Hospital Advisory – Provider Equity Committee Meeting

Wednesday, 21 April 2021

8:30am

A+ Trust Room

Clinical Education Centre
Auckland City Hospital
Grafton

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Published 15 April 2021

Agenda
Hospital Advisory Committee
21 April 2021

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

Time: 8:30am

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

Agenda

Please note that agenda times are estimates only

8.30am **0.** **Karakia**

1. **Attendance and Apologies**

2. **Register and Conflicts of Interest**

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

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

8.35am **3.** **Confirmation of 17 February Minutes 2021**

4. **Action Points 17 February 2021**

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

5.1 Provider Arm Operational Exceptions Report

5.2 Financial Update

5.3 Director Equity Update – Adult Medical

5.4 Director Equity Update – Cardiovascular Services

	5.5	Director Equity Update – Clinical Support
	5.6	Director Equity Update – Community Long Term Conditions
	5.7	Patient and Whānau Voice – Report
9.50am	**6.**	**RESOLUTION TO EXCLUDE THE PUBLIC**

Next Meeting:	Wednesday, 23 June 2021 at 2.30pm A+ Trust Room, Clinical Education Centre Level 5, Auckland City Hospital, Grafton

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

Karakia

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

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

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of life

To the ancient realms of the Creator

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

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

Well Being to All.

Attendance at Hospital Advisory Committee Meetings

Members	12 Feb 2020	18 March 2020	22 April 2020	3 June 2020	15 July 2020	26 August 2020	7 October 2020	18 Nov 2020	17 Feb 2021	21 April 2021
William (Tama) Davis (Chair)	1	1	c	c	c	c	1	1	X	
Joanne Agnew (Deputy Chair)	1	1	c	c	c	c	1	1	1	
Michelle Atkinson	1	1	c	c	c	c	1	1	1	
Doug Armstrong	1	1	c	c	c	c	1	1	1	
Heather Came	NM	NM	NM	NM	NM	NM	1	1	1	
Bernie O'Donnell	1	1	c	c	c	c	x	x	1	
Michael Quirke	1	1	c	c	c	c	1	1	1	
Peter Davis	1	1	c	c	c	c	1	1	1	
Zoe Brownlie	1	1	c	c	c	c	1	1	1	
Fiona Lai	1	1	c	c	c	c	1	1	1	

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

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

Conflicts of Interest Quick Reference Guide

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

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

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

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

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

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

IMPORTANT

If in doubt – declare.

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

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

Register of Interests – Hospital Advisory Committee – Provider Equity

Member	Interest	Latest Disclosure
Jo AGNEW (Deputy Chair)	Professional Teaching Fellow – School of Nursing, Auckland University Casual Staff Nurse – Auckland District Health Board Director/Shareholder 99% of GJ Agnew & Assoc. LTD Trustee - Agnew Family Trust Shareholder – Karma Management NZ Ltd (non-Director, majority shareholder) Member – New Zealand Nurses Organisation [NZNO] Member – Tertiary Education Union [TEU]	30.07.2019
Michelle ATKINSON	Director – Stripey Limited Trustee - Starship Foundation Contracting in the sector Chargenet, Director & CEO – Partner	21.05.2020
Doug ARMSTRONG	Trustee – Woolf Fisher Trust *(both trusts are solely charitable and own shares in a large number of companies some health related. I have no beneficial or financial interest* Trustee- Sir Woolf Fisher Charitable Trust *(both trusts are solely charitable and own shares in a large number of companies some health related. I have no beneficial or financial interest* Member – Trans-Tasman Occupations Tribunal Daughter – *(daughter practices as a Barrister and may engage in health related work from time to time)* Meta – Moto Consulting Firm – (*friend and former colleague of the principal, Mr Richard Simpson)*	20.08.2020
Zoe BROWNLIE	Co-Director – AllHuman Board Member – Waitakere Health and Education Trust Partner – Team Leader, Community Action on Youth and Drugs	02.12.2020
Peter DAVIS	Retirement portfolio – Fisher and Paykel Retirement portfolio – Ryman Healthcare Retirement portfolio – Arvida, Metlifecare, Oceania Healthcare, Summerset, Vital Healthcare Properties Chair – The Helen Clark Foundation	22.12.2020
Fiona LAI	Member – Pharmaceutical Society NZ Casual Pharmacist – Auckland DHB Member – PSA Union Puketapapa Local Board Member – Auckland Council Member – NZ Hospital Pharmacists' Association	26.08.2020
Bernie O'DONNELL	Chairman Manukau Urban Māori Authority(MUMA) Chairman UMA Broadcasting Limited Board Member National Urban Māori Authority (NUMA) Board Member Whānau Ora Commissioning Agency National Board-Urban Maori Representative – Te Matawai Board Member - Te Mātāwai. National Māori language Board Owner/Operator– Mokokoko Limited Senior Advisor to DCE – Oranga Tamariki Engagement Advisor – Ministerial Advisory Panel – Oranga Tamariki	05.03.2021
Michael QUIRKE	Chief Operating Officer – Mercy Radiology Group Convenor and Chairperson – Child Poverty Action Group Director of Strategic Partnerships for Healthcare Holdings Limited	27.05.2020
Teulia PERCIVAL	Director Board of Trustees – Pasifika Medical Association Group Employee Clinician – Counties Manukau Health DHB Chairman, Board of Trustees – South Seas Healthcare Trust, Otara Board Member – Health Promotion Agency (te Hiringa Hauora)	01.10.2020

	Senior Lecturer Researcher – University of Auckland Director Researcher – Moana Research	
Heather CAME	Primary Employer – Auckland University of Technology Contractor – Ako Aotearoa Acting Co-President – Public Health Association of New Zealand Fellow – Health Promotion Forum Co-Chair – STIR (Stop Institutional Racism) Member – Tamaki Tiriti Workers	01.10.2020
William (Tama) DAVIS (Chair)	Director/Owner – Ahikaroa Enterprises Ltd Whanau Director/Board of Directors – Whai Maia Ngati Whatua Orakei Director – Comprehensive Care Limited Board Director – Comprehensive Care PHO Board Board Member – Supporting Families Auckland Board Member – Freemans Bay School Board Member – District Maori Leadership Board Iwi Affiliations – Ngati Whatua, Ngati Haua and Ngati Tuwharetoa Director - - Board of New Zealand Health Partnerships Elected Member – Ngati Whatua o Orakei Trust Board	18.02.2021

Minutes
Hospital Advisory Committee – Provider Equity Meeting
17 February 2021

Minutes of the Hospital Advisory Committee – Provider Equity meeting held via a Zoom meeting commencing at 8:30am

Committee Members Present	**Auckland DHB Executive Leadership Team Present**	
Jo Agnew (Deputy Committee Chair chaired in the absence of Tama Davis)	Ailsa Claire	Chief Executive Officer
Doug Armstrong	Mark Edwards	Chief Quality, Safety and Risk Officer
Michelle Atkinson	Michael Shepherd	Interim Director Provider Services
Heather Came	Sue Waters	Chief Health Professions Officer
Zoe Brownlie	Justine White	Chief Financial Officer
Peter Davis	Dr Margaret Wilsher	Chief Medical Officer
Fiona Lai	**Auckland DHB Senior Staff Present**	
Bernie O'Donnell	Dr John Beca	Director Surgical, Child Health
Michael Quirke	Hineroa Hakiaha	Co-Director Mental Health
	Emma Maddren	Interim Director Starship Child Health
	Rob Sherwin	Director Women's Health
	Tracy Silva Garay	Co-Director Mental Health
	Carly Orr	Director of Communications
	Marlene Skelton	Corporate Business Manager
	Wendy Stanbrook-Mason	Deputy Chief Nursing Officer
	(Other staff members who attend for a particular item are named at the start of the minute for that item)	

KARAKIA

The Karakia was led by Board member Bernie Davis.

1. APOLOGIES

That the apologies of William (Tama) Davis (Committee Chair) and Pat Snedden (Board Chair) ex officio member be received.

That the apologies of Executive Leadership Team members Mel Dooney, Chief People Officer, Margaret Dotchin, Chief Nursing Officer, Dr Debbie Holdsworth, Director of Funding – Auckland and Waitemata DHBs, Meg Poutasi, Chief of Strategy, Participation and Improvement and Shayne Tong, Chief Digital Officer be received.

2. REGISTER AND CONFLICTS OF INTEREST *(Pages 6-8)*

There were no conflicts of interests to any item on the open agenda.

The following changes to the interest register are required:

Heather Came

Delete - Co-President of the NZ PHA and add, interim chair of the AUT branch NZ PHA

Bernie O'Donnell added:

Senior Advisor to DCE – Oranga Tamariki

Engagement Advisor – Ministerial Advisory Panel – Oranga Tamariki

3. CONFIRMATION OF MINUTES 18 NOVEMBER 2020 *(Pages 9-19)*

Resolution: Moved Michael Quirke / Seconded Michelle Atkinson

That the minutes of the Hospital Advisory Committee meeting held on 18 November 2020 be approved

Carried

4. ACTION POINTS

There were no open action points to consider.

5. PERFORMANCE REPORTS

5.1 Provider Arm Operational Update (*Pages 20-23)*

Mike Shepherd, Interim Director Provider Services asked that the report be taken as read, advising as follows:

Kaiārahi Nāhi rōpū and Pacific Care Navigation Service

The organisation is looking to lock in the systems improvements based on the intelligence that has been gathered and supporting those services with required improvements. This fits in well with the planned care portfolio of work.

Women's Health and Perioperative Review

Women's health and the surgical perioperative review issues have previously been signalled to both this committee and the Board. It is worth noting that that these are broad, complex review and engagement consultations. It is a real sign of organisational maturity that the amount of time and energy on such a broad engagement strategy with a really deep equity focus is able to be undertaken. This work is progressing well, but obviously with the amount of work involved will continue over a medium term timeframe.

COVID 19

A key observation from the recent outbreak was the organisations realigned approach to using the escalation planning tool. This allowed the organisation to pivot and adjust its response in a systematic way. There has been a great response from staff. It has allowed clear communication in a rapid timeframe to both the Community and our people around our expectations and has allowed us to maintain the really important planned care that is

required to be delivered as well as keeping our people in our Community safe.

The following was raised in discussion:

Jo Agnew referred to page 20 of the agenda referring to the process for formal evaluation of the Kaiārahi Nāhi rōpū and the Pacific Care Navigation Service approach and asking when a report was likely to come to the Hospital Advisory Committee. Advice was given that this was unknown at this point but would be followed up. It was agreed that this become an action.

Peter Davis congratulated management on the quality of the presentation material relating to the out patients toolkit and theatre management and asked whether there would be any reporting back on, for example, whether the theatre management tool made a difference to the proportion at which theatres were used across the board. He noted that there had been a slight 5% to 6% increase in utilisation of theatres at Greenlane and commented that it would be interesting to get a report back on how well both the theatre initiative and out patients toolkit were performing in improving the efficiency and even the equity of the operation.

Peter Davis had a further question around the maternity service asking whether GPs and Community midwives were involved as the maternity journey starts well before a woman presents at the hospital. The journey is a very lengthy one of which the hospital accounts for only two or three days with much more happening before and after.

Ailsa Claire advised that the work around the maternity pathway related to the gestational time, early pregnancy and the required pregnancy checks all the way through to birth. There was a separate program on the first hundred days which was run out of the Funding and Planning service which can be reported back on. What is before committee members now is particularly related to the gestational time and birth pathway for women.

Mike Shepherd added that other stakeholders in the community would be engaged with around the maternity and delivery pathway agreeing that the hospital presentation was only a small segment of the journey. These pathways mostly have medium term time frames and there is no doubt that they are a combination of service change and technology and they carry some uncertainty and that is why they are monitored very closely in terms of their outcomes and efficacy.

Zoe Brownlie drew attention to page 20 of the agenda and the Kaiārahi Nāhi rōpū report asking for statistical clarification. Were the 500 Māori and 470 Pasifika patients being supported out of 1000 or some other percentage?

Ailsa Claire advised that this was particularly targeted to where inequities had been identified so was initially focused on people who were long waiters and people who did not appear to be going through the pathway correctly. To be clear, this process is not designed to support every Māori or Pacific person coming through the system. It exists to investigate where there are clear issues for individual people and where the system is not providing the

required support.

Bernie O'Donnell commented that if there was not a clear picture of the woman's health status before they come into hospital care then it is hard to monitor their well being through the pathway and when they leave the hospital. It is important to start to understand what is to be measured and to also start to understand that there are other players in the primary care sector and there is a need to know how they work in conjunction with what is happening at the hospital. It is about how they present to the hospital and what happens to them after they leave the hospital. This is an opportunity to be able to develop a good robust monitoring system.

Ailsa Claire commented that this is a difficult and very extensive problem hindered by the way that the maternity service is currently set up. Auckland DHB were partnering with the National Hauora Coalition who have a scheme called 20/40 where they are looking at how to work with primary care and engaging every person right from the beginning of their maternity journey and following them all the way through. The DHB is also looking at how it supports women when they are pregnant and how we develop services in such a way that they are more consistent with what Bernie was describing.

Bernie O'Donnell commented that he was not just referring to service for Māori women but to the overall service framework.

Ailsa Claire clarified for Doug Armstrong that Auckland DHB had a regional role in Women's Health but did not actually have a national role except when it came to genetic and maternal fetal medicine. Doug was assured that the review would consider the complex work undertaken by the Auckland DHB in terms of the regional and national service offered. This area was a challenge for many of the Auckland DHB Services which strive to balance their responsibility to the local community to deliver a good service as well as delivering a regional and national service.

Michael Quirke commented that he supported Peter Davis's comments. He noted the increases seen at the theatre utilisation level and the fact that management were turning to investigating what these successes could look like in other services. What Michael wanted to know was as other specialities were engaged what suite of best fit models of care were available for them to choose from or were they being given the freedom to actually look at these success stories and build their own. What was the approach being promoted?

Michael Shepherd advised that it was a bit of both. It was clear that there were some systemic wide improvements that could be made. However, there was a need for the services to be able to look at their own data, understand their own challenges and complexities and utilise those solutions which made the most sense for them. There is a need for certain systems and processes in place that provide us with assurance, accuracy and quality. It is a matter of working with a service and highlighting the things that are compulsory and then the elements where opportunities exist to adjust based on service requirements and understanding how services interact. There are a myriad of complexities

across services and it is our challenge to work with them to embrace their uniqueness but also to make sure that that they're delivering an efficient and quality service in the best possible way.

There were no further questions.

Action

That the results of the formal evaluation of the Kaiārahi Nāhi rōpū and Pacific Care Navigation Service approach be reported back to the Hospital Advisory Committee when completed.

Resolution:

That the Hospital Advisory Committee receives the Provider Arm Operational Exceptions Report for February 2021.

Carried

5.2 Financial Update (Pages 24-33)

Justine White, Chief Financial Officer asked that the report be taken as read, advising that the report was to the month of December 2020.

The Board was sitting at $3.5M unfavourable at a business as usual level at a budget of $45M unfavourable

The actual raw number is $71M against a $21M deficit year to date, but that $71M is affected by the COVID 19 impacts attributable in the first six months of the year, which is about $25.9M.

The Ministry of Health has instructed that the Holidays Act provision be put through on a monthly basis. Starting from December there is a catch up for the previous six months shown which is why there is $20M provided in this report. This cost was not included in the planning for the $45M unfavourable plan for the year so therefore it is actually showing it as an unusual item so that subsequent clear comparisons can be made.

The net bottom line on page 20 of the agenda shows a figure of $25,137M against $21,600M being what had been planned for this year.

Key risk remains around FTE in terms of annual and sick leave pressure. The January result shows a reversal so there has been a lot of annual leave taken in January, giving people a chance to refresh but also provides a positive impact which starts to reverse a bad position.

Pressure on clinical supplies as a result of the mix of things that are being done remains and is a million or two over in terms of what was planned. This is outlined on page 28 of the agenda. There has also disruption of supply through international shipping routes that has

forced investigation of alternative product.

The following was raised in discussion:

Jo Agnew drew attention to page 28 of the agenda and the unfavourable position of diagnostic genetics due to delayed repatriation asking for an explanation.

Justine White advised that this was where Auckland DHB had outsourced testing but in anticipation of being able to bring the work back in-house which had now been delayed leading to a slight negative impact on the budget.

Doug Armstrong asked the Chief Executive whether in her opinion the Board would be able to recover the $3.5M by the end of the financial year. Advice was given that if COVID and the Holidays Act adjustment was fully funded by the Ministry the Board would be on planned budget.

Justine White added that the forecast at the moment is that the Board would achieve budget at a DHB level. In the Provider Arm it is anticipated that the position would be bettered by $2.5M which is reflective of a donation that was received in November 2020. The overall DHB budget is $45M deficit and is planned to be about $42.5M deficit based on what is known right here and right now. This may not be the case should there be further lockdowns that have impacts on production.

Doug Armstrong was provided with an explanation of the RMO situation as outlined on page 28 of the agenda with Margaret Wilsher advising that at the beginning of the calendar year the DHB take on more RMOs than are needed because there is steady attrition throughout the year, but there is only the one recruitment cycle. The DHB carry a number of supernumeraries which helps cover leave or unexplained gaps providing a little leeway over the summer months when there is a need for other staff to go on holiday, but the net effect at the end of the year is that we are in balance.

Heather Came drew attention to page 26 of the agenda and asked if ethnic breakdown of FTE could be provided so that it is clear what is happening in terms of recruitment of Māori staff.

