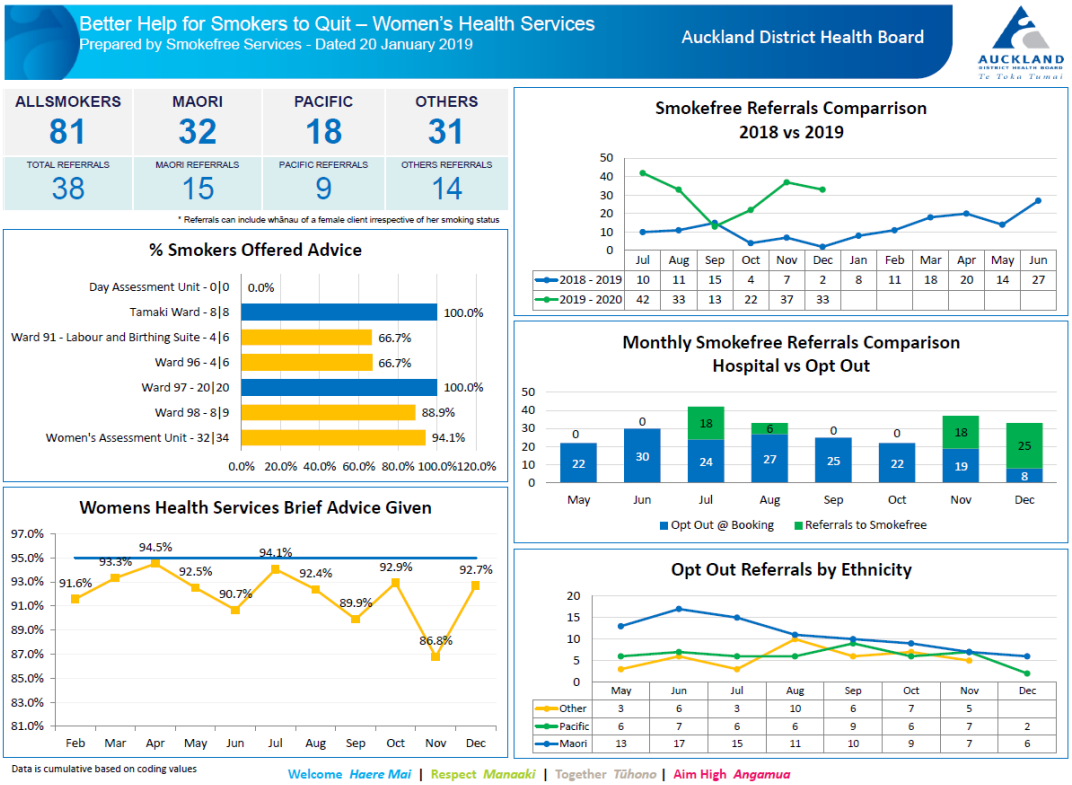
Priority	Area	Commentary
		In December 2019, WHS reviewed the management of datix reporting and follow up within the service, confirming that WHS aims to achieve a high reporting culture with low serious harm. This is supported by: ○ Timely processing of Datix reports ▪ Prompt assessment and SAC scoring ▪ Consistent approach by managers ▪ Feedback to reporters ○ Learning from Datix ▪ Quarterly trend analysis ▪ Auditing of implemented actions ▪ Developing a repository of learning for actions ▪ Strategy for disseminating learning ○ Maternity Triggers ▪ Examples of trigger lists were reviewed and it was agreed that a modified ADHB list should be developed ○ Daily review of Datix reports: ▪ Maternity: Sue Cole (Maternity Quality and Safety Programme Co-ordinator) ▪ Gynaecology: Lisa Middelberg (Associate Nurse Director). **Equity Dashboard** To eliminate health inequities, data collection and stratification is required. This data will inform priority setting and drive improvement activities. We have started to formulate an equity dashboard to assist in the identification of inequities. We will then ask the newly appointed Associate Director of Midwifery (Māori Health and Equity) (ADMM) to lead a co-creation piece of work to identify additional measures that are valued by Māori and Pasifika communities, to support change that matters to our communities.
2	Better outcomes for our priority populations	All programmes and services support this priority, including but not limited to: **Te Manawa o Hine** With the appointment of the ADMM and interim Charge Midwife for Te Manawa o Hine, recruitment to further positions within the service has commenced and one Continuity of Care Midwife is now working within Te Manawa o Hine. We have a second graduate commencing in March and another in June to create a team of three. In the process of developing this service it has become clear there is a significant need for provision of care to Māori women with extremely complex needs. To meet the needs of graduates and Māori women with very complex, social, mental health and medical needs we are in the process of extending the service to offer two Māori Midwife Specialist (Complex care) roles and already have interest from Māori

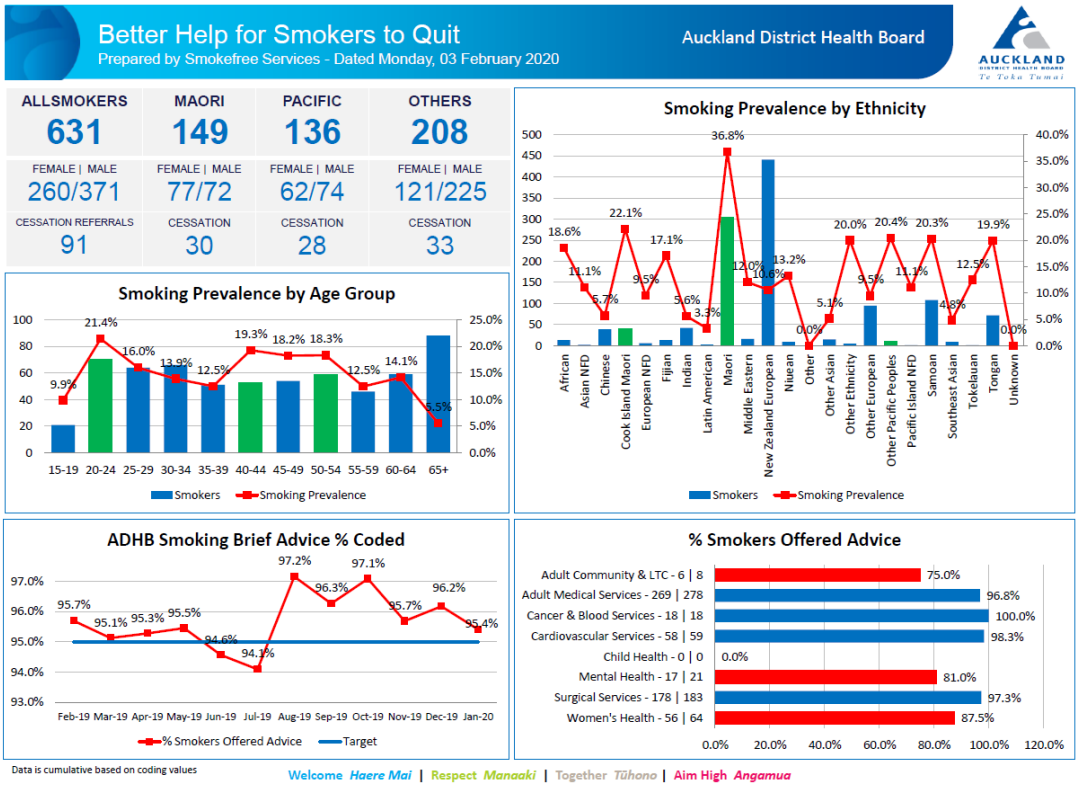
Priority	Area	Commentary
		midwives with expertise in complex care. **LARC (long-acting reversible contraception) Project** Two community clinics are now operating in Glen Innes and Mt Wellington. A further clinic will commence Friday 6 March in the Three Kings area. This clinic is located in an area where a high proportion of Q4 and 5 Māori and Pasifika women live; and Mt Wellington is an easily accessible, accident and emergency clinic with a large patient population and walk in appointments. Two (0.5 FTE) nurse specialists have been recruited to operate the community clinics. A registration of interest for other LARC providers is underway, and GP training will be available from the Mt Wellington community clinic (provided by the WHS Director of Primary Care, who also provides some LARC clinical services at the Mt Wellington clinic). The Walk in midwifery community clinic is also offering a LARC service for postnatal women.
3	Learning and responding to patient experience	**Mesh patient pathway** A workshop was held in December 2019, to draft a patient pathway for women experiencing complications of Mesh. Dr Michael Roberts (CMO Northlands) chaired the workshop and subsequently presented the revised patient pathway document to the Regional Executive Forum (REF). The REF agreed that ADHB will host a Northern Region Mesh MDM; WHS is in the process of operationalising this. **Evidence informed service improvement** The WHS is exploring systematic ways to embed findings from patient experience data into quality and safety improvements across the Directorate, with a focus on equity. **I-Pad consumer feedback process for maternity** This consumer feedback, pilot initiative was finalised and implemented in Ward 98 in late November 2019. Feedback is being sought from women antenatally and postnatally. To date, 34 responses (32% of women identified as European, 9% Māori and 29% Pasifika) have been received with volunteers assisting patients to use i-pads to complete on-line feedback. The majority of feedback has been very positive and there is some feedback which will inform further work. We are now looking to extend the pilot into Tamaki Ward and Ward 96.
4	Workforce capacity and capability meets the service demand	**Workforce metrics** Following a reduction in sick leave and also overtime worked during Q1 and Q2, staff turnover, sick leave and overtime worked has continued to reduce in this quarter. In December 2019, we recorded our lowest rate of staff turnover (over the last 18 months).

Priority	Area	Commentary
		The commencement of an additional Maternal Fetal Medicine specialist (MFM) SMO and additional scanning availability are welcome additions to the service. We are working through options to support the MFM specialist midwives and welcome the commencement of a new MFM/Diabetes Charge Midwife. Upcoming medical vacancies will out pressure on production towards the last quarter of this financial year. Two Gynae-Oncology SMO appointments have been made, with commencement dates in August 2020 and March 2023. There was a modest uptake in MDP module completion over the past quarter. As the overall level remains relatively low, a drive to increase participation is underway, along with a focus on systematising performance conversations. **Staff engagement** Engagement survey action plans have been co-developed with staff and implementation of actions is on track. **Māori and Pasifika nursing and midwifery staff** The appointment of the ADMM has been made and she will commence in post on 30 March 2020. The interim Charge Midwife (CM) for the Te Manawa o Hine service has been appointed and commenced in February. The CM will support the launch of the service, mentor a permanent charge midwife into position and support three graduate midwives within the service. This is the beginning of work to increase the numbers of midwives in our workforce who are Māori and to improve services to Māori women and whānau. We have also been approached by two senior Māori complex care midwives to join the team and provide care to Māori women with highly complex social, mental health and medical needs. **Midwifery Staff Retention Initiative** This initiative was implemented in November 2019. Graduates have received their first instalment of retention payments. Core midwives had until the end of January to signal intentions to increase FTE. Currently HR has reported a 0.4FTE increase, which is small; however, the main intention of the scheme is to support graduates to stay with us after their first year and to reduce staff turnover. Review over time, will identify the programme's success. We have had an encouraging number of graduates apply for positions at ADHB this year and so far, none of last year's NZ graduates have suggested they intend to leave us. Last year we had a net increase in midwifery staffing over the year and there has been a significant improvement in general morale amongst our still pressured staff. We remain in a position where any

Priority	Area	Commentary
		increase in sick leave amongst staff and any resignation is felt within the service. On-going work within the recruitment, retention and responsiveness framework continues to ensure continued growth of the midwifery workforce at ADHB.
5	Develop models of care that are patient focused, sustainable and maximise value	**Theatre utilisation** Discussions are on-going regarding L9 theatre productivity. The decision to staff 9-hour theatre operating sessions is being advanced but has not yet been implemented. **Model of inpatient Care in Maternity** When we opened ward 96 we did so with a mixed model of care with both nurses and midwives working together to provide care for postnatal women, mostly those who have experienced a caesarean section. This is generally working well and both nurses and midwives are committed to providing excellent care. Trendcare data (despite being incomplete in terms of actualisations) shows a consistent deficit in staff hours, particularly during the day. We are working to consider other ways to distribute patient loads throughout the service and offer team approaches to care, to try to ameliorate the associated risks. We are looking forward to the CCDM process later in the year to assist us to identify future staffing requirements for the unit.

Scorecards


Better Help for Smokers to Quit – Women's Health Services
Prepared by Smokefree Services - Dated 20 January 2019
Auckland District Health Board
ALLSMOKERS 81
MAORI 32
PACIFIC 18
OTHERS 31
TOTAL REFERRALS 38
MAORI REFERRALS 15
PACIFIC REFERRALS 9
OTHERS REFERRALS 14
* Referrals can include whānau of a female client irrespective of her smoking status
% Smokers Offered Advice
Day Assessment Unit - 0|0 0.0%
Tamaki Ward - 8|8 100.0%
Ward 91 - Labour and Birthing Suite - 4|6 66.7%
Ward 96 - 4|6 66.7%
Ward 97 - 20|20 100.0%
Ward 98 - 8|9 88.9%
Women's Assessment Unit - 32|34 94.1%
Smokefree Referrals Comparrison 2018 vs 2019
Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun
2018 - 2019 10 11 15 4 7 2 8 11 18 20 14 27
2019 - 2020 42 33 13 22 37 33
Monthly Smokefree Referrals Comparison Hospital vs Opt Out
May Jun Jul Aug Sep Oct Nov Dec
Opt Out @ Booking
Referrals to Smokefree
Womens Health Services Brief Advice Given
Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec
Opt Out Referrals by Ethnicity
May Jun Jul Aug Sep Oct Nov Dec
Other 3 6 3 10 6 7 5
Pacific 6 7 6 6 9 6 7 2
Maori 13 17 15 11 10 9 7 6
Data is cumulative based on coding values
Welcome Haere Mai | Respect Manaaki | Together Tūhono | Aim High Angamua