Zoe Brownlie added that this issue had come up in the People and Culture Subcommittee recently and while attempts are being made to collect that data it is not at a stage yet that it can be reported on.

Heather Came commented that any time FTE data is presented it needs to include ethnicity data. As an EEO employer of a number of years this data should have been collected as a matter of course.

Margaret Wilsher added that the People and Culture report does carry ethnicity data, most accurate for new employees but for some of our most senior long serving employees the

data is possibly not so reliable.

Action

That the Chief People Officer be advised that any time FTE data is presented it include comparable ethnicity data.

Resolution:

That the consolidated statement of financial performance for December 2020 be received.

Carried

5.3 Director Equity Update – Child Health *(Pages 34-44)*

John Beca, Director of Child Health Surgical and Emma Maddren, Interim Director Starship Child Health asked that the report be taken as read, advising as follows:

Emma Maddren advised that there had been a range of equity activity underway for some years with the expectation that it would increase opportunities for Māori and Pacific leaders and further develop the governance structures around our Te Tiriti o Waitangi related activity. Important progress made in recent months has been having a dedicated Kaumātua, Sonny Niha (Te Orewai, Ngāti Hine, Ngāpuhi) appointed and the appointment of Toni Shepherd to the Māori Health Lead and a recent appointment of Mareta Hunt to the Safe Kids leadership position.

Haumaru Hononga (Safety in Partnership) is a staff group first established within Puawaitahi (child protection multi-agency centre with Te Puaruruhau (Starship Child Protection), Police and Oranga Tamariki) in 2019 which deals with cultural safety and practice in that setting. There is a close relationship with Ngāti Whātua around the work undertaken in this area.

John Beca added that he particularly wanted to highlight the work done in the cellulitis pathway which had led to quite a dramatic reduction and avoidance for the need for admission for children with cellulitis and a significant reduction in the number of bed days as well as improving the situation for one of the most complex groups of patients, those requiring spinal surgery, reducing their length of stay and also work around days stay and avoiding cancellations.

Within the resilient services and critical care capacity there are on-going challenges related to the PICU project which was slightly delayed while getting approval from the Ministry. The result is that there are some concerns around completion before winter 2022. The design and build for that will need to be restarted.

The neonatal intensive care unit which, after a period of being very quiet during the initial lockdown, has been extremely busy for the last two or three months and this has resulted in two pregnant mothers needing to be transferred out of region because the entire region was

full. There is a project underway looking at staffing levels and some alternative models of care to address this.

January budget results show that the financial position has been improved. The service was $3.4M favourable as people were off on annual leave. Of the $15 million unfavourable, $12M of that was COVID related. A facet seen throughout children's hospitals within Australasia is that the COVID lockdown has produced a huge drop off of acute volumes. $10M can be attributable to volumes just not being present. There has also been a temporary loss of some of the Pacific Islands work.

The following was raised in discussion:

Peter Davis drew attention to the paragraph at the top of page 40 of the agenda and the comment around unfavourable inpatient volumes and asked what the incentives were to reduce Inpatient volumes if you are actually getting paid for them. He acknowledged the pathways that were being developed that would reduce those cases for inpatient care, but was referring to unnecessary ambulatory sensitive hospitalisations particularly among the under fives which is very high, particularly in a disadvantaged group. Peter would like to see a budgetary system set up that would actually maximise rewards for keeping people out of hospital rather than getting paid according to in- hospital volumes.

John Beca replied that there were a number of projects on-going, some of which were funded by the Foundation in terms of pathways to keep children out of hospital but also to look generally at how Starship was funded overall.

Peter Davis added that he was interested in a different funding model but would like the Executive Leadership team to look at how that might be carried over to other parts of the organisation. At present, if Services are paid on inpatient volumes and that is what they have to maintain there is little incentive to try to lower those volumes.

Mike Shepherd was very clear that as an organisation the focus was on keeping people out of hospitals. This funding anomaly is not a perverse incentive that is being chased. It is a particular issue around some of the specialised services. When that specialised service is delivered well they are able to maintain people in their home DHB. This work is often done via telephone consultations and there is no doubt the current funding mechanisms don't always recognise that. This places an administrative burden on staff to measure and capture that work. This is an area we will continue to investigate and have been looking at with the Ministry of Health to identify national funding mechanisms in order to capture and remunerate the activity.

Peter Davis then drew attention to the performance and medication errors with major harm commenting that all Directorates showed zero errors which Peter found difficult to believe. Mark Edwards advised that there were no reported errors with major harm and actually the rate of major harm from medication error is very low. Peter Davis then commented that this

data should be digital and automatically produced.

Mark Edwards clarified that this data was not all available online or electronically monitored. The incidence of medication error is high in our current system but the incidence of harm through medication error is very low. It is recognised that there should be an e-prescribing system and the DHB was certainly trying to progress that through a queue of digital initiatives. Once that state is achieved there would be opportunities to manage and triangulate data in a range of different ways.

Bernie O'Donnell drew attention to Page 37and point three in the plan saying he would like to see some sort of profile on the kind of Māori kaimahi that exists. Being Māori is one part of the equation the other part is around that person actually being fit for purpose to work with the communities. Whether they carry the Māori values with them or they are learning about them during their work is a different scenario. Ideally, we want them to come with their tikanga and then apply their learning's along with their medical background to the role. It would be good to understand the kind of skills sets and capability that our Māori and Pasifika workforce bring to the kaupapa in terms of what is trying to be achieved. Bernie asked if this was possible to determine. It is only when this state is arrived at that transformative change can occur.

Emma Maddren commented that this was the aspiration of the service and exactly where the service would like to be. There is a way to go and that was one of the reasons why Matua Sonny Niha had been engaged to be part of the Services leadership. The Service is also bringing together Māori staff from across the directorate.

Emma Maddren added that when you are talking about recruitment you are talking about whether you have appointed a Māori candidate from your pool of candidates and obviously one of the really important things is to make sure that you have Māori candidates coming forward for the positions and that the advertising and promoting of these roles occurred in such a way that the right candidate was attracted to the right role.

Bernie O'Donnell commented that what he would really like to see a next level where it was possible to identify the capacity that Māori staff bring with them and what positive results had been made and then to monitor those to show progress.

Mike Shepherd commented that it was quite hard to profile people and do them justice in a written report. Mike would like to spend some time with Bernie O'Donnell working through how this could be done effectively.

Action

That the following questions be answered in August when the Child Health Directorate next reported.

1. **What the actual number of Māori staff was.**
2. **Who were these people and what were their capabilities and their ability to undertake this kaupapa for Māori and Pasifika.**

3. **What budget existed to allow these people to perform their roles.**

Resolution:

That the Director Equity Update – Child Health report for January 2021 be received.

Carried

5.4 Director Equity Update – Mental Health *(Pages 45-58)*

Hineroa Hakiaha and Tracy Silva Garay Co-Directors Mental Health asked that the report be taken as read.

Hineroa Hakiaha reflected on the journey he and Tracy Silva-Garay had embarked on.

In June 2020 Tracy Silva Garay and Hineroa were appointed to their roles. The interview panel decided that it would be good to have two co directors within Mental Health and Addictions; one Māori the other non Māori to assist with the equity movement within Auckland DHB.

Mental Health and Addictions is developing the way forward with te ao Māori, addressing how it would progress that journey of equity. Tracy and Hineroa have spent almost six months to building their relationship together, where it could be demonstrated to their teams, to the directorate and the rest of Auckland DHD that there was an obvious partnership. It had not been an easy journey for either of them. Being nurses and drivers in the Mahi that they do, they are proud of where they have come from and proud of what they have done to date on the journey of equity.

Part of that equity strategy and journey comes from the strategy of 2023 – Te Toku Tumai. When we did the stock take on what it was that was needed to be doing to help move the strategy of 2023 forward it was clear we needed to look at what we were doing as a directorate and what the most pressing things that needed to be addressed in 2021. We decided to focus on training and what currently existed and whether it was appropriately and utilised.

Staff work here because they want to be here, they want to share their skills and do the best that they can for our people. With that in mind we looked at how to create a space and a place to grow our teams. There is a staff of 800 with 72 Māori and 86 Pasifika in the Directorate.

We looked at what are were doing as a directorate in terms of building capability and capacity, and how to support our teams to become capable to work with Māori and Pacific.

In January through March a training package framework is being developed and in April through June the actual training will take place with the leadership groups such as the director leadership team, the service centre directors, operation managers, clinical team leaders and managers and charge nurses.

To be more supportive around this training there will be champions within the teams and services. The challenge will be finding Māori staff who will undertake this role. This will require another set of training for them to be able to deliver to that role.

The following was raised in discussion:

Heather Came commented that it was great to see a co-governance model and wished Hineroa and Tracy the very best with the equity journey.

Jo Agnew drew attention to page 56 of the agenda requesting clarification around screening for family violence asking what form that screening takes as the current result is showing red. What plans were there to address this? Tracy Silva-Garay advised that there was an Allied Health Director leading this work. It required on-going conversations with teams about the importance of screening for family violence. Often clinicians were reluctant to do that if there were other family members present. There were often opportunities for this conversation to occur even if it was not at that first assessment but at another subsequent meeting.

Michael Quirke noted that a housing specialist role was identified in 2017 and asked whether that role had been filled and work actually begun. Advice was given that the role was being recruited for. There were significant mental health and addiction issues to address so along with the housing specialist role there were one or two to pilot sites that had been chosen by the Ministry of Health which would run over the next four years with the expectation that we will start to work with people to get them not only sustainable housing, but individualised packages of care to support them to be able to maintain their housing and wellbeing.

The housing specialist role has been in train for the last three years. Collection of data was required to show that Te Whetu Tawera, our 58 bed adult Inpatient unit, would have at any one time at least 15 out of those 58 people clinically ready for discharge, but that there were significant barriers to their discharge. One of those barriers being housing.

When people have to remain longer than clinically indicated in the unit they actually start to deteriorate and actual harm occurs. Work is being done with an NGO on recruiting a person through the NGO and setting up processes for that person to work with the community outreach service. This service deals with a high rate of Māori so potentially between 50% and 60% of those people are Māori, usually homeless, often with forensic backgrounds and often coming from prison.

There is also an NGO partner role that was started as a trial during the last level three Auckland region lockdown where some NGO resource was used to support people to an earlier discharge. It was noted during the March 2020 lock down that Te Whetu Tawera for the first time ever went down to 75% occupancy because there was the provision of motels for homeless people. Once that lockdown ended there was a massive surge in referrals and a 66% increase in the number of admissions.

A one year pilot with a 0.5FTE role was established to go into Te Whetu Tawera to identify people on admission who perhaps may be discharged early and who with some outside support and the right packages of care could get back to a normal life much more quickly.

Peter Davis drew attention to page 46 of the agenda and community treatment orders where it was highlighted that there were issues over access to free medication and asked for an explanation. Tracy Silva-Garay advised that it was found when talking to whanua that they wanted the patient to remain on a CTO because of issues of access to medication. An audit revealed that barriers to coming off a CTO were not always related to clinical decision making but also access to medication. There is now twice yearly training provided so improve staff understanding of the issues and to imbed some more consistency around the use of the mental health plan.

Peter Davis drew attention to page 55 of the agenda where the "funder to provider revenue wash up for the CSW service transferred to the funder" was mentioned asking what that meant with Tracy advising that it was a change proposal that occurred in 2019. As a result of consultation process, the CSW Service at Point Chevalier was disestablished with a transfer or resource to the NGO sector with its focus on community based wellbeing and recovery, whereas the DHB provider's core business is the delivery of specialist clinical services.

NGO CSWs are one of the largest groups of the mental health and addiction workforce. NGOs see people in their own homes; support people to address some of the social determinants that impact upon their mental health and, importantly, are community based, well connected with other agencies and able to see people closer to home as per the Government's health strategy. Workforce development that takes place in this sector is focused on the delivery of this model. The core business of NGOs is supported by a management infrastructure that is fit for purpose for the non-registered community support workforce.

The Service Coordination Team has been strengthened via the appointment of a full time Clinical Team leader to lead and manage the team and to coordinate wider management of access to support hours and placements across CMHCs and NGOs. The team has been centralised to support effective engagement with key stakeholders, supporting an integrated effective single referral pathway and timely response and consistency of service delivery across the Directorate.

Bernie O'Donnell commented that this is what he envisaged that the future would look like when recruiting for the co-director role and was an endorsement of the decision to have mental health co-directors. He acknowledged that it would not have been an easy transition and thanked both for their effort.

Resolution:

That the Director Equity Update – Mental Health for January 2021 be received.

Carried

5.5 Director Equity Update – Women's Health *(Pages 59-69)*

Rob Sherwin, Director Women's Health asked that the report be taken as read, advising as follows:

Noting that the report format is new. Nicole Pihima who is the Associate Director of Midwifery for Māori Health and equity has helped shape this new format.

Not included in the report is an update about the external expert advisory panel reviewing the four maternal incident reports. The panel have met twice on-line and they are about to start interviewing people who were part of the review panels for those four maternal deaths. When they have feedback it will be provided to the Committee and Board.

On 1 March the Board Chair, Chief Executive and other interested board members along with the Leadership Team will be present at a hui to outline what is trying to be achieved with the engagement plan which is to surface the inequities within women's health and some of the possible solutions to achieve equity. That piece of work is anticipated to be completed in June with a paper to the Board outlining some possible solutions to the inequities.

The following was raised in discussion:

Peter Davis drew attention to page 56 of the agenda and the scorecard showing a New Zealand average induction for labour was 7.6% but the Auckland average is five times that rate; not only for private obstetricians but across self employed midwives in the community. Rob Sherwin commented that the New Zealand average reported is from 2017. Since then there has been national policy which has basically increase the number of women who would be offered induction of labour in an effort to reduce stillbirths.

Since 2017 there had been some new New Zealand averages released. They are always about three or four years behind the current data set. Personal experience from the UK is that the average induction rate goes up about 10% every year. It is probable that the primip data will now be around 25% since the change in national policy. New Zealand guidelines were written by Auckland practitioners we follow the New Zealand guidelines pretty much to the letter, other units don't. We would expect to be at least at or above the New Zealand average because of our practice at Auckland DHB

It was explained that while the induction rate had changed for the above reasons, that was not the case for caesarean section rates where Auckland DHB was a clear outlier with higher rates than everywhere else in the country.

Peter Davis drew attention to the same table and intact lower genital tract figures where across the country the figure is 27% but for Auckland DHB it is in the single figures asking if that was due to another change in practice or are we again, an outlier? Rob Sherwin advised that unfortunately Auckland DHB was an outlier. The episiotomy rate showed that Auckland

DHB was much more of an interventionist with this practise than the rest of the New Zealand.

Peter Davis commented on the statement made that the IT system was technically and functionally obsolete, saying it was depressing to hear this yet again. Rob Sherwin advised that there were a number of legacy systems that required attention and Ministry approval to change had been obtained for this particular one. The DHB were trying to get its systems more up to date and robust but that requires a lot of investment.

The lesson learned from the recent maternal deaths revealed that the most vulnerable women often move domicile between the different DHBs and the new system allows sharing of information between those different DHBs and to protect and care for these most vulnerable women. There are equity and health outcome benefits from the new systems.

Resolution:

That the Director Equity Update – Women's Health for January 2021 be received.

Carried

6. RESOLUTION TO EXCLUDE THE PUBLIC (*Pages 70-71)*

Resolution: Moved Zoe Brownlie / Seconded Fiona Lai

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

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
1. Karakia Attendance and Apologies	N/A	N/A
2. Conflicts of Interest	As per that stated in the open agenda	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3. Confirmation of	**Commercial Activities** **Information contained in this report is related to commercial**	That the public conduct of the whole or the relevant part of the

Confidential Minutes 18 November 2020	**activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public** [Official Information Act 1982 s9(2)(i)]	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 - Nil	**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 Vulnerable Service Update	**Prejudice to Health or Safety** Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.1 Major Risk & Issues – Verbal Report	**Commercial Activities** **Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public** [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time [Official Information Act 1982 s9(2)(k)]	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 Planned Care – Programme Update - Presentation	**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)] **Prevent Improper Gain**	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

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

The meeting closed at 12 noon.

Signed as a true and correct record of the Hospital Advisory Committee meeting held on Wednesday, 17 February 2021

Deputy Chair: _____ Date: _____

Jo Agnew

Action Points from Previous Open Hospital Advisory Committee Meeting

As at Wednesday, 21 April 2021

Meeting and Item	Detail of Action	Designated to	Action by
17 February 2021 Item 5.1	**Kaiārahi Nāhi rōpū and Pacific Care Navigation Service Evaluation** That the results of the formal evaluation of the Kaiārahi Nāhi rōpū and Pacific Care Navigation Service approach be reported back to the Hospital Advisory Committee when completed.	M Shepherd	TBA
17 February 2021 Item 5.2	**FTE Data Reporting** That the Chief People Officer be advised that any time FTE data is presented it include comparable ethnicity data.	M Skelton to M Dooney	Completed
17 February 2021 Item 5.3	Māori **Staff in Child Health** That the following questions be answered in August when the Child Health Directorate next reported. 1. What the actual number of Māori staff was. 2. Who were these people and what were their capabilities and their ability to undertake this kaupapa for Māori and Pasifika. 3. What budget existed to allow these people to perform their roles.	J Beca	18 August 2021

Provider Arm Operational Exceptions Report

Recommendation

That the Hospital Advisory Committee receives the Provider Arm Operational Exceptions Report for April 2021.