Better Help for Smokers to Quit
Prepared by Smokefree Services - Dated Monday, 03 February 2020
Auckland District Health Board
ALLSMOKERS 631
MAORI 149
PACIFIC 136
OTHERS 208
FEMALE | MALE 260/371
FEMALE | MALE 77/72
FEMALE | MALE 62/74
FEMALE | MALE 121/225
CESSATION REFERRALS 91
CESSATION 30
CESSATION 28
CESSATION 33
Smoking Prevalence by Age Group
15-19 20-24 25-29 30-34 35-39 40-44 45-49 50-54 55-59 60-64 65+
Smokers
Smoking Prevalence
Smoking Prevalence by Ethnicity
African Asian NFD Chinese Cook Island Maori European NFD Fijian Indian Latin American Maori Middle Eastern New Zealand European Niuean Other Other Asian Other Ethnicity Other European Other Pacific Peoples Pacific Island NFD Samoan Southeast Asian Tokelauan Tongan Unknown
Smokers
Smoking Prevalence
ADHB Smoking Brief Advice % Coded
Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20
% Smokers Offered Advice
Target
% Smokers Offered Advice
Adult Community & LTC - 6 | 8 75.0%
Adult Medical Services - 269 | 278 96.8%
Cancer & Blood Services - 18 | 18 100.0%
Cardiovascular Services - 58 | 59 98.3%
Child Health - 0 | 0 0.0%
Mental Health - 17 | 21 81.0%
Surgical Services - 178 | 183 97.3%
Women's Health - 56 | 64 87.5%
Data is cumulative based on coding values
Welcome Haere Mai | Respect Manaaki | Together Tūhono | Aim High Angamua

Auckland DHB - Women's Health

HAC report for January 2020

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

Safety

Metric		Actual	Target	Previous
Medication errors with major harm	PR215	0	Lower	0
Nosocomial pressure injury point prevalence (% of in-patients)	PR097	0%		0%
Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	PR185	0%		0%
Number of falls with major harm	PR199	0	Lower	0
Number of reported adverse events causing harm (SAC 1&2)	PR084	3	Lower	0
Unviewed/unsigned Histology/Cytology results >=30 days	PR596	20	Lower	38
% Hand hygiene compliance	PR195	80.19%	>=80%	93.06%

Patient-centred

Metric		Actual	Target	Previous
% hospitalised smokers offered advice and support to quit	PR129	88.64%	>=95%	91.57%
% DNA rate for outpatient appointments - Māori	PR057	19.87%	<=9%	20.11%
% DNA rate for outpatient appointments - Pacific	PR058	21.49%	<=9%	24.03%
% DNA rate for outpatient appointments - All Ethnicities	PR056	10.52%	<=9%	10.76%
% DNA rate for outpatient appointments - Deprivation Scale Q5	PR338	16.59%	<=9%	17.43%
% Very good and excellent ratings for overall inpatient experience	# PR154	82%	>=90%	72.4%
% Very good and excellent ratings for overall outpatient experience	# PR179	82.5%	>=90%	89.8%
% Very good and excellent ratings for coordination of care after discharge	# PR493	66%	>=90%	66.7%
% Response rate to ADHB patient experience inpatient survey	# PR315	17%	>=25%	18%
Number of CBU Outliers - Adult	PR173	121	<=300	139
Number of patient discharges to Birthcare	PR192	290	TBC	296
Breastfeeding rate on discharge excluding NICU admissions	# PR099	78%	>=75%	76.8%

Timeliness

Metric		Actual	Target	Previous
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Māori	PR329	2	Lower	0
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Pacific	PR330	3	Lower	0
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Total	PR328	35	Lower	4
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Deprivation Scale Q5	PR332	6	Lower	1
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Māori	PR323	0	Lower	2
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Pacific	PR324	2	Lower	0

(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Total	PR327	8	Lower	10
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Deprivation Scale Q5	PR326	2	Lower	1

Effectiveness

Metric		Actual	Target	Previous
28 Day Readmission Rate - Māori	# PR079	**4.42%**	<=6%	6.32%
28 Day Readmission Rate - Pacific	# PR080	**3.57%**	<=6%	3.7%
28 Day Readmission Rate - Deprivation Scale Q5	# PR322	**4.49%**	<=6%	5.24%
Post Gynaecological Surgery 28 Day Acute Readmission Rate	# PR210	9.42%		4.55%

Efficiency

Metric		Actual	Target	Previous
Elective day of surgery admission (DOSA) rate	PR048	**94.92%**	>=68%	94.03%
% Day Surgery Rate	PR052	**47.33%**	>=50%	31.94%
Average LOS for WIES funded discharges (days) - Acute	PR219	**1.75**	<=2.1	1.77
Average LOS for WIES funded discharges (days) - Elective	PR220	**1.12**	<=1.5	1.33
HT2 Elective discharges cumulative variance from target	PR035	**0.97**	>=1	0.97
Inhouse Elective WIES through theatre - per day	# PR053	**8.78**	>=4.5	8.87

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

#	Actual is the latest available result prior to January 2020

Scorecard Commentary

Safety

- Hand Hygiene compliance rate (80.19%) has reduced compared with the previous month but remains on target (at 80%).

Patient-centred

- The percentage of smokers offered advice and support to quit has slightly reduced and remains below target; on-going work in all units is underway to improve.
- Do not attend (DNA) rates for Māori, Pasifika and Deprivation Scale Quintile 5 patients have not improved and remain above target. Learning from successes in other directorates and DHBs will be used to inform an improvement plan.

- 'Very Good' and 'Excellent' patient experience inpatient ratings have improved, and 'Very Good' and 'Excellent' outpatient ratings have reduced slightly compared with the previously reported rates; both remain below the target of 90%. With planned model of care changes, we anticipate improvements in the experience of our patients, their whānau and staff, along with improvements in the quality of care. This will be monitored closely.
- 'Very Good' and 'Excellent' Coordination of care after discharge ratings remain below the target of 90%.

Timeliness

- Elective discharge targets and ESPI compliance are within the predicted levels. These targets will require close monitoring with a focus on preventing further breaches in the current quarter; however, this will be extremely challenging with the anticipated RMO and SMO vacancies.

Effectiveness

- Readmission rates for Māori, Pasifika and Deprivation Scale Quintile 5 women have all improved and are all within target.

Efficiency

- The day surgery rate remains unfavourable against the arbitrary 50% target rate.
- Average LOS for Weighted Inlier Equivalent Separation (WIES) funded discharges (acute and elective) have improved since the previously reported averages and remain favourable to target.

Recent key achievements

- **Key appointments and midwifery leadership restructure:** Director of Midwifery, Deb Pittam; Associate Director Nursing, Lisa Middelberg; General Manager, Dr Angela Beaton; Associate Director of Midwifery Physiological Birth, Christine Mellor; and Associate Director of Midwifery (Māori and Equity), Nicole Te Aroha Pihema. All staff have commenced apart from Nicole, who joins us at the end of March 2020. Nicole will lead on-going work to embed the principles of Turanga Kaupapa into everyday midwifery practice across Auckland DHB and further develop and lead the implementation of the Māori and Pacific midwifery workforce development plan.
- **Te Manawa o Hine:** WHS is committed to establishing equity of outcomes for Māori and Pasifika women and to increasing support for women to achieve physiological birth. Te Manawa o Hine has launched (see earlier for progress).
- **Reopening ward 96:** This ward was closed in Oct 2018 as part of consolidation of services. Ward 96 was re-opened in July 2019 with a focus on the delivery of high quality post-natal care.
- **Review of Service Clinical Directorate reporting:** Reporting for services within the directorate was reviewed to support operational and clinical excellence.
- **Development of the 2019/20 A3 directorate plan:** The directorate business plan has been developed and key actions by quarter are on track.
- **Review of the clinical governance structure within WHS and Just Culture training for key staff**: It was agreed there would be two key WHS governance groups, one for Maternity and one for Gynaecology. Representatives of individual speciality groups will report to the relevant

governance group; a short report will be submitted prior to the meeting and a 2-minute verbal report will be timetabled. Priorities for each speciality group will contribute to the WHS A3 and the governance groups will monitor project delivery and progress towards the A3. The governance groups will provide final sign off/approval for guidelines and consumer information.

Areas off track and remedial plans

The implementation of Te Manawa o Hine has been delayed, although it is now underway. The appointment of the Associate Director of Midwifery (Māori and Equity) and the interim Charge Midwife Te Manawa o Hine, along with approval for capital expenditure to enable implementation, will expedite progress on this initiative in the next quarter.

Key issues and initiatives identified in coming months

- Compliance with the Directorate's SMO post call charter and re-timetabling work to be completed in Q3 and 4.
- Mitigating the impact of our ongoing midwifery vacancies whilst developing a sustainable pipeline of midwives remains an ongoing challenge. The chronic midwifery workforce shortage requires daily monitoring of capacity and demand, to flex the bed base, (re-)assign resources and develop more sustainable models of care. Flexible rostering options are being considered along with a strong focus on growing and nurturing students and graduates in the workplace.
- Mitigating workforce challenges to ensure continuity of our Maternal Fetal Medicine and Gynae-Oncology tertiary services.
- Ensuring our A3, Annual Plan and business as usual commitments are met in the context of current workforce challenges.
- Preparation to replace Healthware, our current maternity clinical information system by end 2021, which constitutes a major project for the directorate requiring careful planning and significant Auckland DHB investment. A single stage business case will be prepared over the next six months with the support of seed funding.
- Possible reconfiguration of local and regional abortion services following legislative changes and metro Auckland discussions.
- Review and refine management oversight of mandatory training and performance conversations for all Women's Health staff and professional groups.

Financial Results

STATEMENT OF FINANCIAL PERFORMANCE

Womens Health Services

Reporting Date Jan-20

($000s)	MONTH			YEAR TO DATE (7 months ending Jan-20)		
	Actual	Budget	Variance	Actual	Budget	Variance
REVENUE						
Government and Crown Agency	165	197	(32) U	997	1,427	(430) U
Funder to Provider Revenue	8,505	7,080	1,426 F	54,858	52,976	1,882 F
Other Income	(482)	174	(657) U	1,280	1,221	58 F
Total Revenue	**8,189**	**7,451**	**737 F**	**57,135**	**55,625**	**1,510 F**
EXPENDITURE						
Personnel						
Personnel Costs	4,117	3,794	(323) U	27,789	27,726	(64) U
Outsourced Personnel	114	86	(28) U	622	593	(29) U
Outsourced Clinical Services	22	47	25 F	308	328	20 F
Clinical Supplies	524	464	(60) U	3,531	3,465	(66) U
Infrastructure & Non-Clinical Supplies	145	122	(24) U	790	822	32 F
Total Expenditure	**4,922**	**4,512**	**(410) U**	**33,040**	**32,934**	**(106) U**
Contribution	**3,267**	**2,939**	**327 F**	**24,095**	**22,690**	**1,404 F**
Allocations	721	724	3 F	5,467	5,429	(38) U
NET RESULT	**2,546**	**2,215**	**331 F**	**18,628**	**17,261**	**1,367 F**

Paid FTE

	MONTH (FTE)			YEAR TO DATE (FTE) (7 months ending Jan-20)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	70.3	71.6	1.3 F	71.3	71.6	0.4 F
Midwives, Nursing	259.2	262.3	3.1 F	260.7	260.3	(0.4) U
Allied Health	9.0	9.7	0.7 F	11.1	9.7	(1.4) U
Support	0.0	0.0	0.0 F	0.0	0.0	0.0 F
Management/Administration	38.7	39.6	0.9 F	36.9	39.6	2.7 F
Other	0.0	0.0	0.0 F	0.0	0.0	0.0 F
Total excluding outsourced FTEs	**377.3**	**383.3**	**6.0 F**	**379.9**	**381.3**	**1.3 F**
Total :Outsourced Services	7.9	3.1	(4.8) U	5.0	3.1	(1.9) U
Total including outsourced FTEs	**385.1**	**386.3**	**1.2 F**	**384.9**	**384.3**	**(0.6) U**

Comments on major financial variances (YTD)

The Directorate's five months result is $1,367k F to budget, largely due to favourable revenues (above contract performance volumes while holding overall costs to budget). Overall YTD Case Weighted Discharge (CWD) volumes stand at 102.8% of contract, with Specialist Neonates at 118%.

Gynaecology acute WIES 99% to contract; Gynaecology elective WIES 103% to contract; Gynae-Oncology elective WIES 99.5% to contract; and Obstetric inpatient WIES 102.9% to contract.

Key factors impacting on the 2019/20 Year to Date performance are as follows:

1. Revenue $1,510k Favourable YTD

    - Largely due to over-performance of PVS volume $1,302k F (Obstetric volumes have increased above last year, which was the basis for contract volumes), placement training income $193k F, ACC elective and contract income $32k F, private and non-residents revenue $111k F, and offset by other shortfalls of $128 k U.

2. Expenditure $144k Unfavourable YTD (that is, 0.4% of all $38.4m YTD budgeted expenditure)

    - Personnel costs YTD $64k F, Outsourced personnel $24k U, Clinical supplies $66k U, including Blood products $50k U (one high cost patient received $50k of products over this 7-month time period). Infrastructure and Non-Clinical $32k F; Internal Allocations total $38k U including Lab $111k U (mainly Gynaecology), offset by Nutrition charges $52k F.

Financial Performance

Consolidated Statement of Financial Performance - January 2020

Provider	Month (Jan-20)			YTD (7 months ending Jan-20)		
$000s	Actual	Budget	Variance	Actual	Budget	Variance
Income						
Government and Crown Agency sourced	9,067	8,010	1,057 F	60,253	60,446	(194) U
Non-Government & Crown Agency Sourced	8,027	8,630	(603) U	62,360	61,470	890 F
Inter-DHB & Internal Revenue	1,099	1,146	(47) U	8,840	8,257	582 F
Internal Allocation DHB Provider	126,136	125,781	355 F	861,028	856,320	4,708 F
	144,330	**143,568**	**761 F**	**992,480**	**986,494**	**5,986 F**
Expenditure						
Personnel	89,495	85,352	(4,143) U	634,641	635,633	992 F
Outsourced Personnel	2,052	1,135	(917) U	15,533	7,953	(7,580) U
Outsourced Clinical Services	3,157	3,001	(156) U	25,667	26,039	371 F
Outsourced Other	5,615	5,608	(7) U	39,224	39,258	34 F
Clinical Supplies	24,331	23,065	(1,266) U	183,496	178,468	(5,028) U
Infrastructure & Non-Clinical Supplies	20,231	17,061	(3,170) U	127,047	126,229	(817) U
Internal Allocations	652	652	0 F	4,565	4,565	0 F
Total Expenditure	**145,533**	**135,876**	**(9,657) U**	**1,030,172**	**1,018,145**	**(12,027) U**
Net Surplus / (Deficit)	**(1,203)**	**7,693**	**(8,896) U**	**(37,692)**	**(31,651)**	**(6,041) U**