Prepared by: Michael Shepherd (Interim Director Provider Services)
Endorsed by: Ailsa Claire (Chief Executive)

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

1. Exceptions Report

The Executive Leadership Team highlights the following exceptions for the April 2021 Hospital Advisory Committee Meeting:

- Since the establishment of the Kaiārahi Nāhi rōpū and Pacific Care Navigation Service, over 1980 Māori and 1566 Pacific patients have been engaged and supported as they progress through the planned care journey from the point of being waitlisted for surgery. Currently 572 Māori and 311 Pacific patients and their whānau are being actively supported by the services. The Kaiārahi Nāhi Principles of Care and future service blueprint have been drafted and are currently being reviewed. The Pacific Model of Care and a future service blueprint has been finalised and is now being used when working with services. A formal evaluation of the Kaiārahi Nāhi navigation approach is currently underway, with the final report due mid-June. The Pacific evaluation has been completed and the final report is expected in the coming week. Planning has commenced to engage earlier in the patient journey from the point of referral and entering the DHB planned care system.
- The Women's Health engagement plan was launched on 1 March 2021 facilitated by the Board Chair, Deputy Board Chair, Chief Executive Officer and members of the Executive and Directorate leadership teams. Due to Level 3 restrictions, this hui was held via zoom, however there was still opportunity and time allocated to answering participants questions. The presentation included patient outcome statistics presented by Women's Health Epidemiologist, and a video that captured two journeys of women who had given birth at Te Papakāinga Atawhai o Tāmaki, Auckland City Hospital. The next phase of the engagement work commences over the next week, with a scheduled workshop led by Kahurangi Rangimarie Naida Glavish, attended by the Associate Director of Midwifery, members of the leadership team whom will be engaging with Te Toka Tumai staff, Lead Maternity Carers Access holders and industry service providers, in order to seek input from whānau in our communities to discuss timing and approach for our upcoming equity hui. Engagement with other internal and external stakeholders will be managed and coordinated by a newly appointment member of the Directorate Leadership Team

and Communications teams this week. This wider piece of engagement work will commence later in the month, with venues and facilitators currently being sourced.

- The success of the Women's Health engagement plan launch hui has been noted across the organisation, with Mental Health and Addictions and Te Pūriri o Te Ora (Cancer and Blood Services) replicating the essence of the hui to kick start their Directorate-wide Tiriti o Waitangi and Equity training commencing April/May. These hui will provide an opportunity to hear from our Board Chair and Deputy Board Chair and the commitments that the Board has made to its obligations to Te Tiriti o Waitangi and Equity, as outlined in our new organisational strategy, and to provide a forum to begin critical reflection.
- Work focussing on building capability to support the organisation's aspiration to achieve equity, as part of Pūmanawa Tāngata, our People Plan, continues. Tools and approaches for people leaders which promote reflective practice and sense-making of learnings continue to be developed. A framework outlining broader learning objectives pertaining to cultural safety, Māturanga Māori and Te Tiriti o Waitangi is being established. This includes comprehensive self-directed learning opportunities and sustained ongoing and supportive mechanisms to compliment the equity training workshops being undertaken by Directorates.
- Directorate business planning for 2021/2022 is currently underway. As part of this process, Māori leaders across the DHB are being engaged. Provider Directors are committed to keeping Māori knowledge at the forefront and ensuring Māori oversight during this process.
- Anthony Hawke, a descendant of Ngāti Whātua Ōrākei, commenced work at Te Toka Tumai at the end of March. In addition to other work, Anthony will support Directorates to develop their equity plans as well as manage the relationship between Ngāti Whātua Ōrākei and Te Toka Tumai.
- Transplant volumes total 68 heart, lung and liver and 97 renal transplants, totalling 165 transplants year to date.

Hospital occupancy

- All Te Toka Tumai hospitals have observed an increase in occupancy during March 2021. For Te Papakāinga Atawhai o Tāmaki, Auckland City Hospital (adult health), there was a 5.5 % increase in midnight occupancy during March compared to 2019 (during 2020 the country entered alert Level 4 and hospital occupancy was significantly lower than expected). This required some beds normally reserved for winter flex capacity to be utilised to maintain safe patient care, and additional staff resource.
- It is expected that winter 2021 will be very challenging and require all physical beds to be open to enable acute and planned care to continue. Plans are in place to resource all beds as well as carefully review planned care plans to avoid cancelling any patients at short notice. Staffing will be a significant challenge due to multiple regional demands.

COVID-19

- Te Toka Tumai continues to manage the impacts of COVID-19 on our hospitals and provider services. The COVID-19 response team remains in place to coordinate activity and respond to any increased community transmission. The team continues to work closely with the Northern Region Health Coordination Centre and the other DHBs in the region to ensure regional consistency where appropriate. Te Toka Tumai successfully managed the recent returns to alert Levels 3 and 2 in the Auckland region.

- An appropriate screening tool is in use to identify patients presenting with higher index of suspicion or with COVID-19 symptoms, which support the appropriate clinical management of patients and use of personal protective equipment. Although the level of community transmission is very low, a number of patients continue to be identified with symptoms each day and are managed as such until test results and other clinical information is available.
- There are daily admissions from managed isolation and quarantine facilities for a range of (usually non-COVID-19) health complaints. Infection prevention and control measures are in place to ensure that patients and staff remain safe. This includes the appropriate use of personal protective equipment where indicated.
- The vaccination roll-out is gaining pace. All Te Toka Tumai employees, volunteers, student and partner agency employees who work in a patient-facing environment have been invited to book their vaccination appointment. In addition, the majority of employees working in non-patient-facing roles have also been invited. The remaining people will be invited over the next week.
- To date, the Te Toka Tumai vaccination centre has vaccinated (dose 1) over 4,000 people and is currently the busiest vaccination site in New Zealand.
- Extensive communications and messaging is being deployed to encourage vaccination uptake.
- The community vaccination sites are being established across the city with support from employees from Te Toka Tumai. The impact on the workforce is being managed, however remains a risk as we observe increased hospital occupancy and need to resource additional inpatient beds.
- There continue to be supply chain challenges due to the global disruption caused by COVID-19. These are managed closely with the clinical teams involved. Where possible alternative products are sourced to avoid reducing any care delivery.
- It is apparent that COVID-19 will continue to disrupt the delivery of healthcare and require on-going work to manage. Should further cases emerge, an incident management team can be stood-up at short notice if required. The reduced COVID-19 response team remains in place.

2. Ministry of Health Planned Care Performance Dashboard

The Executive Leadership Team highlights the following updates from the March 2021 Ministry of Health Performance Planned Care Dashboard:

ESPI Performance

- January 2021 ESPI 2 position is 7% noncompliant, compared with 5.6% noncompliant for December 2020.
- January ESPI 5 position is 14.7% noncompliant, compared with 11.7% noncompliant at the end of December 2020.

2020/21 Planned Care – Year to Date performance

- We have completed 13,336 planned care interventions year to date in January 2021 against a plan of 13,745 (97%).
- Outpatient volumes continue to recover following August and March lockdowns however ESPI 2 breaches have deteriorated across some services.

Financial Performance

Consolidated Statement of Financial Performance - February 2021

Provider	Month (Feb-21)			YTD (8 months ending Feb-21)		
$000s	Actual	Budget	Variance	Actual	Budget	Variance
Income						
Government and Crown Agency sourced	11,147	9,817	1,331 F	84,914	80,401	4,514 F
Non-Government & Crown Agency Sourced	8,085	8,771	(686) U	69,048	70,555	(1,507) U
Inter-DHB & Internal Revenue	1,529	1,565	(36) U	12,053	11,981	71 F
Internal Allocation DHB Provider	138,132	130,465	7,667 F	1,041,065	1,043,718	(2,654) U
	158,894	**150,618**	**8,276 F**	**1,207,080**	**1,206,655**	**424 F**
Expenditure						
Personnel	96,476	92,706	(3,771) U	812,216	771,190	(41,026) U
Outsourced Personnel	2,336	1,559	(777) U	22,798	12,471	(10,327) U
Outsourced Clinical Services	4,740	3,934	(806) U	32,295	29,767	(2,528) U
Outsourced Other	6,079	6,106	27 F	48,644	48,845	201 F
Clinical Supplies	25,181	25,596	415 F	219,710	215,967	(3,742) U
Infrastructure & Non-Clinical Supplies	18,632	18,330	(302) U	142,425	146,025	3,600 F
Internal Allocations	804	805	0 F	6,437	6,437	0 F
Total Expenditure	**154,249**	**149,035**	**(5,214) U**	**1,284,525**	**1,230,703**	**(53,821) U**
Net Surplus / (Deficit)	**4,645**	**1,583**	**3,062 F**	**(77,445)**	**(24,048)**	**(53,397) U**
Covid-19 Net Impact on Bottom Line	(295)	0	295 F	27,250	4	(27,246) U
Holidays Act Net Impact on Bottom Line	3,333	0	(3,333) U	26,667	0	(26,667) U
BAU Net Impact on Bottom Line	**7,683**	**1,583**	**6,100 F**	**(23,529)**	**(24,044)**	**516 F**

Consolidated Statement of Personnel by Professional Group – February 2021

Employee Group $000s	Month (Feb-21)			YTD (8 months ending Feb-21)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical Personnel	33,462	33,345	(117) U	289,210	277,500	(11,711) U
Nursing Personnel	34,269	31,666	(2,603) U	280,977	260,580	(20,397) U
Allied Health Personnel	14,955	14,319	(636) U	125,002	120,560	(4,441) U
Support Personnel	2,683	2,624	(59) U	23,055	21,961	(1,094) U
Management/ Admin Personnel	11,108	10,752	(356) U	93,971	90,589	(3,383) U
Total (before Outsourced Personnel)	**96,476**	**92,706**	**(3,771) U**	**812,216**	**771,190**	**(41,026) U**
Outsourced Medical	1,321	1,039	(283) U	10,113	8,308	(1,805) U
Outsourced Nursing	97	66	(31) U	1,649	532	(1,117) U
Outsourced Allied Health	68	60	(8) U	879	479	(400) U
Outsourced Support	31	26	(5) U	308	208	(100) U
Outsourced Management/Admin	819	368	(451) U	9,850	2,945	(6,904) U
Total Outsourced Personnel	**2,336**	**1,559**	**(777) U**	**22,798**	**12,471**	**(10,327) U**
Total Personnel	**98,813**	**94,265**	**(4,548) U**	**835,014**	**783,661**	**(51,352) U**

Consolidated Statement of FTE by Professional Group – February 2021

FTE by Employee Group	Month (Feb-21)			YTD (8 months ending Feb-21)		
	Actual FTE	Budget FTE	Variance	Actual FTE	Budget FTE	Variance
Medical Personnel	1,568	1,536	(31) U	1,553	1,536	(17) U
Nursing Personnel	4,025	4,011	(14) U	4,062	4,032	(30) U
Allied Health Personnel	2,053	2,025	(28) U	2,022	2,030	8 F
Support Personnel	519	531	12 F	528	531	3 F
Management/ Admin Personnel	1,541	1,554	12 F	1,532	1,554	22 F
Total (before Outsourced Personnel)	**9,705**	**9,657**	**(48) U**	**9,698**	**9,683**	**(14) U**
Outsourced Medical	41	29	(12) U	39	29	(10) U
Outsourced Nursing	0	3	3 F	0	3	3 F
Outsourced Allied Health	4	2	(2) U	5	2	(3) U
Outsourced Support	6	0	(6) U	10	0	(10) U
Outsourced Management/Admin	100	23	(77) U	169	23	(145) U
Total Outsourced Personnel	**152**	**58**	**(94) U**	**224**	**58**	**(166) U**
Total Personnel	**9,857**	**9,715**	**(142) U**	**9,922**	**9,741**	**(180) U**

Consolidated Statement of FTE by Directorate – February 2021

Employee FTE by Directorate Group (including Outsourced FTE)	Month (Feb-21)			YTD (8 months ending Feb-21)		
	Actual FTE	Budget FTE	Variance	Actual FTE	Budget FTE	Variance
Adult Medical Services	1,090	1,084	(7) U	1,075	1,054	(22) U
Adult Community and LTC	511	502	(9) U	556	545	(11) U
Surgical Services	937	902	(36) U	931	902	(29) U
Women's Health	387	389	1 F	386	389	3 F
Child Health	1,384	1,362	(22) U	1,397	1,362	(35) U
Cardiac Services	562	555	(7) U	568	562	(7) U
Clinical Support Services	1,423	1,406	(17) U	1,407	1,401	(7) U
Patient Management Services	460	459	(1) U	468	461	(7) U
Perioperative Services	788	811	23 F	784	810	26 F
Cancer & Blood Services	432	410	(21) U	419	412	(7) U
Operational - Others	15	(9)	(24) U	27	(0)	(27) U
Mental Health & Addictions	796	806	10 F	779	806	27 F
Ancillary Services	1,072	1,039	(33) U	1,123	1,039	(85) U
Total Personnel	**9,857**	**9,715**	**(142) U**	**9,922**	**9,741**	**(180) U**

Month Result

The Provider Arm result for the month is $3.1M favourable. This result is driven by a $7.0M decrease in the provision for planned care and IDF revenue washup, partly offset by a $3.3M increase in the provision for Holidays Act liability.

Total revenue for the month is $8.3M (5.5%) favourable. Variances relating to Covid-19 were $2.3M favourable, with BAU $6.0M favourable. The key variances are as follows:

- Provision for planned care and IDF revenue washup $7.0M favourable – reflecting high volumes in December/January and therefore a reduction in the YTD washup position.
- MOH side contract income $2.2M favourable due to additional laboratory income for high volumes of Covid-19 testing.
- Non Resident revenue $1.2M unfavourable – primarily reflecting reduced Pacific contract cases as a result of Covid-19.

Total expenditure for the month is $5.2M (3.5%) unfavourable. Variances relating to Covid-19 were $2.0M unfavourable and the increase in the provision for Holidays Act liability was $3.3M unfavourable, leaving the underlying BAU variance very close to budget at $0.1M favourable. The key variances are as follows:

- Personnel/Outsourced Personnel costs $4.5M (4.8%) unfavourable, with the Covid-19 impact $1.1M unfavourable, Holidays Act remediation $3.3M unfavourable and the BAU variance very close to budget at $0.1M unfavourable. Excluding unbudgeted Covid FTE, total FTE are 54 over budget, equating to approximately $0.5M unfavourable.
- Clinical Supplies $0.4M (1.6%) favourable. Covid-19 costs were $0.3M unfavourable. Excluding these costs, the underlying Clinical Supplies variance is $0.7M favourable, in line with volumes below contract for the month of February.

Year to Date Result

The Provider Arm result for the year to date is $53.4M unfavourable. This result is primarily driven by the impacts of Covid-19 ($27.2M) combined with an increase of $26.7M in the provision for Holidays Act liability. The underlying BAU result is $0.5M favourable.

Overall volumes (for total Auckland DHB and IDF Funders) are reported at 97.7% of the seasonally phased contract, equating to $21.6M below contract. The year to date result includes an $11.0M provision for estimated washup liability in relation to the Planned Care and IDF funding components of the YTD variance.

Total revenue for the year to date is $0.4M (0%) favourable, with a net $1.8M favourable variance attributable to Covid-19, and BAU $1.4M unfavourable. The key variances are as follows:

- Provision for planned care and IDF revenue washup - $11.0M unfavourable – reflecting significantly reduced volumes during the Covid-19 resurgence period in August, and lower acute volumes for the period immediately following the return to alert level 1.
- Non Resident revenue $7.3M unfavourable – primarily reflecting reduced Pacific contract cases as a result of Covid-19.
- Capital Charge income $4.6M unfavourable due to MOH claw back on capital charge funding to reflect the reduction of capital charge rate from 6% to 5%.
- Public Health (base services excluding Covid-19) income $3.0M unfavourable due to assumed deficit support not received.
- MOH side contract income $17.4M favourable due to additional laboratory income for high volumes of Covid-19 testing.
- Retail Pharmacy revenue $4.7M favourable (mostly offset by additional cost of goods sold).
- New MOH funding for the Integrated Primary Mental Health Initiative $1.5M favourable.
- Research Income $1.7M favourable (offset by additional research costs so bottom line neutral).
- Donations $1.3M favourable - this income fluctuates from month to month depending on timing of donations for key projects.

Total expenditure for the year to date is $53.8M (4.4%) unfavourable. Nearly all of this variance is attributable to additional costs arising from Covid-19 ($29.0M) and the increase in the provision for the Holidays Act liability ($26.7M), with the underlying BAU variance $1.9M favourable. The key variances are as follows:

- Personnel/Outsourced Personnel costs $51.4M (6.6%) unfavourable with the key variances as follows:
  - Unbudgeted Covid-19 related expenditure of $20.6M.
  - Increase in the provision for Holidays Act liability $26.7M unfavourable
  - Excluding unbudgeted Covid FTE, total FTE are 54 over budget, equating to approximately $4.3M of this variance.
- Outsourced Clinical Services $2.5M (8.5%) unfavourable, with the key variances as follows:
  - Unbudgeted Covid-19 related expenditure of $0.4M (for laboratory outsourced tests).
  - Diagnostic Genetics $0.6M unfavourable due to delayed repatriation of tests previously not done in house – this variance will reduce once repatriation is complete.
  - Planned outsourcing for colonoscopy has been completed earlier than budget phasing resulting in a $0.4M unfavourable variance which will correct during the year.
  - Additional MRI outsourcing $0.5M unfavourable for which additional one off MOH funding has been received.