Consolidated Statement of Financial Performance – January 2020

Performance Summary by Directorate

By Directorate $000s	Month (Jan-20)			YTD (7 months ending Jan-20)		
	Actual	Budget	Variance	Actual	Budget	Variance
Adult Medical Services	(335)	12	(348) U	3,316	4,393	(1,077) U
Adult Community and LTC	1,239	1,239	() U	8,317	8,366	(48) U
Surgical Services	9,503	9,815	(312) U	72,458	75,127	(2,669) U
Women's Health	2,546	2,215	331 F	18,628	17,261	1,367 F
Child Health	2,876	2,500	376 F	30,371	32,788	(2,417) U
Cardiac Services	1,269	1,737	(468) U	12,901	18,033	(5,132) U
Clinical Support Services	(1,374)	(1,427)	53 F	(7,503)	(9,559)	2,057 F
Patient Management Services	(2,635)	(2,638)	3 F	(17,715)	(18,044)	329 F
Perioperative Services	(11,474)	(10,770)	(705) U	(80,545)	(79,806)	(739) U
Cancer & Blood Services	2,196	1,938	258 F	11,807	12,284	(476) U
Operational - Other	5,442	8,601	(3,159) U	45,092	45,138	(45) U
Mental Health & Addictions	777	508	269 F	2,871	380	2,491 F
Ancillary Services	(11,233)	(6,039)	(5,193) U	(137,690)	(138,010)	320 F
Net Surplus / (Deficit)	**(1,203)**	**7,693**	**(8,896) U**	**(37,692)**	**(31,651)**	**(6,041) U**

Consolidated Statement of Personnel by Professional Group – January 2020

Employee Group $000s	Month (Jan-20)			YTD (7 months ending Jan-20)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical Personnel	31,778	30,685	(1,093) U	230,683	230,988	305 F
Nursing Personnel	32,584	29,444	(3,140) U	216,595	214,265	(2,329) U
Allied Health Personnel	12,883	13,163	280 F	96,385	100,774	4,389 F
Support Personnel	2,850	2,308	(542) U	18,063	15,987	(2,076) U
Management/ Admin Personnel	9,399	9,752	353 F	72,915	73,618	703 F
Total (before Outsourced Personnel)	**89,495**	**85,352**	**(4,143) U**	**634,641**	**635,633**	**992 F**
Outsourced Medical	1,198	834	(364) U	6,973	5,834	(1,139) U
Outsourced Nursing	105	15	(90) U	2,309	104	(2,205) U
Outsourced Allied Health	138	49	(89) U	648	343	(305) U
Outsourced Support	53	28	(26) U	426	193	(232) U
Outsourced Management/Admin	558	210	(348) U	5,177	1,479	(3,699) U
Total Outsourced Personnel	**2,052**	**1,135**	**(917) U**	**15,533**	**7,953**	**(7,580) U**
Total Personnel	**91,546**	**86,487**	**(5,059) U**	**650,173**	**643,586**	**(6,588) U**

Consolidated Statement of FTE by Professional Group – January 2020

FTE by Employee Group	Month (Jan-20)			YTD (7 months ending Jan-20)		
	Actual FTE	Budget FTE	Variance	Actual FTE	Budget FTE	Variance
Medical Personnel	1,519	1,502	(16) U	1,504	1,499	(5) U
Nursing Personnel	3,941	4,017	76 F	3,970	3,957	(13) U
Allied Health Personnel	1,946	2,002	56 F	1,926	2,001	75 F
Support Personnel	519	531	13 F	510	531	22 F
Management/ Admin Personnel	1,458	1,502	44 F	1,462	1,502	40 F
Total (before Outsourced Personnel)	**9,382**	**9,555**	**173 F**	**9,373**	**9,491**	**118 F**
Outsourced Medical	38	25	(13) U	31	25	(6) U
Outsourced Nursing	1	1	() U	1	1	0 F
Outsourced Allied Health	9	0	(9) U	7	0	(7) U
Outsourced Support	12	0	(12) U	16	0	(16) U
Outsourced Management/Admin	89	7	(82) U	116	7	(109) U
Total Outsourced Personnel	**148**	**33**	**(116) U**	**171**	**33**	**(138) U**
Total Personnel	**9,530**	**9,588**	**57 F**	**9,543**	**9,523**	**(20) U**

Consolidated Statement of FTE by Directorate – January 2020

Employee FTE by Directorate Group (including Outsourced FTE)	Month (Jan-20)			YTD (7 months ending Jan-20)		
	Actual FTE	Budget FTE	Variance	Actual FTE	Budget FTE	Variance
Adult Medical Services	1,022	1,040	18 F	1,039	1,020	(19) U
Adult Community and LTC	566	564	(1) U	580	564	(16) U
Surgical Services	948	865	(82) U	917	873	(44) U
Women's Health	385	386	1 F	385	384	(1) U
Child Health	1,361	1,330	(31) U	1,375	1,330	(45) U
Cardiac Services	564	569	5 F	570	570	0 F
Clinical Support Services	1,357	1,350	(7) U	1,343	1,349	6 F
Patient Management Services	435	444	9 F	449	444	(5) U
Perioperative Services	774	802	28 F	762	803	41 F
Cancer & Blood Services	403	405	2 F	392	405	13 F
Operational - Others	0	70	70 F	0	21	21 F
Mental Health & Addictions	757	796	39 F	764	796	32 F
Ancillary Services	957	965	8 F	968	965	(3) U
Total Personnel	**9,530**	**9,588**	**57 F**	**9,543**	**9,523**	**(20) U**

Month Result

The Provider Arm result for the month is $8.9M unfavourable. This unfavourable result is driven by a year to date adjustment to the budget in the month of January to reflect the revised annual budget position. The budget adjustment results in an abnormal result for the month, but a correct year to date position.

Overall volumes for the month (for total Auckland DHB and IDF Funders) are reported at 96% of the seasonally phased contract - this equates to $2.0M below the month contract.

Total revenue for the month is $0.8M (0.5%) favourable, with the key variances as follows:

- Funder to Provider revenue is $0.4M favourable due to additional hospital medicines rebates received $0.2M favourable and additional MOH MECA funding $0.1M favourable.
- ACC revenue is $0.5M favourable reflecting additional invoicing for prior month.
- Retail Pharmacy revenue $0.4M favourable (partly offset by additional cost of goods sold).
- Other Income $0.6M unfavourable reflecting additional revenue assumed for budget initiatives not yet received.

Total expenditure for the month is $9.7M (7.1%) unfavourable. As noted, this is an abnormal result for the month and is driven by a year to date adjustment to the budget in the month of January to reflect the revised annual budget position. The key variances are as follows:

- Personnel/Outsourced Personnel costs are $5.1M (5.8%) unfavourable. Total FTE for the month were 9,530, which was 57 below budget. The unfavourable variance is due to a $2.7M year to date budget adjustment and $2.4M reflects higher cost per FTE for the month due to actual versus budget phasing. While this creates an unfavourable variance for the month, cost per FTE is tracking close to budget for year to date.
- Clinical Supplies $1.3M (5.5%) unfavourable driven by PCT cancer drugs $0.6M over contract for the month (subject to washup with other DHBs), with the remaining $0.7M unfavourable reflecting the year to date budget adjustment ($0.8M).
- Infrastructure & Non Clinical Supplies $3.2M (18.6%) unfavourable due to a year to date adjustment for Capital Charge $4.0M – while unfavourable for the month, the year to date actual is tracking to budget.

Year to Date Result

The Provider Arm result for the year to date is $6.0M unfavourable. This result is expenditure driven with the key driver being unfavourable Personnel (including Outsourced Personnel) costs.

Overall volumes for the year to date (for total Auckland DHB and IDF Funders) are reported at 100.1% of the seasonally phased contract - this equates to $0.7M above the year to date contract.

Total revenue for the year to date is $6.0M (0.6%) favourable, with the key variances as follows:

- Funder to Provider revenue is $4.7M favourable, however $2.6M of this revenue was planned as external revenue streams and is directly offset by equivalent unfavourable variances, meaning the underlying variance is $2.1M favourable. This key items are:
    - Additional hospital medicines rebates received $1.4M favourable
    - Additional MECA funding from MOH $0.5M favourable

- Haemophilia funding $1.5M favourable for high haemophilia blood product usage, offset by increased expenditure and therefore bottom line neutral.
- Research Income $2.0M favourable (offset by additional research costs so bottom line neutral).
- Donation income $1.5M favourable – this income fluctuates from month to month depending on timing of larger donations for key projects.
- Other Government revenue streams $1.3M favourable, reflecting a number of smaller variances across a range of services (including ACC revenue $0.5M favourable).
- Retail Pharmacy revenue $1.2M favourable (partly offset by additional cost of goods sold).
- Non Resident revenue $0.4M favourable – this revenue fluctuates from month to month with the full year expected to be close to budget.
- Inter DHB income $0.6M favourable – reflecting small variances across a range of services.
- MOH Side Contract revenue $3.5M unfavourable, however $2.6M of this has been received as Funder to Provider revenue, meaning the underlying variance is $0.9M unfavourable, due to revenue assumed for budget initiatives not yet received.
- Other Income $4.3M unfavourable reflecting additional revenue assumed for budget initiatives not yet received.

Total expenditure for the year to date is $12.0M (1.2%) unfavourable, with the key variances as follows:

- Personnel/Outsourced Personnel costs $6.6M (1.0%) unfavourable, driven by the following key variances:
    - Year to date average FTE are 20 (0.2%) above budget - equating to $2.3M unfavourable.
    - Security staff $1.2M unfavourable but offset with favourable Outsourced security costs, reflecting transfer of security services in-house.
    - One off backdated costs relating to prior year $1.0M.
    - The balance of the variance, $2.1M, represents a small variation in cost per FTE (0.3%) which is expected to track back to budget by year end.
- Clinical Supplies $5.0M (2.8%) unfavourable due to funded pharmaceutical cancer treatment (PCT) costs which are $3.0M over budget and Haemophilia blood product which is $1.4M over budget – both of these are fully funded and will be subject to full wash up. The remaining variance of $0.6M reflects savings not fully achieved in the blood product project.
- Infrastructure & Non Clinical Supplies $0.8M (0.6%) unfavourable, with the key variances being**:**
    - Cost of Goods Sold in Retail Pharmacy $0.8M unfavourable which is offset by additional retail income.
    - Building depreciation $1.7M unfavourable due to the revaluation of the building asset category.
    - Outsourced security costs $1.2M favourable (offset with Personnel costs).
    - All other costs $0.5M favourable reflecting a number of smaller variances over a range of services.

FTE

Total FTE (including outsourced) for the month of January were 9,530 which was 57 (0.6%) below budget.

2019/20 Provider Financial Sustainability

The full year Provider Financial Sustainability plan is $31.9M. For January year to date savings of $11.5M have been achieved against plan of $16.3M, $4.9M unfavourable to plan. The full year forecast is an improvement on this position due to later timing of revenue initiatives.

2019/20 Provider Financial Sustainability	YTD Actual $000	YTD Target $000	YTD Variance $000	Full Year Forecast $000	Full Year Target $000	Full Year Variance $000
Increase revenue	0	1,896	-1,896	3,312	5,751	-2,439
Personnel – including vacancy management and cost per FTE	7,476	6,547	929	14,600	11,224	3,376
Managing MRI outsourcing requirements	1,075	1,598	-523	2,740	2,740	0
Blood utilisation	294	1,167	-873	600	2,000	-1,400
Reduce interpreter costs	19	583	-564	500	1,000	-500
Clinical Supplies savings	767	378	389	1,315	1,648	-333
Procurement savings	1606	2100	-494	3,600	3,600	0
Delivering more planned care	0	1,725	-1,725	1,479	2,958	-1,479
Reducing unnecessary time in hospital	184	163	20	655	655	0
Review of funded transport	0	175	-175	100	300	-200
Total	**11,422**	**16,334**	**-4,912**	**28,901**	**31,875**	**-2,975**

Volume Performance

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

		Jan-2020				YTD (7 months ending Jan-20)			
		$000s				$000s			
Directorate	**Service**	**Cont**	**Act**	**Var**	**Prog %**	**Cont**	**Act**	**Var**	**Prog %**
Adult Community & LTC	Ambulatory Services	1,297	1,310	13	101.0%	9,853	10,277	425	104.3%
	Community Services	1,882	1,808	(74)	96.1%	13,751	14,511	760	105.5%
	Diabetes	539	498	(41)	92.4%	3,873	3,864	(9)	99.8%
	Palliative Care	39	39	0	100.0%	273	273	0	100.0%
	Reablement Services	2,035	2,035	0	100.0%	14,246	14,246	0	100.0%
	Sexual Health	483	513	30	106.2%	3,482	4,035	553	115.9%
Adult Community & LTC Total		**6,275**	**6,203**	**(72)**	**98.9%**	**45,478**	**47,206**	**1,729**	**103.8%**
Adult Medical Services	AED, APU, DCCM, Air Ambulance	2,383	2,754	370	115.5%	17,747	18,587	840	104.7%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	12,394	12,403	10	100.1%	94,643	94,575	(68)	99.9%
Adult Medical Services Total		**14,777**	**15,157**	**380**	**102.6%**	**112,390**	**113,162**	**772**	**100.7%**
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	9,240	8,872	(369)	96.0%	68,808	71,020	2,213	103.2%
	N Surg, Oral, ORL, Transpl, Uro	10,137	9,205	(933)	90.8%	75,276	74,258	(1,018)	98.6%
	Orthopaedics Adult	3,890	3,847	(43)	98.9%	31,639	31,185	(453)	98.6%
Surgical Services Total		**23,268**	**21,924**	**(1,344)**	**94.2%**	**175,723**	**176,464**	**741**	**100.4%**
Cancer & Blood Services	Cancer & Blood Services	10,006	9,482	(524)	94.8%	70,913	71,453	540	100.8%
	Genetics	303	178	(125)	58.8%	2,206	1,827	(378)	82.8%
Cancer & Blood Services Total		**10,309**	**9,660**	**(649)**	**93.7%**	**73,118**	**73,280**	**162**	**100.2%**
Cardiovascular Services		**11,531**	**11,157**	**(374)**	**96.8%**	**91,700**	**87,270**	**(4,430)**	**95.2%**
Children's Health	Child Health Community Services	1,852	1,880	27	101.5%	20,018	19,695	(323)	98.4%
	Child Health Medical	4,689	4,712	23	100.5%	43,385	42,181	(1,204)	97.2%
	Child Health Surgical	9,181	9,439	258	102.8%	70,706	72,031	1,325	101.9%
Children's Health Total		**15,723**	**16,031**	**308**	**102.0%**	**134,109**	**133,907**	**(202)**	**99.8%**
Clinical Support Services		**3,639**	**3,393**	**(246)**	**93.2%**	**26,140**	**26,421**	**281**	**101.1%**
DHB Funds		**10,428**	**9,928**	**(500)**	**95.2%**	**73,472**	**72,169**	**(1,302)**	**98.2%**
Perioperative Services		**17**	**6**	**(12)**	**32.2%**	**125**	**102**	**(23)**	**81.7%**
Public Health Services		**147**	**147**	**0**	**100.0%**	**1,028**	**1,028**	**0**	**100.0%**
Support Services		**102**	**102**	**0**	**100.0%**	**716**	**716**	**0**	**100.0%**
Women's Health Total		**7,080**	**7,310**	**230**	**103.3%**	**52,976**	**55,969**	**2,993**	**105.6%**
Grand Total		**103,297**	**101,018**	**(2,279)**	**97.8%**	**786,976**	**787,695**	**719**	**100.1%**