  - Additional outsourcing in Ophthalmology in order to meet contract $0.7M unfavourable.
- Clinical Supplies $3.7M (1.7%) unfavourable. This variance is due to Laboratory consumable costs which are $4.8M unfavourable for the cost of Covid-19 tests. Excluding these costs, the underlying Clinical Supplies BAU variance is $0.9M favourable, reflecting overall volume performance slightly below contract.
- Infrastructure & Non Clinical Supplies $3.6M (2.5%) favourable, with the key variances being:
  - Unbudgeted Covid-19 related expenditure of $3.7M unfavourable
  - Cost of Goods Sold $3.8M unfavourable for retail pharmacy, offset by additional retail revenue for the year to date.
  - Capital Charge $7.6M favourable due to the reduction in the capital charge rate from 6% to 5% combined with a lower crown equity balance.
  - Interest & Finance Charges $0.3M favourable.
  - All Other Operating Expenses such as Professional Fees, Training, Travel & Accommodation $3.4M favourable.

FTE

Total FTE (including outsourced) for February were 9,857 which is 142 higher than budget. The key drivers of the FTE over budget are unbudgeted FTE for Covid-19 (88 FTE) and RMOs above budgeted FTE (40 FTE).

Volume Performance

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

		Feb-2021				YTD (8 months ending Feb-21)			
		$000s				$000s			
Directorate	**Service**	**Cont**	**Act**	**Var**	**Prog %**	**Cont**	**Act**	**Var**	**Prog %**
Adult Community & LTC	Ambulatory Services	1,336	1,393	57	104.2%	11,944	13,158	1,213	110.2%
	Community Services	1,803	1,722	(81)	95.5%	15,354	16,644	1,290	108.4%
	Diabetes	538	579	41	107.7%	4,502	4,952	450	110.0%
	Palliative Care	39	39	0	100.0%	312	312	0	100.0%
	Reablement Services	1,273	1,303	31	102.4%	14,455	15,024	570	103.9%
	Sexual Health	513	503	(10)	98.0%	4,313	4,308	(5)	99.9%
Adult Community & LTC Total		**5,502**	**5,539**	**38**	**100.7%**	**50,880**	**54,398**	**3,519**	**106.9%**
Adult Medical Services	AED, APU, DCCM, Air Ambulance	2,689	2,575	(114)	95.7%	22,418	22,466	48	100.2%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	13,405	12,828	(576)	95.7%	115,223	113,703	(1,520)	98.7%
Adult Medical Services Total		**16,094**	**15,403**	**(691)**	**95.7%**	**137,641**	**136,168**	**(1,473)**	**98.9%**
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	10,593	9,797	(796)	92.5%	86,153	86,673	520	100.6%
	N Surg, Oral, ORL, Transpl, Uro	10,336	10,481	145	101.4%	91,377	89,937	(1,440)	98.4%
	Orthopaedics Adult	4,773	4,455	(319)	93.3%	40,370	38,423	(1,947)	95.2%
Surgical Services Total		**25,702**	**24,733**	**(970)**	**96.2%**	**217,900**	**215,033**	**(2,867)**	**98.7%**
Cancer & Blood Services	Cancer & Blood Services	10,941	10,193	(748)	93.2%	94,909	92,620	(2,290)	97.6%
	Genetics	304	276	(28)	90.7%	2,598	2,777	179	106.9%
Cancer & Blood Services Total		**11,245**	**10,469**	**(776)**	**93.1%**	**97,507**	**95,397**	**(2,111)**	**97.8%**
Cardiovascular Services		**12,672**	**12,157**	**(515)**	**95.9%**	**110,775**	**103,728**	**(7,046)**	**93.6%**
Children's Health	Child Health Community Services	2,970	2,051	(919)	69.1%	24,709	19,659	(5,050)	79.6%
	Child Health Medical	5,646	5,220	(426)	92.4%	50,158	46,979	(3,179)	93.7%
	Child Health Surgical	10,375	9,296	(1,079)	89.6%	86,306	82,500	(3,807)	95.6%
Children's Health Total		**18,991**	**16,567**	**(2,424)**	**87.2%**	**161,173**	**149,137**	**(12,036)**	**92.5%**
Clinical Support Services		**3,718**	**3,589**	**(129)**	**96.5%**	**31,061**	**31,021**	**(40)**	**99.9%**
DHB Funds		**10,239**	**9,110**	**(1,128)**	**89.0%**	**79,797**	**78,601**	**(1,197)**	**98.5%**
Perioperative Services		**16**	**3**	**(13)**	**18.3%**	**132**	**66**	**(67)**	**49.6%**
Public Health Services		**155**	**155**	**0**	**100.0%**	**1,238**	**1,238**	**0**	**100.0%**
Support Services		**102**	**102**	**0**	**100.0%**	**818**	**818**	**0**	**100.0%**
Women's Health Total		**7,542**	**7,884**	**342**	**104.5%**	**64,757**	**66,439**	**1,681**	**102.6%**
Grand Total		**111,977**	**105,710**	**(6,267)**	**94.4%**	**953,681**	**932,045**	**(21,637)**	**97.7%**

2) Total Discharges for the YTD (8 Months to February 2021)

		Cases Subject to WIES Payment		All Discharges			Same Day discharges		Same Day as % of all discharges	
		Inpatient								
Directorate	**Service**	**2020**	**2021**	**Last YTD**	**This YTD**	**% Change**	**Last YTD**	**This YTD**	**Last YTD**	**This YTD**
Adult Community & LTC	Ambulatory Services	1,677	1,796	1,704	1,812	6.3%	1,612	1,747	94.6%	96.4%
	Community Services	0	5	0	15	0.0%	0	8	0.0%	53.3%
	Reablement Services	0	0	1,457	1,341	(8.0%)	71	64	4.9%	4.8%
Adult Community & LTC Total		1,677	1,801	3,161	3,168	0.2%	1,683	1,819	53.2%	57.4%
Adult Medical Services	AED, APU, DCCM, Air Ambulance	10,334	10,481	10,612	10,597	(0.1%)	7,315	7,458	68.9%	70.4%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	14,193	13,514	14,453	13,722	(5.1%)	2,362	2,373	16.3%	17.3%
Adult Medical Services Total		24,527	23,995	25,065	24,319	(3.0%)	9,677	9,831	38.6%	40.4%
Cancer & Blood Total		3,601	3,164	4,163	3,521	(15.4%)	2,199	1,686	52.8%	47.9%
Cardiovascular Services Total		5,593	5,633	5,801	5,797	(0.1%)	1,516	1,529	26.1%	26.4%
Children's Health	Child Health Community Services	1,941	1,334	1,950	1,339	(31.3%)	143	143	7.3%	10.7%
	Child Health Medical	7,992	7,716	8,836	8,757	(0.9%)	6,198	6,377	70.1%	72.8%
	Child Health Surgical	7,241	6,486	7,688	6,812	(11.4%)	3,163	2,694	41.1%	39.5%
Children's Health Total		17,174	15,537	18,474	16,908	(8.5%)	9,504	9,214	51.4%	54.5%
Clinical Support Services Total		0	0	9	0	0.0%	8	0	88.9%	0.0%
DHB Funds Total		1,085	1,339	1,088	1,340	23.2%	837	1,073	76.9%	80.1%
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	12,930	12,146	13,930	12,981	(6.8%)	7,672	6,862	55.1%	52.9%
	N Surg, Oral, ORL,	8,269	8,086	8,864	8,602	(3.0%)	3,609	3,453	40.7%	40.1%
	Orthopaedics Adult	3,205	3,292	3,334	3,415	2.4%	558	680	16.7%	19.9%
Surgical Services Total		24,404	23,524	26,128	24,998	(4.3%)	11,839	10,995	45.3%	44.0%
Women's Health Total		14,162	13,453	14,693	13,880	(5.5%)	5,462	5,061	37.2%	36.5%
Grand Total		**92,223**	**88,446**	**98,573**	**93,942**	**(4.7%)**	**42,717**	**41,218**	**43.3%**	**43.9%**

3) Caseweight Activity for the YTD (8 Months to February 2021 (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 & LT Conditions	Ambulatory Services	831	888	57	4,607	4,923	317	106.9%	74	24	(51)	413	130	(283)	31.6%	905	911	6	5,019	5,054	34	100.7%
	Community Services	0	2	2	0	11	11	0.0%	0	11	11	0	60	60	0.0%	0	13	13	0	71	71	0.0%
Adult Community & LTC		**831**	**890**	**59**	**4,607**	**4,934**	**328**	**107.1%**	**74**	**34**	**(40)**	**413**	**190**	**(223)**	**46.0%**	**905**	**924**	**19**	**5,019**	**5,124**	**105**	**102.1%**
Adult Medical Services	AED, APU, DCCM, Air Ambulance	2,794	2,881	87	15,494	15,975	480	103.1%	0	0	0	0	0	0	0.0%	2,794	2,881	87	15,494	15,975	480	103.1%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	14,080	13,363	(717)	78,078	74,100	(3,978)	94.9%	22	0	(22)	122	0	(122)	0.0%	14,102	13,363	(739)	78,200	74,100	(4,100)	94.8%
Adult Medical Services Total		**16,874**	**16,243**	**(631)**	**93,572**	**90,074**	**(3,498)**	**96.3%**	**22**	**0**	**(22)**	**122**	**0**	**(122)**	**0.0%**	**16,896**	**16,243**	**(653)**	**93,694**	**90,074**	**(3,619)**	**96.1%**
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	6,795	7,051	255	37,681	39,098	1,417	103.8%	5,001	4,794	(207)	27,733	26,583	(1,150)	95.9%	11,796	11,845	48	65,414	65,681	266	100.4%
	N Surg, Oral, ORL, Transpl, Uro	6,792	7,228	436	37,663	40,084	2,420	106.4%	5,065	4,515	(550)	28,089	25,039	(3,050)	89.1%	11,857	11,744	(114)	65,753	65,123	(630)	99.0%
	Orthopaedics Adult	4,228	4,161	(67)	23,445	23,071	(374)	98.4%	2,535	2,043	(491)	14,056	11,332	(2,724)	80.6%	6,763	6,204	(559)	37,501	34,403	(3,098)	91.7%
Surgical Services Total		**17,815**	**18,440**	**625**	**98,789**	**102,252**	**3,463**	**103.5%**	**12,602**	**11,353**	**(1,249)**	**69,879**	**62,954**	**(6,925)**	**90.1%**	**30,417**	**29,792**	**(624)**	**168,668**	**165,206**	**(3,462)**	**97.9%**
Cancer & Blood Services		**4,468**	**4,133**	**(335)**	**24,778**	**22,920**	**(1,857)**	**92.5%**	**0**	**0**	**0**	**0**	**0**	**0**	**0.0%**	**4,468**	**4,133**	**(335)**	**24,778**	**22,920**	**(1,857)**	**92.5%**
Cardiovascular Services		**11,068**	**10,817**	**(252)**	**61,377**	**59,981**	**(1,395)**	**97.7%**	**6,775**	**5,678**	**(1,097)**	**37,570**	**31,484**	**(6,086)**	**83.8%**	**17,843**	**16,494**	**(1,349)**	**98,946**	**91,465**	**(7,481)**	**92.4%**
Children's Health	Child Health Community	2,481	1,561	(920)	13,758	8,659	(5,100)	62.9%	0	0	0	0	0	0	0.0%	2,481	1,561	(920)	13,758	8,659	(5,100)	62.9%
	Child Health Medical	5,618	5,118	(500)	31,154	28,380	(2,774)	91.1%	39	47	9	214	262	48	122.3%	5,657	5,165	(492)	31,369	28,642	(2,726)	91.3%
	Child Health Surgical	7,896	7,371	(526)	43,786	40,871	(2,914)	93.3%	4,830	4,641	(189)	26,782	25,736	(1,045)	96.1%	12,726	12,012	(714)	70,567	66,608	(3,960)	94.4%
Children's Health Total		**15,995**	**14,050**	**(1,945)**	**88,698**	**77,910**	**(10,788)**	**87.8%**	**4,868**	**4,688**	**(180)**	**26,996**	**25,998**	**(998)**	**96.3%**	**20,864**	**18,738**	**(2,125)**	**115,694**	**103,908**	**(11,786)**	**89.8%**
Women's Health Services		**6,763**	**6,695**	**(69)**	**37,503**	**37,123**	**(380)**	**99.0%**	**1,524**	**1,526**	**2**	**8,451**	**8,460**	**9**	**100.1%**	**8,287**	**8,220**	**(67)**	**45,954**	**45,583**	**(371)**	**99.2%**
DHB Funds		**180**	**0**	**(180)**	**998**	**0**	**(998)**	**0.0%**	**1,426**	**1,336**	**(90)**	**7,909**	**7,410**	**(499)**	**93.7%**	**1,606**	**1,336**	**(270)**	**8,907**	**7,410**	**(1,497)**	**83.2%**
Grand Total		**73,995**	**71,267**	**(2,728)**	**410,323**	**395,196**	**(15,126)**	**96.3%**	**27,291**	**24,615**	**(2,677)**	**151,338**	**136,495**	**(14,843)**	**90.2%**	**101,287**	**95,882**	**(5,404)**	**561,661**	**531,692**	**(29,969)**	**94.7%**
Excludes caseweight Provision																						

Acute Services

Year to date February acute performance to contract is 96.3%. December and January were nearly 1,500 WIES more than the same period last year which has increased the overall position.

- Acute medical services saw a decrease in January (which is not unexpected). However, January was still higher than the same month last year. Overall discharges are down 3.5% on the same period last year. Average WIES is also down by 2% reflecting the reduced complexity due to the lack of severe respiratory illnesses over the year, although the average length of stay has not changed.
- Acute surgical discharges are now 5% lower than the same period last year. December saw high volumes but both January and February had lower discharges than the same period last year. Average WIES continues to be higher than the same period last year, although it continues to drop slightly and is now only 6% higher. Average length of stay has also dropped and is now only 5% higher than the same period last year.
- Obstetric discharges have increased slightly, although they are still 10% lower than the same period last year. Average length of stay is up nearly 4% on the same period last year. Average WIES has increased slightly and is now 1% higher than the same period last year. New born discharges are 9% higher than same period last year, but with a lower average WIES (down 6%) and length of stay (down 4%).

Elective Services

Elective performance to contract is now 90%. The short February lockdown does not appear to have impacted on elective discharges for the month. Average WIES is 2% lower than the same period last year.

4) Non-DRG Activity (ALL DHBs)

		Feb-2021				YTD (8 months ending Feb-21)			
		$000s				$000s			
Directorate	**Service**	**Cont**	**Act**	**Var**	**Prog %**	**Cont**	**Act**	**Var**	**Prog %**
Adult Community & LTC	Ambulatory Services	808	851	43	105.3%	6,925	8,104	1,179	117.0%
	Community Services	1,803	1,692	(111)	93.9%	15,354	16,574	1,219	107.9%
	Diabetes	538	579	41	107.7%	4,502	4,952	450	110.0%
	Palliative Care	39	39	0	100.0%	312	312	0	100.0%
	Reablement Services	1,273	1,303	31	102.4%	14,455	15,024	570	103.9%
	Sexual Health	513	503	(10)	98.0%	4,313	4,308	(5)	99.9%
Adult Community & LTC Total		**4,974**	**4,968**	**(6)**	**99.9%**	**45,860**	**49,274**	**3,414**	**107.4%**
Adult Medical Services	AED, APU, DCCM, Air Ambulance	830	764	(67)	92.0%	6,924	6,491	(433)	93.7%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	4,878	4,666	(212)	95.6%	37,023	39,603	2,580	107.0%
Adult Medical Services Total		**5,709**	**5,430**	**(279)**	**95.1%**	**43,947**	**46,094**	**2,147**	**104.9%**
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	2,421	2,172	(248)	89.7%	20,738	20,992	254	101.2%
	N Surg, Oral, ORL, Transpl, Uro	3,084	2,972	(112)	96.4%	25,624	24,815	(810)	96.8%
	Orthopaedics Adult	337	580	243	172.0%	2,870	4,020	1,150	140.1%
Surgical Services Total		**5,842**	**5,724**	**(118)**	**98.0%**	**49,232**	**49,827**	**594**	**101.2%**
Cancer & Blood Services	Cancer & Blood Services	8,290	7,549	(741)	91.1%	70,131	69,699	(432)	99.4%
	Genetics	304	276	(28)	90.7%	2,598	2,777	179	106.9%
Cancer & Blood Services Total		**8,594**	**7,825**	**(769)**	**91.0%**	**72,730**	**72,476**	**(253)**	**99.7%**
Cardiovascular Services		**1,331**	**1,257**	**(74)**	**94.4%**	**11,828**	**12,263**	**435**	**103.7%**
Children's Health	Child Health Community Services	1,336	1,273	(63)	95.3%	10,951	11,000	49	100.5%
	Child Health Medical	2,210	1,951	(259)	88.3%	18,789	18,336	(453)	97.6%
	Child Health Surgical	1,901	1,824	(76)	96.0%	15,739	15,892	153	101.0%
Children's Health Total		**5,447**	**5,049**	**(399)**	**92.7%**	**45,479**	**45,229**	**(250)**	**99.4%**
Clinical Support Services		**3,718**	**3,589**	**(129)**	**96.5%**	**31,061**	**31,021**	**(40)**	**99.9%**
DHB Funds		**8,882**	**8,809**	**(73)**	**99.2%**	**70,890**	**71,191**	**301**	**100.4%**
Perioperative Services		**16**	**3**	**(13)**	**18.3%**	**132**	**66**	**(67)**	**49.6%**
Public Health Services		**155**	**155**	**0**	**100.0%**	**1,238**	**1,238**	**0**	**100.0%**
Support Services		**102**	**102**	**0**	**100.0%**	**818**	**818**	**0**	**100.0%**
Women's Health Total		**2,215**	**2,271**	**56**	**102.5%**	**18,803**	**20,855**	**2,052**	**110.9%**
Grand Total		**46,984**	**45,180**	**(1,804)**	**96.2%**	**392,020**	**400,353**	**8,333**	**102.1%**

Outpatient activity has continued to improve and continues at over 100% of contract. However, the wash up for other DHBs is now negative after lower than contract performance in January and February for Cancer Services.