2) Total Discharges for the YTD (7 Months to January 2020)

		Cases Subject to WIES Payment		All Discharges			Same Day discharges		Same Day as % of all discharges	
		Inpatient								
Directorate	**Service**	**2019**	**2020**	**Last YTD**	**This YTD**	**% Change**	**Last YTD**	**This YTD**	**Last YTD**	**This YTD**
Adult Community & LTC	Ambulatory Services	1,375	1,437	1,825	1,462	(19.9%)	1,742	1,375	95.5%	94.0%
	Reablement Services	0	0	1,196	1,297	8.4%	34	70	2.8%	5.4%
Adult Community & LTC Total		1,375	1,437	3,021	2,759	(8.7%)	1,776	1,445	58.8%	52.4%
Adult Medical Services	AED, APU, DCCM, Air Ambulance	7,766	9,148	8,025	9,248	15.2%	5,636	6,379	70.2%	69.0%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	12,574	12,709	12,843	12,847	0.0%	2,044	2,114	15.9%	16.5%
Adult Medical Services Total		20,340	21,858	20,868	22,095	5.9%	7,680	8,493	36.8%	38.4%
Cancer & Blood Total		2,980	3,179	3,471	3,680	6.0%	1,884	1,950	54.3%	53.0%
Cardiovascular Services Total		5,130	4,930	5,351	5,093	(4.8%)	1,429	1,281	26.7%	25.2%
Children's Health	Child Health Community Services	1,647	1,799	1,659	1,804	8.7%	125	136	7.5%	7.5%
	Child Health Medical	7,058	7,083	7,925	7,790	(1.7%)	5,638	5,452	71.1%	70.0%
	Child Health Surgical	6,173	6,397	6,573	6,743	2.6%	2,749	2,802	41.8%	41.6%
Children's Health Total		14,878	15,279	16,157	16,337	1.1%	8,512	8,390	52.7%	51.4%
DHB Funds Total		985	1,046	987	1,050	6.4%	793	839	80.3%	79.9%
Surgical Services	Gen Surg, Trauma,	10,331	11,191	11,992	11,962	(0.3%)	6,913	6,522	57.6%	54.5%
	N Surg, Oral, ORL, Transpl, Uro	7,027	7,283	7,602	7,772	2.2%	3,148	3,172	41.4%	40.8%
	Orthopaedics Adult	2,577	2,817	2,745	2,916	6.2%	477	493	17.4%	16.9%
Surgical Services Total		19,935	21,292	22,339	22,650	1.4%	10,538	10,187	47.2%	45.0%
Women's Health Total		11,557	12,573	12,015	13,000	8.2%	4,437	4,828	36.9%	37.1%
Grand Total		**77,180**	**81,594**	**84,209**	**86,664**	**2.9%**	**37,049**	**37,413**	**44.0%**	**43.2%**

3) Caseweight Activity for the YTD (7 Months to January 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		**704**	**721**	**17**	**3,674**	**3,762**	**88**	**102.4%**	**67**	**34**	**(32)**	**348**	**179**	**(169)**	**51.3%**	**771**	**755**	**(16)**	**4,022**	**3,941**	**(81)**	**98.0%**
Adult Medical Services	AED, APU, DCCM, Air Ambulance	2,320	2,488	168	12,104	12,980	875	107.2%	0	0	0	0	0	0	0.0%	2,320	2,488	168	12,104	12,980	875	107.2%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	12,299	12,230	(70)	64,155	63,792	(363)	99.4%	5	0	(5)	27	0	(27)	0.0%	12,304	12,230	(75)	64,182	63,792	(390)	99.4%
Adult Medical Services Total		**14,620**	**14,718**	**98**	**76,259**	**76,772**	**513**	**100.7%**	**5**	**0**	**(5)**	**27**	**0**	**(27)**	**0.0%**	**14,625**	**14,718**	**93**	**76,286**	**76,772**	**486**	**100.6%**
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	5,533	6,034	501	28,860	31,473	2,613	109.1%	4,290	4,231	(59)	22,375	22,069	(307)	98.6%	9,822	10,264	442	51,235	53,542	2,306	104.5%
	N Surg, Oral, ORL, Transpl, Uro	5,954	5,925	(29)	31,059	30,905	(154)	99.5%	4,443	4,288	(155)	23,173	22,366	(807)	96.5%	10,397	10,213	(184)	54,232	53,271	(961)	98.2%
	Orthopaedics Adult	3,409	3,739	330	17,780	19,504	1,723	109.7%	2,044	1,582	(462)	10,663	8,252	(2,411)	77.4%	5,453	5,321	(132)	28,443	27,755	(688)	97.6%
Surgical Services Total		**14,896**	**15,698**	**802**	**77,699**	**81,882**	**4,182**	**105.4%**	**10,776**	**10,100**	**(676)**	**56,211**	**52,686**	**(3,525)**	**93.7%**	**25,672**	**25,798**	**126**	**133,911**	**134,568**	**657**	**100.5%**
Cancer & Blood Services		**3,930**	**3,871**	**(59)**	**20,498**	**20,190**	**(308)**	**98.5%**	**0**	**0**	**0**	**0**	**0**	**0**	**0.0%**	**3,930**	**3,871**	**(59)**	**20,498**	**20,190**	**(308)**	**98.5%**
Cardiovascular Services		**9,219**	**9,452**	**233**	**48,086**	**49,304**	**1,218**	**102.5%**	**6,303**	**5,238**	**(1,065)**	**32,877**	**27,321**	**(5,556)**	**83.1%**	**15,521**	**14,690**	**(832)**	**80,963**	**76,625**	**(4,338)**	**94.6%**
Children's Health	Child Health Community	2,245	2,179	(66)	11,709	11,364	(345)	97.0%	0	0	0	0	0	0	0.0%	2,245	2,179	(66)	11,709	11,364	(345)	97.0%
	Child Health Medical	5,274	5,225	(49)	27,509	27,254	(255)	99.1%	10	25	15	54	131	77	242.9%	5,284	5,250	(34)	27,563	27,386	(177)	99.4%
	Child Health Surgical	6,449	6,947	498	33,639	36,239	2,600	107.7%	4,119	3,846	(273)	21,487	20,061	(1,426)	93.4%	10,568	10,793	225	55,127	56,300	1,174	102.1%
Children's Health Total		**13,968**	**14,351**	**383**	**72,857**	**74,857**	**2,000**	**102.7%**	**4,130**	**3,871**	**(259)**	**21,541**	**20,192**	**(1,349)**	**93.7%**	**18,097**	**18,222**	**125**	**94,399**	**95,049**	**651**	**100.7%**
Women's Health Services		**5,892**	**6,159**	**266**	**30,736**	**32,124**	**1,388**	**104.5%**	**1,267**	**1,254**	**(14)**	**6,611**	**6,540**	**(71)**	**98.9%**	**7,160**	**7,412**	**253**	**37,347**	**38,664**	**1,317**	**103.5%**
DHB Funds		**94**	**0**	**(94)**	**476**	**0**	**(476)**	**0.0%**	**1,167**	**1,032**	**(134)**	**6,086**	**5,384**	**(701)**	**88.5%**	**1,261**	**1,032**	**(228)**	**6,561**	**5,384**	**(1,177)**	**81.9%**
Grand Total		**63,322**	**64,969**	**1,647**	**330,286**	**338,891**	**8,605**	**102.6%**	**23,715**	**21,529**	**(2,185)**	**123,700**	**112,302**	**(11,398)**	**90.8%**	**87,036**	**86,498**	**(538)**	**453,986**	**451,193**	**(2,793)**	**99.4%**
Excludes caseweight Provision																						