Adult Medical Directorate

Prepared by: Jess Patten (General Manager – Adult Medical Directorate)
Speaker: Barry Snow (Director – Adult Medical Directorate)

Kuputaka: Glossary

Acronym/term	Definition
Adult Medical Directorate	Adult Medical Directorate is made up of eight services: General Medicine, Emergency Department (including Clinical Decision Unit), Department of Critical Care Medicine, Gastroenterology, Neurology, Infectious Diseases, Renal and Respiratory
COPD	Chronic Obstructive Pulmonary Disease
Hui	Meeting
Kaimahi Māori	Employee who identifies as Māori
Taiao Ora	Ward 51 which provides acute stroke, neurology and rehabilitation services

1. Te Tiriti o Waitangi in Action

The Adult Medical Directorate is committed to upholding Te Tiriti o Waitangi and is at the beginning stages of action.

- **Kāwanatanga**

Several services have held hui and partnered with kaimahi Māori, patients, whānau, and external agencies to better understand how to meet the obligations of Te Tiriti o Waitangi and to achieve health equity. The Emergency Department held a hui in February 2021 involving the Māori Patient and Whānau Experience team, Australasian College for Emergency Medicine, He Kāmaka Waiora, University of Auckland and Ōrākei Health Care. The aim of the hui was to understand where inequities exist for patients and whānau attending the Emergency Department and to develop an action plan.

There are currently no Māori in leadership roles across the Adult Medical Directorate. However, there is commitment to improving genuine representation and decision making authority (e.g. exploring the role of a Māori Health Director as well as the identification and support for Māori staff within the Directorate).

- **Tino Rangatiratanga**

Work is underway with the Kaimahi Māori Experience team to ensure all recruitment processes are following best practice guidelines including all Māori candidates who meet the core criteria are automatically shortlisted, and where these candidates are interviewed but not selected, specific feedback is provided.

With the implementation of Taiao Ora, a benefit realisation plan has been developed to increase the representation of Māori staff to 8% by 2022 and 9.09% by 2023 (service user population). In addition, with new FTE granted to the Renal Service in December 2020, active measures to recruit a representative workforce are being progressed.

- **Ōritetanga**

Adult Medical is committed to understanding where inequities exist for each service. The initial phase is to ensure all current and future reports, report on Māori outcomes. For example, a new internal weekly colonoscopy performance report highlights that there are timeliness challenges for Māori patients waiting for a colonoscopy procedure. A pre-assessment nurse has been recruited as a pilot to engage Māori (and other priority patients) in preparation for their endoscopy procedure.

All

Priority	% compliance within target timeframe (Target)*	% compliance within maximum timeframe (Target)**	Total Events Waiting as at 15/03/21	Longest Waiting Event
Urgent	100.00% (90% seen within 14 days)	100.00% (100% seen within 30 days)	10	13
Routine	81.66% (70% seen within 42 days)	100.00% (100% seen within 90 days)	225	81
Surveillance	78.04% (70% seen within 84 days)	9 (100% seen within 120 days)		

Weekly Report of Colonoscopy Performance (WT37), 15/3/21

Maori

Priority	% compliance within target timeframe (Target)*	% compliance within maximum timeframe (Target)**	Total Events Waiting as at 15/03/21	Longest Waiting Event
Urgent	100.00% (90% seen within 14 days)	100.00% (100% seen within 30 days)	1	11
Routine	66.67% (70% seen within 42 days)	100.00% (100% seen within 90 days)	14	66
Surveillance	68.75% (70% seen within 84 days)	100.00% (100% seen within 120 days)	12	105

- **Te Ritenga**

To create a culturally safe environment, education about Te Tiriti o Waitangi and Tikanga is critical. Within Adult Medical, 54% of staff have completed the online Tikanga training online course and 48% have completed Te Tiriti o Waitangi online course. The objective is to increase this to 100% by the end of 2022.

Some services have established regular hui to support Māori staff to feel safe to express and share their culture within the organisation. The objective is to support all services in establishing this for Māori staff.

2. Eliminate Inequity

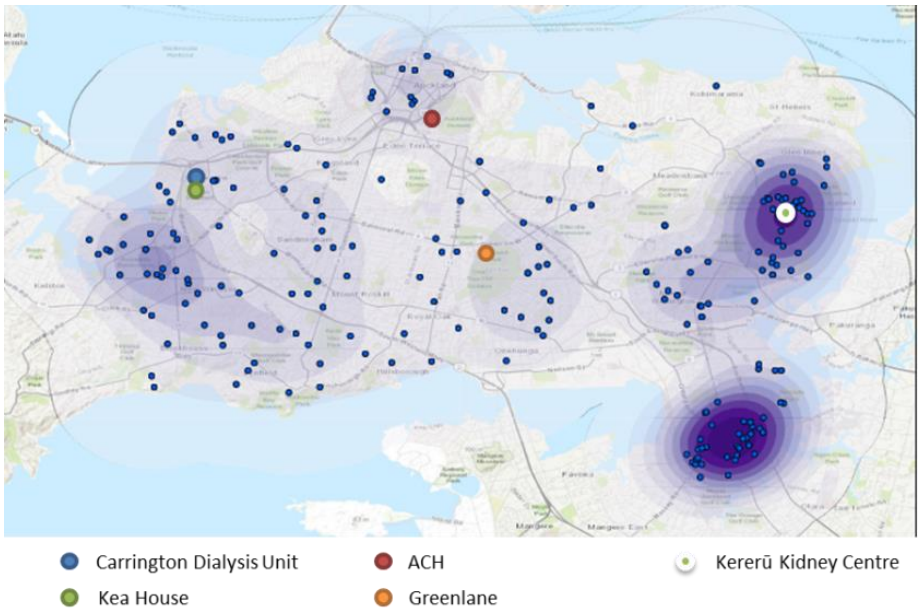
Adult Medical are at the beginning stages of understanding where inequity exists and addressing these. However, there are a few specific initiatives underway:

- The Māori Patient Experience team and Ara Manawa recently supported General Medicine Service in researching experiences of Māori patients and whānau on the wards. This provided rich, qualitative information about opportunities to improve access, quality and culturally appropriate services. This information will be turned into an action plan to address the findings.
- A separate but similar research project has been completed for Pasifika patients and whānau experiences in General Medicine. This is also being incorporated into the General Medicine improvement project.
- High Did Not Attract rates remain a concern, particularly for Māori patients. We plan to bring a more detailed analysis of the data and an action plan back in our next HAC report.
- The Respiratory Service is collaborating with the Pacific Navigator team to support Pasifika patients who are waiting for a sleep study or who are struggling to maintain their sleep treatment. The aim is to develop connections with patients, support attending their appointments and maintaining treatment.
- The Respiratory Service has also initiated a research project investigating the use of an app, developed overseas and adapting this to Māori and Pasifika patients who have COPD.

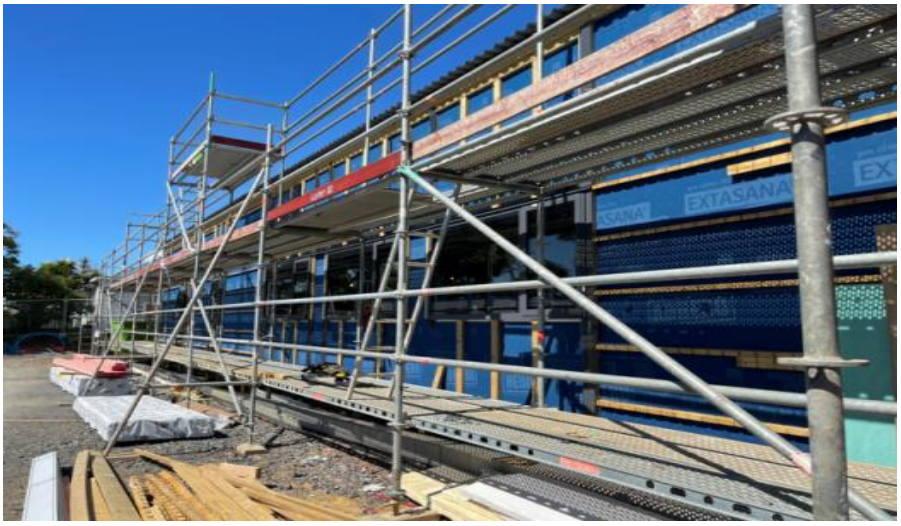
3. People, Patients and Whānau at the Centre

The Adult Medical directorate recently opened Taiao Ora (stroke, neurology and rehabilitation ward) in November 2021. This is a new, 41 bed ward, based on level 5 of the main building at Auckland City Hospital and provides integrated acute and rehabilitation care to patients suffering from stroke or other neurological conditions. It involved combining two services (Ward 61 and Rangitoto Ward) and two teams into one location and one team. Initial feedback is positive, with the first benefit report submitted to Building for the Future. Initial performance data is encouraging with the total length of stay trending down from 33 days in December 2020 to 30 days in January 2021 and 29 days in February 2021. A partial provisional audit was conducted in February with a small number of corrective actions and the service is currently conducting a 90 day review of building, equipment and furniture needs.

The Renal Service is building a new dialysis unit in Glen Innes. Renal failure requiring dialysis disproportionately affects Māori and Pasifika who are forced to travel long distances from Glen Innes multiple times per week for treatment. The aim is to provide dialysis care closer to patient's homes, and a large number of patients come from Glen Innes. Construction is on-track and the unit is expected to open in August 2021. The service is working closely with the Tāmaki Regeneration Company and Kidney Society in maintaining connections and partnerships with the community. A consultation document has been released to the Renal Service proposing the vision of being able to deliver different dialysis types at all locations so that patients can dialyse close to their home.



Patient Domicile and Dialysis Unit Location



Construction of the Kererū Kidney Centre, 23/3/21

4. Digital Transformation

The focus for Digital Transformation has been developed with the Business Intelligence team at Te Toka Tumai and involves:

- Improving access to our current data sets
- Presenting data sets by ethnicity
- Up-skilling managers and key staff to analyse data sets
- Identifying gaps in these data sets and determining new reports that are required (ensuring all reports provide an ethnicity breakdown)
- Collaborating with Business Intelligence to support complex data analysis

Adult Medical is currently involved in large-scale IT projects including the roll out of Windows 10 across Te Toka Tumai. The directorate also have service specific IT initiatives underway including piloting electronic notes in the Emergency Department for nursing staff and cloud management of data from sleep studies completed at home.

5. Resilient Services

Covid-19 Response

Adult Medical directorate continue to play a critical role in the Covid-19 response at Te Toka Tumai.

- The Infectious Diseases team provide leadership, advice and support across Te Toka Tumai, develop policies and processes to keep our people safe and represent Te Toka Tumai regionally.
- The Respiratory Service and General Medical teams manage patients with Covid and those from managed isolation and quarantine facilities.
- The Emergency Department manage all patients coming into the hospital with appropriate screening measures to maximise safety within the hospital.
- The Ministry of Health have approved extra resources to support Intensive Care units to address potential surges in demand. The Department of Critical Care Medicine has begun this process.
- Building works to increase the number of negative pressure rooms are underway. Initial work has been completed in the Department of Critical Care Medicine and plans are being finalised for the Emergency Department.

Hospital 6-hour Target

Volumes of patients attending the Emergency Department dropped during the first Covid lockdown in March 2020 but have since returned to pre-Covid levels. Achieving the six-hour target has been challenging during the latter half of 2020 and early 2021. Reasons include:

- High demand surges
- Complex admission processes for patients who meet the high risk criteria for Covid infection
- Episodes of potential Covid exposure risk requiring large numbers of staff to isolate
- High sick leave
- Trials of different medical models
- Changes in the Emergency Department leadership team

Going forward, the plan to improve the target includes:

- Stabilise the leadership team (including a current search for a permanent Service Clinical Director, Nurse Unit Manager and Operations Manager)
- Finalise the medical model
- Establish acute flow groups across the hospital, in which the Emergency Department will play a key role
- Closer working with the inpatient services

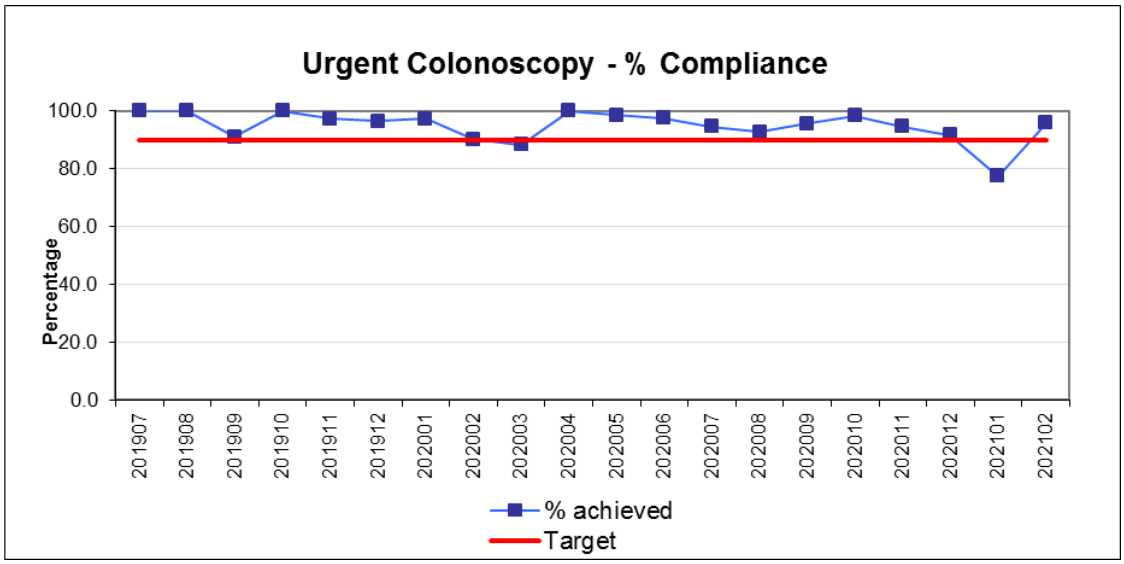
- Continue to build links and relationships with Primary Care and Community Services team to ensure where possible, care is provided to people in their home and avoid admission.

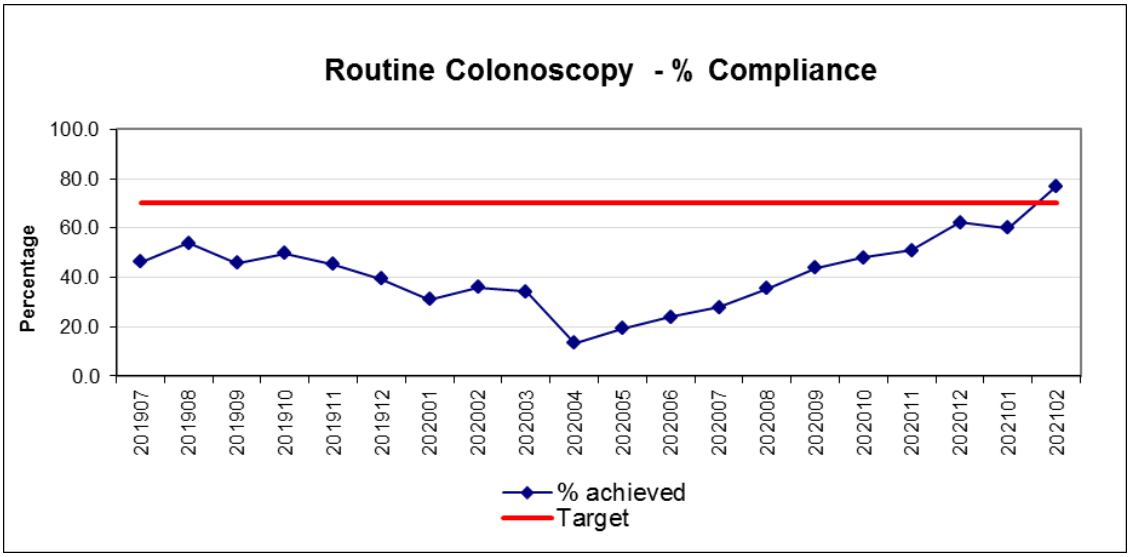
Gastroenterology Capacity and Demand

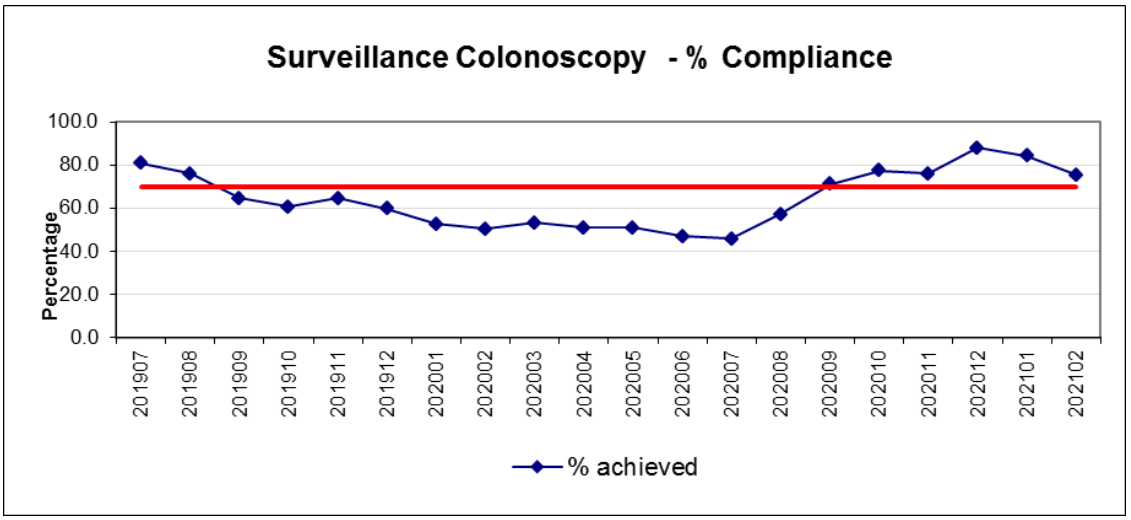
In February 2021, the Gastroenterology Service became compliant with the Ministry of Health colonoscopy targets. This was achieved by outsourcing 700 colonoscopy procedures during 2020 and improved booking and scheduling activities. Achieving compliance was critical to the roll out of the Bowel Screening Programme which went live in November 2020.

However, the service is experiencing challenges with the gastroscopy waitlist (~1,100 patients on the waitlist, with the 90th percentile of patients waiting 176 days) and ESPI2 (267 breaches for February 2021). This challenge is exacerbated by the unplanned leave of a full time Senior Medical Officer and no clear return date.

The service is working to increase capacity particularly for first assessments. This is through converting follow-up appointments to first assessments for a limited time period, increasing the number of clinics and improving booking and scheduling processes.







Ministry of Health Colonoscopy Targets and Performance (Business Intelligence, 23/3/21)

Sleep Service Capacity and Demand

The Sleep Service has ~1,100 patients waiting for a sleep study, with the 90th percentile wait time of 518 days (February 2021). The Sleep team at Te Toka Tumai provide a regional service to Counties Manukau, Northland and Waitematā District Health Boards. Covid has had a negative impact on the utilisation of sleep studies being conducted in the hospital and the waitlist has grown since the first lockdown in 2020.

To address this, there is a current review of all patients on the waitlist to determine which patients are able to have their sleep study at home (versus completing this at Auckland City Hospital). By increasing the number of sleep studies at home, this is expected to reduce the waitlist and wait time. Conversations are also on-going with Waitematā District Health Board in reviewing the model of care for Waitematā patients and ensuring sleep services are delivered close to where patients live.

A significant step forward for the service and our patients is the introduction of cloud-based monitoring of home CPAP and other respiratory support machines. This allows management at a

distance without forcing our patients to travel to and from the hospital to have their devices adjusted. This has been a significant benefit to our patients with limited resources making transport and parking difficult.

Neurology Regional Service

The Neurology Service currently provides an on-call service to the Northern region. In addition, the Service manages clot extraction for hyperacute stroke for the upper North Island. Recently the service has also supported the Capital and Coast service to the lower North Island as that service has been limited by insufficient staffing.

Recently, Northland and Capital and Coast District Health Board have requested more formal stroke-related support due to the resource challenges in their teams. The Funder at Te Toka Tumai is involved and a Service Level Agreement is in development.

6. Financial Sustainability

The table below outlines the financial performance of the Adult Medical directorate.

Approximately two thirds of the $6m deficit within the Adult Medical directorate is directly and indirectly related to Covid.

($000s)	YEAR TO DATE (8 months ending Feb-21)		
	Actual	Budget	Variance
REVENUE			
Government and Crown Agency	2,694	3,429	(735) U
Funder to Provider Revenue	134,453	135,235	(782) U
Other Income	3,859	5,271	(1,413) U
Total Revenue	**141,006**	**143,936**	**(2,930) U**
EXPENDITURE			
Personnel Costs			
Medical	40,113	39,979	(134) U
Nursing	46,556	44,245	(2,310) U
Allied Health	3,567	3,433	(134) U
Support	290	281	(9) U
Management/Adminstration	4,000	3,919	(81) U
Total Personnel Costs	**94,525**	**91,857**	**(2,668) U**
Outsourced Personnel	637	762	125 F
Outsourced Clinical Services	485	429	(56) U
Clinical Supplies	19,710	19,446	(264) U
Infrastructure & Non-Clinical Supplies	2,637	2,764	128 F
Total Expenditure	**117,993**	**115,258**	**(2,735) U**
Contribution	**23,013**	**28,677**	**(5,664) U**
Allocations	23,496	23,113	(383) U
NET RESULT	**(483)**	**5,565**	**(6,048) U**

Revenue:

- Inpatient services (General Medicine, Infectious Diseases and Respiratory) experienced a drop in hospital related volumes particularly during the winter months of 2020 ($782,000 unfavourable).

- Revenue related to non-residents continues to be below expected volumes due to the closed borders ($1,413,000 unfavourable).

Expenditure:

- Approximately 80% of the unfavourable nursing variance is related to rostering extra staff to manage Covid, mainly in the Emergency Department. The unfavourable variance also includes higher annual leave liability, overtime costs and sick leave.
- Approximately $300,000 has been spent on one off back pay costs.
- The unfavourable variance in Internal Allocations relates to the extra laboratory support due to the outsourcing of 700 colonoscopy procedures in late 2020 and increased requirements for radiology in the Department of Critical Care Medicine.

Table of FTE	YEAR TO DATE (FTE) (8 months ending Feb-21)		
	Actual	Budget	Variance
Medical	240.3	226.1	(14.2) U
Nursing	699.8	691.9	(7.9) U
Allied Health	54.0	55.0	1.0 F
Support	6.2	6.0	(0.2) U
Management/Administration	71.4	70.3	(1.1) U
Savings	0.0	0.0	0.0 F
Total excluding outsourced FTEs	**1,071.7**	**1,049.2**	**(22.5) U**
Total :Outsourced Services	3.6	4.5	0.8 F
Total including outsourced FTEs	**1,075.4**	**1,053.7**	**(21.7) U**

The directorate is 21.7 FTE unfavourable for the financial year primarily due to Covid as well as over-allocation of House Officers in General Medicine

7. Scorecard and Exceptions

Auckland DHB - Adult Medical Services

HAC report for February 2021

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%		2.3%
Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	PR185	2.8%		2.1%
Number of falls with major harm	PR199	0	Lower	0
Number of reported adverse events causing harm (SAC 1&2)	PR084	1	Lower	2
Unviewed/unsigned Histology/Cytology results >=30 days	PR596	11	Lower	14
% Hand hygiene compliance	PR195	**83.91%**	>=80%	85.49%
Central line associated bacteraemia rate per 1,000 central line days	PR087	**0**	<=1	0

Patient-centred

Metric		Actual	Target	Previous
% Patients cared for in a mixed gender room at midday - Adult	PR175	33.48%	Lower	45.95%
% Patients cared for in a mixed gender room at midday - Adult (excluding Level 2)	PR196	25.23%	TBC	42.07%
Number of CBU Outliers - Adult	PR173	266	Lower	266
% hospitalised smokers offered advice and support to quit	PR129	**95.23%**	>=95%	93.35%
% DNA rate for outpatient appointments - Māori	PR057	**25.37%**	<=9%	18.69%
% DNA rate for outpatient appointments - Pacific	PR058	**14.29%**	<=9%	17.12%
% DNA rate for outpatient appointments - All Ethnicities	PR056	**10.47%**	<=9%	10.53%
% DNA rate for outpatient appointments - Deprivation Scale Q5	PR338	**14.11%**	<=9%	14.18%
% Very good and excellent ratings for overall inpatient experience	# PR154	**86.4%**	>=90%	81.8%
% Very good and excellent ratings for overall outpatient experience	# PR179	**87.3%**	>=90%	89.2%
% Very good and excellent ratings for coordination of care after discharge	# PR493	**53.8%**	>=90%	20%
% Response rate to ADHB patient experience inpatient survey	# PR315	**21%**	>=25%	18%

Timeliness

Metric		Actual	Target	Previous
(MOH-01) % AED patients with ED stay < 6 hours	PR013	**81.36%**	>=95%	87.9%
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Pacific	PR330	20	Lower	10
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Total	PR328	261	Lower	141
% Urgent diagnostic colonoscopy compliance	PR044	**96.00%**	>=90%	78.43%
% Non-urgent diagnostic colonoscopy compliance	PR045	**77.80%**	>=70%	61.31%
% Surveillance diagnostic colonoscopy compliance	PR183	**76.38%**	>=70%	82.02%

Effectiveness				
Metric		**Actual**	**Target**	**Previous**
28 Day Readmission Rate - Māori	# PR079	**15.08%**	<=6%	16.73%
28 Day Readmission Rate - Pacific	# PR080	**14.56%**	<=6%	13.87%
28 Day Readmission Rate - Total	# PR078	**13.64%**	<=10%	13.58%
28 Day Readmission Rate - Deprivation Scale Q5	# PR322	**13.01%**	<=6%	14.82%

Efficiency				
Metric		**Actual**	**Target**	**Previous**
Average LOS for WIES funded discharges (days) - Acute	PR219	3.51	TBC	3.72

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 February 2021

Since the beginning of the financial year, there have been three SAC 1 events in the Adult Medical directorate. Processes to review these have begun. These include:

- Two in the Emergency Department - Ectopic pregnancy and a suicide.
- One in Gastroenterology – Fall.

Did Not Attract (DNA) rates continue to remain above the target of 9%. As part of the work on equity, this will be a core part of our plan for this year.

Cardiovascular Services

Prepared by: Joanne Bos (General Manager), Jo Wright (Nurse Director), Vaughn Woods (HR Manager) & Dawson Ward (Ngāpuhi, Ngāti Whātua; Kaiārahi Nāhi Hautū)
Speaker: Joanne Bos (General Manager)

Kuputaka : Glossary

Acronym/term	Definition
Kaiārahi Nāhi	Māori Nurse Navigator
Haūtu	Leader
NETP	New to Practice (Nurses)

1. Te Tiriti o Waitangi in Action

- **Kāwanatanga**

Development of Māori Workforce

We have 20 Māori nurses in the Directorate in addition to 4 nurses supporting Kaiārahi Nāhi. This number is relatively stable with some fluctuation related to staff turnover in the NETP workforce. 63% of Māori nurses are level 1 and 2 and 37% are level 3 or 4. We have 4 Māori nurses in senior roles with 2 senior nurses in secondment to the Kaiārahi Nāhi team.

We have been holding quarterly hui for Māori nurses for just over a year. These hui are run by our senior Māori nurses. The directorate supports this by providing a room, clerical support for coordination and kai. These hui are well attended. The outputs are disseminated to the Nurse Director and improvement initiatives are prioritised. We are currently assessing performance conversation completion rate, recruitment and levels of practice and how we can support Māori nurses to progress through the levels.

Through these hui, it was identified that our recruitment process could better support Māori. Working in partnership, Māori employees, the Nurse Director, HR and Recruitment have created a plan to enhance our recruitment initiatives. This plan is three pronged, focussing on (1) attracting Māori applicants (the directorate only received two Māori applications for the months of November, December and January combined), (2) improving our selection process and (3) ensuring a great start to the employment journey of Māori personnel. The working group has meet twice and will continue to meet on a monthly basis to report back on work completed, improvements and further development opportunities.

As an outcome of these hui, an initiative has been established to review the advancement of Māori nurses to senior roles. As part of this work, we plan to compare the time taken to advance through nurse levels between Māori and Non-Māori employees and ensure that there is no difference in the time taken to advance between levels for Māori employees. Where Māori nurses haven't advanced, they will be engaged supportively to identify if they desire to advance and how the organisation could support them to do so.

Staff Education

The directorate has focused on all staff completing the Te Tiriti o Waitangi mandatory training, with the aim of having 80% completed by the end of the financial year. In addition to this, the directorate leadership team has agreed to introduce an annual grand round, specificaly focused on educating staff about Te Tiriti o Waitangi. This will be lead by Māori staff members.

A regular agenda item is now included on the Quality Board agenda to educate the directorate leadership team about Te Tiriti o Waitangi and the key concepts of Māori culture, also led by Māori staff within the directorate.

- **Tino Rangatiratanga**

Dawson Ward (Ngāpuhi, Ngāti Whātua ; Kaiārahi Nāhi Haūtu and CVICU Nurse Specialist) has been invited to attend monthly directorate board and quality meetings to provide input and to inform the group about tangata whaiora Māori needs, the Kaiārahi Nāhi work and insights, and to educate the group regarding Māori culture and tikanga.

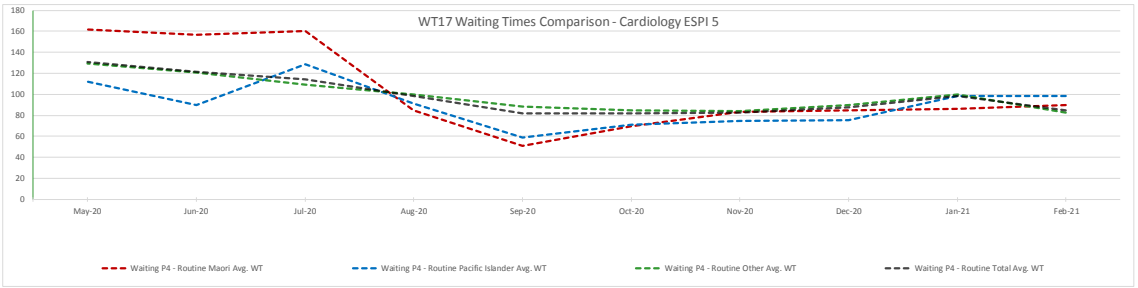
Regular hui have been established for Māori nurses, providing a forum for whanaungatanga and manaakitanga as well as to look at issues specific to this workforce, professional development and ideas for improved processes for Maori patients. If assistance is required, the nurse Director is asked to support. For example, a wider forum, including HR, was established to provide a working forum that could look at recruitment and levels of practice as an outcome of the last hui. This work is underway.

The Regional Cardiac Network has invited a Māori representative to be part of the core group to provide Māori input into regional service development and decision making.

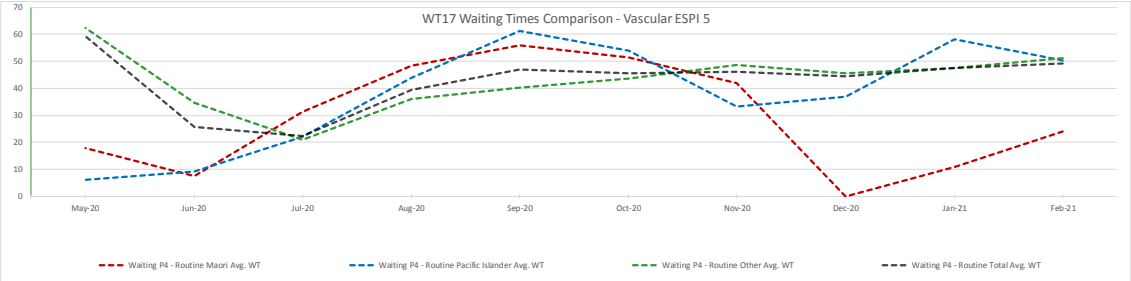
- **Ōritetanga**

The directorate has implemented an equity adjustor for planned care for Māori patients referred to the Cardiology and Vascular Services. This has resulted in elimination of the historical discrepancy in waiting times for Māori waiting times and other ethnicities as shown in the graphs below. No adjustor has been applied to cardiothoracic surgery due to the small numbers on the waitlist. However, the waiting times for Māori are monitored to ensure that there is no discrepancy in wait times as per the graph below.