Acute Inpatient Services

The acute discharges increase eased off a little in January compared to the same period last year and discharges are now 7% higher. After excluding Adult ED the increase in discharges is 5.5%. ED discharges continue to be 17% higher than last year, but as previously noted this is likely to be due to a longer length of stay within the department shifting activity into WIES funding (rather than an ED outpatient event). Average WIES is 1% lower than the same period last year, as is the average length of stay.

Activity by service type:

- The growth in acute medical has remained stable since September and discharges are 6% higher than last year. However, as noted previously, if the Adult ED inpatient discharges are removed, the growth in discharges is 2.4%. The average WIES has dropped slightly compared to last year, and ALOS is now at the same level as last year. For Adult Medical (excluding ED) discharges have increased slightly and are now 1% higher than the same period last year while Cancer is nearly 7% higher and Child Health is 2%.
- Acute surgical demand is 8.8% higher than the same period last year. Average WIES is 2.5% lower and ALOS is the same as last year.
- Obstetric discharges have further increased and are now 10% higher for January YTD compared to the same period last year. Of note, birth numbers have continued to increase and are now 5% higher than the same period last year. Both ALOS and average WIES are 5% lower.
- Newborn discharges have dropped overall (reflecting an administrative change), they have increased on YTD December. Both ALOS and average WIES have increased.

Elective Inpatient Services

Elective discharges are up 1.5% on the same period last year and performance to contract is 90%. However, both the average WIES and ALOS have increased with average WIES now 3% higher than the same period last year and ALOS is up 5%.

4) Non-DRG Activity (ALL DHBs)

		Jan-2020				YTD (7 months ending Jan-20)			
		$000s				$000s			
Directorate	**Service**	**Cont**	**Act**	**Var**	**Prog %**	**Cont**	**Act**	**Var**	**Prog %**
Adult Community & LTC	Ambulatory Services	799	785	(14)	98.3%	5,831	6,336	506	108.7%
	Community Services	1,882	1,808	(74)	96.1%	13,751	14,511	760	105.5%
	Diabetes	539	498	(41)	92.4%	3,873	3,864	(9)	99.8%
	Palliative Care	39	39	0	100.0%	273	273	0	100.0%
	Reablement Services	2,035	2,035	0	100.0%	14,246	14,246	0	100.0%
	Sexual Health	483	513	30	106.2%	3,482	4,035	553	115.9%
Adult Community & LTC Total		**5,777**	**5,678**	**(99)**	**98.3%**	**41,456**	**43,266**	**1,810**	**104.4%**
Adult Medical Services	AED, APU, DCCM, Air Ambulance	775	843	68	108.8%	5,643	5,607	(36)	99.4%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	4,197	4,066	(131)	96.9%	30,461	30,782	321	101.1%
Adult Medical Services Total		**4,972**	**4,909**	**(63)**	**98.7%**	**36,104**	**36,390**	**286**	**100.8%**
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	2,413	2,154	(259)	89.3%	17,573	17,479	(94)	99.5%
	N Surg, Oral, ORL, Transpl, Uro	2,942	2,653	(289)	90.2%	21,044	20,987	(58)	99.7%
	Orthopaedics Adult	443	553	110	124.8%	3,196	3,430	235	107.3%
Surgical Services Total		**5,798**	**5,360**	**(438)**	**92.4%**	**41,813**	**41,896**	**84**	**100.2%**
Cancer & Blood Services	Cancer & Blood Services	6,913	6,661	(252)	96.4%	50,415	51,263	848	101.7%
	Genetics	303	178	(125)	58.8%	2,206	1,827	(378)	82.8%
Cancer & Blood Services Total		**7,216**	**6,839**	**(377)**	**94.8%**	**52,621**	**53,091**	**470**	**100.9%**
Cardiovascular Services		**1,498**	**1,391**	**(107)**	**92.8%**	**10,738**	**10,645**	**(92)**	**99.1%**
Children's Health	Child Health Community Services	1,175	1,171	(4)	99.7%	8,309	8,331	22	100.3%
	Child Health Medical	2,180	1,792	(388)	82.2%	15,822	14,795	(1,027)	93.5%
	Child Health Surgical	2,189	2,147	(42)	98.1%	15,579	15,731	151	101.0%
Children's Health Total		**5,544**	**5,110**	**(434)**	**92.2%**	**39,710**	**38,857**	**(853)**	**97.9%**
Clinical Support Services		**3,639**	**3,393**	**(246)**	**93.2%**	**26,140**	**26,421**	**281**	**101.1%**
DHB Funds		**9,558**	**9,541**	**(17)**	**99.8%**	**66,910**	**66,785**	**(125)**	**99.8%**
Perioperative Services		**17**	**6**	**(12)**	**32.2%**	**125**	**102**	**(23)**	**81.7%**
Public Health Services		**147**	**147**	**0**	**100.0%**	**1,028**	**1,028**	**0**	**100.0%**
Support Services		**102**	**102**	**0**	**100.0%**	**716**	**716**	**0**	**100.0%**
Women's Health Total		**2,158**	**1,987**	**(171)**	**92.1%**	**15,630**	**17,305**	**1,675**	**110.7%**
Grand Total		**46,428**	**44,464**	**(1,964)**	**95.8%**	**332,990**	**336,502**	**3,512**	**101.1%**

Non DRG activity decreased slightly in January. This is likely to smooth out during the latter part of the year.

The non DRG wash up with other DHBs has moved back to unfavourable for ADHB which is driven by Cancer volumes in January, where the patient population treated was skewed towards ADHB for the month. As patients have multiple visits within a short period, a small number of patients can skew the results.

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 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 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]
6.5 Women's Health –	**Commercial Activities** Information contained in this report is	That the public conduct of the whole or the relevant part of the meeting would

Midwifery Recruitment and Retention Oversight Report	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.	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 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]