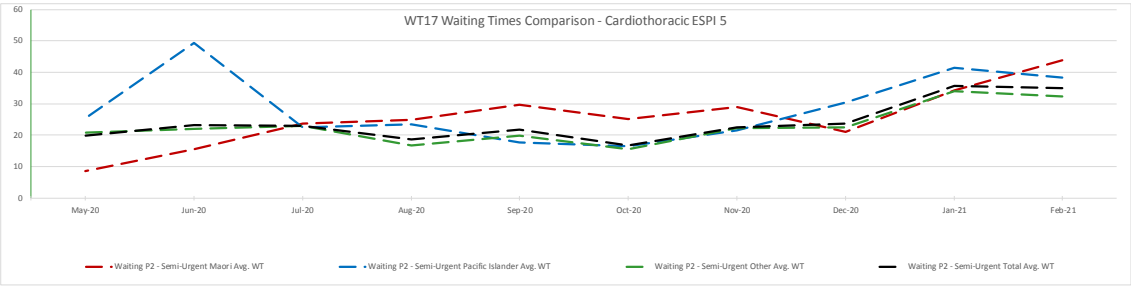
Average Waiting Times for Cardiology Patients – Routine Procedures



Average Waiting Times for Vascular Patients – Routine Procedures

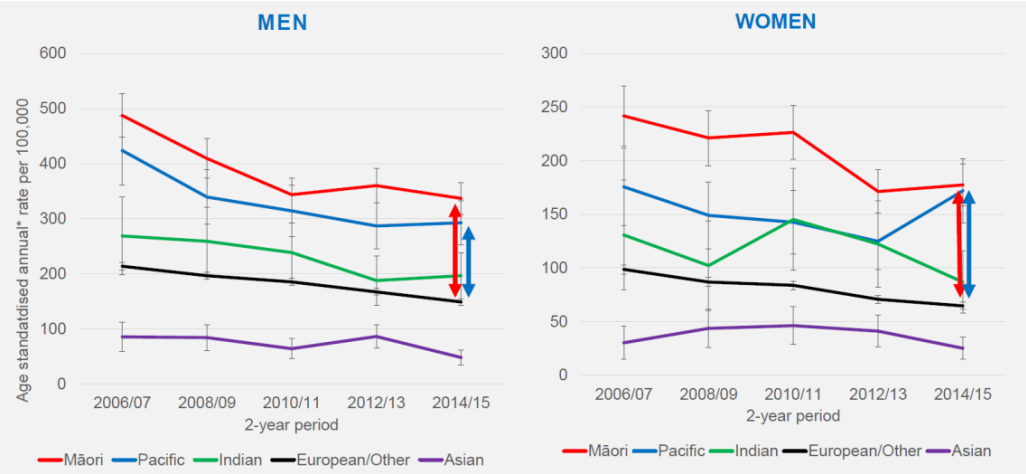


Average Waiting Times for Cardiothoracic Surgery – Semi-Urgent



The Regional Cardiac Network has a regional service plan that includes the development of plans to promote equity of cardiac outcomes across ethnicities in the northern region. This includes Cardiac Surgery, Rheumatic Heart disease, Heart Failure and timely access to investigations and therapy. This recognises that the mortality rates for Māori (and Pacific) patients with coronary heart disease have historically been higher than for other ethnicities (see graphs below).

The agreed first initiative for the regional cardiac network is to develop a co-ordinated approach to anticoagulation following cardiac surgery for young people with Rheumatic Heart Disease, which almost universally affects Māori (and Pacific peoples).



- **Te Ritenga**

The directorate now routinely includes karakia at the beginning and end of all directorate management meetings and is introducing a regular item on the directorate Quality and Governance

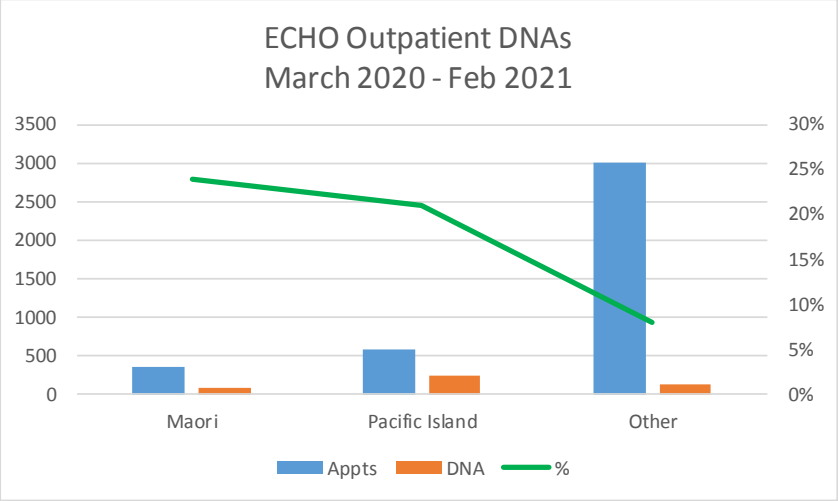
meeting agenda for education on key concepts of Māori culture, led by Māori staff within the directorate.

A plan is being developed to establish a quarterly welcome ceremony for new staff in the directorate. Māori staff will be consulted to provide input into this ceremony so that it appropriately reflects Māori cultural practices and values.

2. Eliminate Inequity

As outlined above, an equity adjustor has been applied to the Cardiology and Vascular surgical waitlists and this has been successful in eliminating the historical discrepancy in waiting times for Māori and Pacific patients and other ethnicities. Work is underway at the organisation level to develop a similar adjustor for outpatient and diagnostic waitlists and the directorate is keen to introduce these as soon as approval is given.

The proportion of Māori and Pacific patients who we fail to attract for outpatient echocardiogram appointments is very high at 24% and 21% respectively (see graph below). The service is working with the Performance Improvement team and the Kaiārahi Nāhi and Pacific Navigator teams to understand the barriers and develop solutions to address them.



The Regional Cardiac Network is supporting Counties Manukau Health and Northland DHB to commission additional catheter lab capacity to improve access to diagnostic angiograms and cardiac interventional treatment for their patients. For Northland DHB, which has a high Māori population, this will allow many patients to receive treatment in Whangārei, reducing the barriers to access caused by the cost and inconvenience of travel to Auckland that exist today. The Cardiology Service is working with Northland DHB to provide training and SMO support and with Counties Manukau DHB to provide catheter lab capacity during a period when their current lab is expected to be out of operation.

3. People, Patients and Whānau at the Centre

A project was established in 2020 to reduce the non-attendance rate for Māori patients at our Heart Failure clinics. The project implemented the following initiatives to improve this.

- Early enquiry as to cultural needs with referral to Kaumātua/Kaiatawhai and to Te Hononga support, to act as kaiāwhina
- Heart Failure education offered to both patients and whānau; barriers to attending explored (taxi/parking vouchers where needed)
- Referrral to Te Hononga nurses and Māori social worker for assistance
- Clinic reminders at 48 hour phone call and call/text/email day prior to clinic

The aim was to reduce non-attendance at Heart Failure clinics for Māori from 19% to <15% in 20/21 FY. The current non-attendance rate is 7.5%.

Breast cancer patients who require Herceptin treatment require regular echocardiograms to monitor their heart health. Until recently all patients in the region were required to attend an appointment at the Greenlane Clinical Centre for this purpose. All patients are now able to have these echocardiograms at their DHB of domicile. This reduces the travel costs and time required to attend these appointments.

A multi-disciplinary clinic has been established for patients with Rheumatic Heart Valve Disease, 95% of whom are of Māori or Pacific descent. This allows patients to attend a single clinic that provides care co-ordination across the Cardiology, Infectious Diseases and Oral Health services. Active support being is being provided by Kaiārahi Nahi and Pacific Navigators and the Cardiac Psychology team. Patients taking warfarin after valve surgery are now able to undertake INR (international normalised ratio) blood testing at home so that they do not have to attend clinic appointments for this purpose, thereby removing a barrier to continued use of anticoagulation after valve surgery which improves outcomes and reduces risk of stroke.

4. Digital Transformation

The directorate has identified a critical risk related to the outcomes of cardiac investigation requests (e.g. echocardiograms, holter monitors and ambulatory blood pressure tests). The current paper based and non-integrated electronic processes do not provide any ability to audit appropriate receipt and sign off by the ordering clinician. The most critical need relates to echocardiograms due to the volume and potential clinical risk. Funding has been approved to replace the current echocardiogram system with the system that is used by all the other DHBs in the region and to implement the required integration to enable electronic echocardiogram order entry and signoff.

A data management team has been established within the directorate to co-ordinate the measurement of performance and change across our services and to improve access to operational, outcome and research data and insights. This brings together all staff that are supporting databases and systems and providing data analysis and aligns with the Health IT strategy for the directorates to be self-sufficient with respect to data and reporting.

5. Resilient Services

A review of the Vascular service across the region has highlighted a number of issues that indicate that there are significant vulnerabilities that could impact service provision. These include:

- SMO recruitment and retention issues, exacerbated by the impending retirement of a number of long serving staff
- Dependency on locums to maintain an on call roster
- Evidence of inequitable access to treatment, e.g., lower limb amputation rates for Māori are twice the rate of non-Māori and those living in Northland and Waitematā face long and expensive commutes to outpatient clinics for treatment.

The original driver for this review was the publication of *Model of Care: Vascular Services, by Ministry of Health* in December 2016, which recommended a regional model of care and service delivery centred on a specialist vascular centre supported by other centres providing some vascular services. The goal of this model is to improve the quality of care for patients.

The outcome of this review process was an agreement by the Regional Executive Forum to develop and implement a regional integrated multi-site model to deliver an integrated regional vascular service which is more equitable and delivers the same high quality vascular services at all DHB sites across the Northern Region; and which is also more resilient to the vagaries of current workforce recruitment and retention issues.

The implementation project for this service model is being led by the Northern Region Alliance. A recruitment process for a project manager and clinical lead has recently been completed and the project is expected to commence in early April.

6. Financial Sustainability

The directorate is significantly over budget, with a YTD position as at the end of February of $8.7M unfavourable. This is almost wholly related to a shortfall in revenue. Some of this can be attributed to reduced production during COVID-19 lockdown periods and there has been a substantial loss of revenue from patients referred from Tahiti. No patients have been referred from Tahiti in the current financial year, which accounts of $3.5M lost revenue for the current financial year.

Cardiothoracic surgery production was severely impacted by staffing issues in CVICU in January and very low demand in the first quarter but production has now improved, with cardiothoracic surgery achieving 110% of budgeted volumes in February. Vascular Surgery has achieved 95% of budgeted volumes YTD but production was impacted by SMO leave in January and February. We expect this to improve over the coming months. Cardiology volumes are at 92% of budget, which is largely due to reduced acute volumes compared with the same period last year.

Costs are largely in line with revenue – 92% of the budgeted revenue has been received against 92% of the budgeted expenditure. Expenditure is reviewed at directorate and service level meetings to identify opportunities for cost savings.

We continue to work on opportunities to reduce supply costs e.g. reviewing graft and stent usage and engaging Healthsource to negotiate rebates with suppliers. There have been a number of

procurement initiatives implemented over this and previous financial years that have provided significant benefit.

7. Scorecard and Exceptions

Exceptions

- Did Not Attract rates for Outpatient Appointments – these have reduced since the last quarter but continue to be impacted by COVID lockdowns. We are working with the Kaiārahi Nāhi and Pacific Navigator teams to identify barriers to attendance and solutions to mitigate these, for example the cost of transport to attend appointments.
- Patient Rating of Care – the directorate reviews all patient complaints and identifies opportunity for improvement. We have observed a reduction in patient satisfaction related to visitor arrangements during COVID lockdown periods.
- Elective Angiography – the demand has increased significantly since May 2020 and this has led to an increase in waiting times. However, with improved scheduling and some additional sessions, this is now improving.
- Outpatient Waitlist for Chest Pain Clinic – this clinic has been impacted by a staff retirement, which reduced capacity significantly. A replacement has now been appointed and is currently undergoing training. We are also experiencing increased demand and are developing plans to increase resource for this clinic.
- Readmission Rates – we are working with Kaiārahi Nāhi and Pacific Navigators to better support patients through their surgery and post-operative care. We are also establishing a cross-directorate working group to focus on reviewing the end to end patient pathway and patient outcomes.
- Elective Discharges – elective throughput has been impacted by an increase in acute demand, high hospital occupancy and SMO leave. We expect this to improve in the next quarter.

Scorecard for February 2021

Auckland DHB - Cardiovascular Services

HAC report for February 2021

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%		4.1%
Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	PR185	5.1%		5%
Number of falls with major harm	PR199	0	Lower	1
Number of reported adverse events causing harm (SAC 1&2)	PR084	0	Lower	2
Unviewed/unsigned Histology/Cytology results >=30 days	PR596	9	Lower	8
% Hand hygiene compliance	PR195	82.98%	>=80%	86.78%
Central line associated bacteraemia rate per 1,000 central line days	PR087	0	<=1	0

Patient-centred

Metric		Actual	Target	Previous
% Patients cared for in a mixed gender room at midday - Adult	PR175	15.5%	Lower	10.29%
% hospitalised smokers offered advice and support to quit	PR129	97.56%	>=95%	97.8%
% DNA rate for outpatient appointments - Māori	PR057	15.57%	<=9%	22%
% DNA rate for outpatient appointments - Pacific	PR058	14.79%	<=9%	18.38%
% DNA rate for outpatient appointments - All Ethnicities	PR056	8.3%	<=9%	8.28%
% DNA rate for outpatient appointments - Deprivation Scale Q5	PR338	10.66%	<=9%	12.89%
% Very good and excellent ratings for overall inpatient experience	# PR154	91%	>=90%	95.7%
% Very good and excellent ratings for overall outpatient experience	# PR179	90.2%	>=90%	90.2%
% Very good and excellent ratings for coordination of care after discharge	# PR493	80%	>=90%	100%
% Response rate to ADHB patient experience inpatient survey	# PR315	34%	>=25%	28%
Number of CBU Outliers - Adult	PR173	55	<=300	40

Timeliness

Metric		Actual	Target	Previous
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Māori	PR323	12	Lower	14
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Pacific	PR324	10	Lower	10
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Total	PR327	91	Lower	113
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Deprivation Scale Q5	PR326	18	Lower	27
Cardiac bypass surgery waiting list	PR042	79	<=115	88
% Accepted referrals for elective coronary angiography treated within 3 months	PR043	74.87%	>=90%	73.11%
Vascular surgical waitlist - longest waiting patient (days)	PR235	119	<=150	157
Outpatient wait time for chest pain clinic patients (% compliant against 42 day target)	PR236	48.57%	>=70%	50%

Effectiveness

Metric		Actual	Target	Previous
28 Day Readmission Rate - Māori	# PR079	14.29%	<=6%	6.67%
28 Day Readmission Rate - Pacific	# PR080	18.92%	<=6%	12%
28 Day Readmission Rate - Total	# PR078	11.41%	TBC	12.12%
28 Day Readmission Rate - Deprivation Scale Q5	# PR322	16.67%	<=6%	13.16%

Efficiency

Metric		Actual	Target	Previous
Elective day of surgery admission (DOSA) rate	PR048	24%	TBC	22.73%
% Day Surgery Rate	PR052	15.49%	TBC	21.31%
Average LOS for WIES funded discharges (days) - Acute	PR219	6.02		6.33
Average LOS for WIES funded discharges (days) - Elective	PR220	2.6		1.88
HT2 Elective discharges cumulative variance from target	PR035	0.77	>=1	0.79
Inhouse Elective WIES through theatre - per day	# PR053	11.84	TBC	21.2
% Adjusted Session Theatre Utilisation	PR198	88.6%	>=85%	80.3%
% Theatre Cancellations	PR218	7.41%	TBC	18.18%

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 February 2021

Clinical Support Services

Prepared by: Kelly Teague (General Manager) and Ian Costello (Director)
Speaker: Ian Costello (Director)

1. Te Tiriti o Waitangi in Action

- **Kāwanatanga**

Leadership talent mapping and development pathways have been completed, with a particular focus on our Māori staff, to actively support development into leadership positions. There has been a particular focus on staff in the non-registerable health professions category (Therapy Assistants, Lab Assistants etc.) to create leadership and career progression opportunities. We have also actively participated as a Directorate Leadership Team in the DHB Career Fair held in December 2020.

- **Tino Rangatiratanga**

Appointments in the Clinical Support Services Directorate this quarter have included 4 Māori (2 Technical; 2 Non-Clinical) staff.

Pharmacy intern interviewing is taking place in March/April 2021. In conjunction with the School of Pharmacy, University of Auckland (UoA), Māori candidates have been prioritised to attend the assessment centre, supported by UoA Māori advocates. One of the intern positions has been identified for a Māori candidate only.

The Directorate is in the process of identifying champions for Māori patient and staff experience and support. The role of our champions will include implementing the five truths of a gold standard Māori patient / whānau experience, monitoring Māori workforce participation and progression in our Directorate and applying Te Reo and Tikanga across our Directorate which includes the capability of our workforce to correctly pronounce Māori names and words.

All services are engaged in the Rangatahi programme, with active participation in school visits, career open days and work experience for students.

- **Ōritetanga**

Radiology has a Greenbelt project underway to understand options to better support patients to attend diagnostic imaging appointments, with a particular focus on Māori patients.

- **Te Ritenga**

Dame Nadia Glavish has been working with the Contact Centre team to provide greetings messages on all automated phone messages in Te Reo Māori which went live from mid-January 2021.

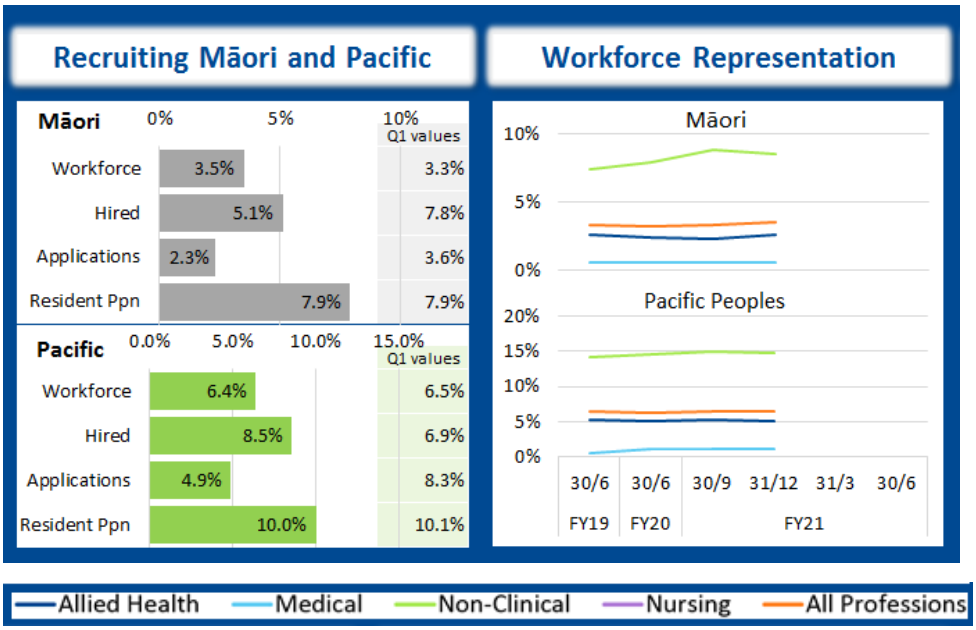
A review of Māori language options has been completed in the Patient Administration Service, with the aim of enabling all patients and whānau to converse in the language of their choice with our contact centre and bookers and schedulers. A strategy to recruit staff with appropriate languages in underway.

During Te Wiki o Te Reo Māori, some teams started their meetings in Te Reo. As a Directorate we see an opportunity to support our teams to be involved in Tikanga in Practice and Te Tiriti o Waitangi

in practice training sessions which are available through Te Toka Tumai, and to encourage the use Te Reo Māori routinely in our business.

2. Eliminate Inequity

- A Greenbelt project is being undertaken in Radiology to understand how Māori and Pacific Did Not Attract rates can be improved.
- All of our clinical and patient facing services, and in particular Radiology, PAS and Allied Health, are actively engaged in the Māori and Pacific Fast Pathway Planned Care Response.
- The Patient Access, Booking and Choice policy for Te Toka Tumai is being reviewed at present by members of the Māori & Pacific Fast Pathway Planned Care Regional Response. The updated policy will be implemented by Clinical Support Services once revised.
- The Leading for Equity training programme has been completed by 21 managers, with another 20 managers in progress for completion. A focus is for all people managers to complete this course next quarter.
- A joint approach to recruitment has been developed with Patient Management Services to enable career development and carrer change from entry pathways. Pathways have been agreed, prioritising Māori and Pacific staff recruitment. Initial advertisement for appropriate positions will be to the Patient Management To Thrive groups only.
- Demonstrated in the diagram below is the directorates update in relation to Māori and Pacific recruitment over the last quarter.



3. People, Patients and Whānau at the Centre

- As a Directorate we see an opportunity to support our teams to be involved in Te Tiriti o Waitangi in practice training sessions which are available through Te Toka Tumai. All services have a target to ensure their staff have completed the training and the leadership team have been asked to develop a strategy for their service for implementation from June 2021.
- Review of language availability and interpreter services underway, with the aim of enabling patients and whānau to converse in the language of their choice with our contact centre and bookers/schedulers.

4. Digital Transformation

Laboratory Demand Stewardship

LabPlus provide over 1000 different types of laboratory test, delivering at total of 4.6 million tests per annum at an average direct test cost of $6. Studies typically identify a significant number of hospitalized ordered tests are repeated, over-utilised and simply unnecessary and could be eliminated. The laboratory service is implementing three key initiatives to reduce unnecessary testing:

- The implementation of electronic ordering to optimise ordering decisions. A detailed business cases is in development.
- The development of dashboard reporting to support referring services identify areas of over ordering based on standard testing patterns for hospitalised patients.
- The development of a clinical governance to provide diagnostic stewardship for new test development.

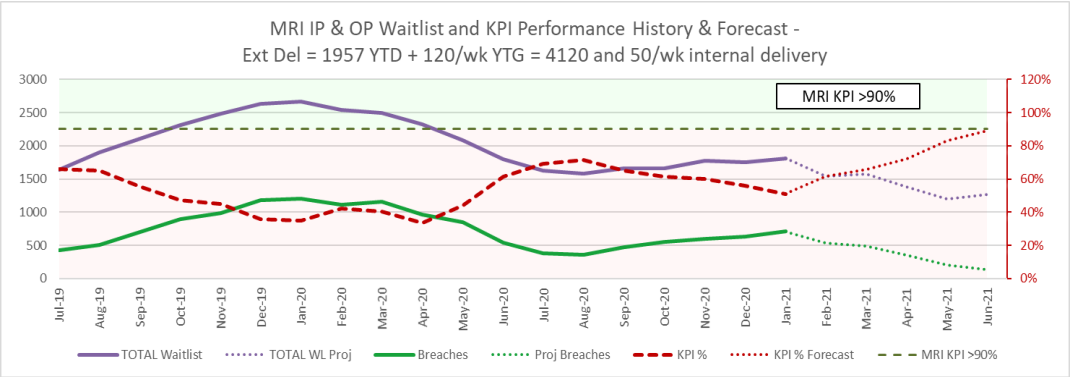
CCDM – Allied Health

- The CCDM program was updated and re-launched a year ago. With vastly improved staff compliance, CCDM is now increasingly being used for Variance Response Management (VRM) and allocation of resources based on prioritisation guidelines. This is currently used in both the adult and paediatric inpatient services.
- The challenge for a fully-fledged implementation of CCDM in Allied Health is resourcing, as we are dependent on staff input for data sourcing and on line managers thereafter for review and decision making.
- There is an oversight group chaired by the CHPO, relevant AHD's, SCD's and a liaison from TAS.

5. Resilient Services

2020/21 Planned Care – Year to Date performance

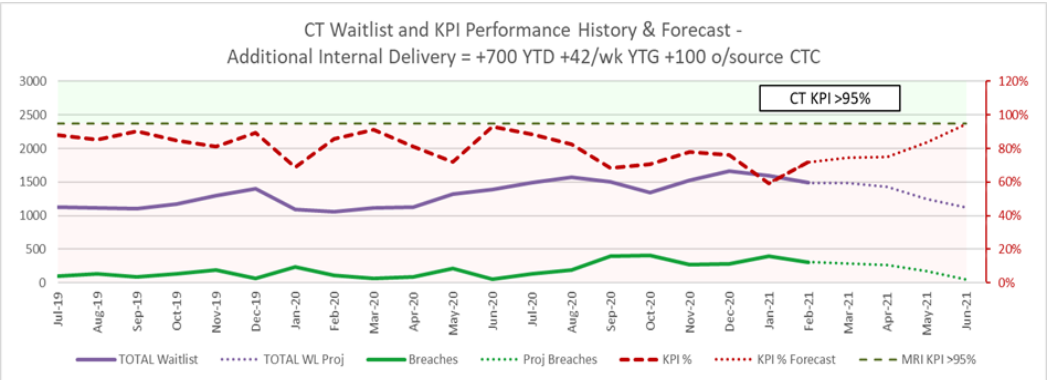
Magnetic Resonance Imaging



The above trajectory states that we will meet the 90% MOH target of treating all outpatients within 6 weeks by 30 June 2021. This is subject to the following:

- The private providers can deliver the additional volumes – currently 500 under performing against plan year to date.
- Cardiac MRI is compliant – Cardiac have recently lost a session on the CAMRI magnet (above contracted sessions) and the options available are to undertake additional Saturday sessions (discussions currently underway with the Cardiologists) and to take an additional two sessions from General MRI. An additional 160 MRI's will need to be outsourced as a result of losing these two CAMRI sessions. On 19 March 2021 at the planned care meeting Radiology received approval to outsource the 160 additional scans and for Cardiac to undertake Saturday sessions.

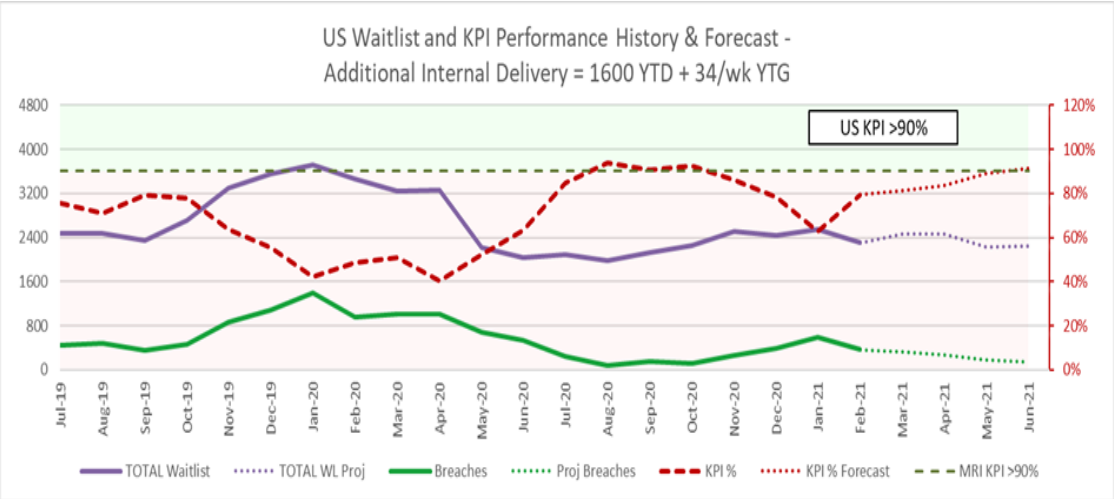
Computerised Tomography



The above trajectory states that we will meet the 95% MOH target of treating all outpatients within 6 weeks by 30 June 2021. This is subject to the following:

- Outsource 100 CTC examinations which is additional to the 615 CT scans as originally projected due to demand.
- Outsource an additional 200 CT scans by 30 June 2021 should the demand continue to increase.

Ultrasound



Additional sessions are being undertaken to meet the planned care recovery volumes and there are currently no issues in relation to meeting the projected compliance by 30 June 2021 as demonstrated in the above trajectory.

Patients not being added to the waiting list/being lost to follow up

As a result of an adverse incident review in March 2021, the Operations Manager, PAS service has been asked to write a business case to describe the residual short and long term risk, and the resources necessary to mitigate that risk, of surgical wait list forms going missing. The risk of lost forms is that patients are not transferred to the surgical waiting list. The case will describe the scale and scope of the risk and the resources what to manage the manual review and validation of the data quality reports.

6. Financial Sustainability

Auckland DHB - Clinical Support Services

Statement of Financial Performance for February 2021

Month end YTD result excluding abnormal COVID revenue and expenditure

($000s)	MONTH			YEAR TO DATE (8 months ending Feb-21)		
	Actual	Budget	Variance	Actual	Budget	Variance
REVENUE						
Government and Crown Agency	1,565	1,645	(80) U	13,003	14,660	(1,657) U
Funder to Provider Revenue	3,712	3,718	(6) U	31,525	31,061	463 F
Other Income	3,286	3,261	25 F	31,614	26,090	5,524 F
Total Revenue	**8,563**	**8,624**	**(61) U**	**76,142**	**71,812**	**4,330 F**
EXPENDITURE						
Personnel Costs						
Medical	3,610	3,778	(168) U	31,892	31,479	(413) U
Nursing	244	271	(27) U	2,112	2,202	90 F
Allied Health	6,252	6,328	(76) U	52,059	53,115	1,056 F
Support	0	0	0 F	12	0	(12) U
Management/Adminstration	1,622	1,593	29 F	13,839	13,435	(404) U
Savings	0	0	0 F	0	0	0 F
Total Personnel Costs	**11,728**	**11,970**	**(242) U**	**99,914**	**100,231**	**317 F**
Outsourced Personnel	23	30	7 F	425	243	(182) U
Outsourced Clinical Services	952	875	(78) U	8,537	7,142	(1,396) U
Clinical Supplies	4,030	4,055	25 F	35,254	34,223	(1,031) U
Infrastructure & Non-Clinical Supplies	2,506	2,407	(99) U	23,275	19,359	(3,917) U
Total Expenditure	**19,239**	**19,337**	**98 F**	**167,405**	**161,197**	**(6,208) U**
Contribution	**(10,676)**	**(10,713)**	**37 F**	**(91,264)**	**(89,386)**	**1,878 F**
Allocations	(8,628)	(8,985)	(357) U	(77,834)	(75,957)	1,877 F
NET RESULT	**(2,048)**	**(1,728)**	**(320) U**	**(13,429)**	**(13,429)**	**(1) U**

Paid FTE

	MONTH (FTE)			YEAR TO DATE (FTE) (8 months ending Feb-21)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	153.0	154.6	1.6 F	152.8	154.7	2.0 F
Nursing	31.6	32.9	1.3 F	31.2	32.5	1.3 F
Allied Health	918.2	936.7	18.5 F	907.8	932.1	24.3 F
Support	0.0	0.0	0.0 F	0.3	0.0	(0.3) U
Management/Administration	298.3	279.7	(18.6) U	292.3	279.3	(13.0) U
Savings	0.0	0.0	0.0 F	0.0	0.0	0.0 F
Total excluding outsourced FTEs	**1,401.2**	**1,403.9**	**2.8 F**	**1384.3**	**1,398.6**	**14.3 F**
Total :Outsourced Services	2.7	2.1	(0.6) U	3.8	2.1	(1.7) U
Total including outsourced FTEs	**1,403.8**	**1,406.0**	**2.2 F**	**1388.1**	**1,400.7**	**12.6 F**

Comments on major financial variances

February YTD result excluding abnormal Laboratory COVID items is very close to budget at $1K U. This is made up of offsetting variances summarised below.

1. Personnel costs including outsourced were $135K F to budget. This is due to vacancies across the directorate. A number of vacancies in Laboratories are due to the delay in the roll out of the National Bowel screening (FIT testing) contract.
2. Outsourced Clinical Services were $1,396K U. The main contributor is MRI scans in Radiology and send-away work in Diagnostic Genetics. The $470K overspend in Radiology is partially offset by additional revenue of $267K received from the Ministry. Additional planned care

outsourcing is the balance. The work to repatriate some of the diagnostic genetic work has been delayed due to COVID and the time taken to train staff.

3. Clinical Supplies are overspent across the directorate mainly due to additional volumes in Radiology, offset by favourable internal income reflected in 'Allocations'.
4. Infrastructure and Non Clinical Supplies were $ 3,917K U. This is mainly in our Retail Pharmacy and is offset by revenue. A funding change by Pharmac for some high dollar value drugs is the main contributor.
5. Revenue is $4,330K F. $4,886 K relates to Pharmacy and is offset by costs of goods sold and clinical supplies.

7. Scorecard

Auckland DHB - Clinical Support Services

HAC report for February 2021

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*	0	Lower	3

Timeliness

Metric		Actual	Target	Previous
% Outpatients and community referred MRI completed < 6 weeks	*PR046*	**63.91%**	>=95%	51.1%
% Outpatients and community referred CT completed < 6 weeks	*PR047*	**71.82%**	>=95%	59.36%
% Outpatients and community referred US completed < 6 weeks	*PR229*	**79.3%**	>=95%	62.8%

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.

Radiology

Performance against the MRI target of 90% of referrals completed within six weeks has improved for month end February 2021 to 63.9 % compared to 51.1% for month end January 2021.

Cardiac MRI:

Cardiac Adult MRI is showing 38.1% compliance for month end February 2021 which has improved from 31.5% at month end January 2021 for MoH reporting. The number of adult cardiac patients on the waiting list waiting longer than 42 days is 60 at month end February, a slight reduction from 67 at month end January, with the total waiting slightly decreasing from 107 at month end January to 104 at month end February.

In order for Cardiac MRI to be compliant against the target at the end of June 2021, additional Saturday sessions on the CAMRI magnet plus taking over 2 of the general MRI sessions on the CAMRI Magnet. As at 19 March 2021 Saturday sessions for Cardiac were approved alongside an additional 160 outsourced MRIs (displaced general MRIs as a result of Cardiac utilising the general MRI CAMRI sessions).

Cardiac Paediatric MRI is showing 47.1% compliance at month end February which has improved from 13.9% at month end January. The number of paediatric cardiac patients on the waiting list waiting longer than 42 days is 14 at month end February, a reduction from 21 at month end January. The total waiting is unchanged at 27.

Non-Cardiac MRI:

The number of MRI MIT vacancies has reduced as a result of increasing the number of trainees. We have increased our weekly outsourcing volumes since December 2020 (58 per week budgeted within the current financial year's budget and additional scans for the MoH Planned Care funding (a total of 1326 scans funded until 30 June 2021). At the end of January 2021, 325 of the 1326 additional outsourced scans have been completed. The challenge remains with the additional capacity being available in the private sector.

Adult MRI is showing 70.2% compliance for month end February which has improved from 56.1% at month end January for MoH reporting. The number of adult patients on the waiting list waiting longer than 42 days is 103 at month end February compared with 186 at month end January with the total waiting decreasing from 638 at month end January to 561 at month end February.

Paediatric MRI is showing 49.5% compliance at month end of February which has improved from 43.0% at month end January for MoH reporting. The number of paediatric patients on the waiting list waiting longer than 42 days has increased slightly from 70 at month end January to 79 at month end February with the total waiting also showing minimal increase from 133 at month end January compared to 144 at month end February. The majority of these patients are procedures under GA and we are currently working with Paediatric Anaesthetics to see if the scheduling of additional GA sessions is an option.

CT:

Performance against the MoH indicator of 95% of out-patients completed within six weeks has improved to 71.8% compliance at month end February compared with 59.4% at month end January for MoH reporting. As previously identified, weekly reporting for Adult CT although showing no significant issues, we remain non-compliant with the MoH monthly reporting and is reflective of a

service at capacity. An additional 100 CTC examinations (above the 615 scans approved by the MoH) will need to be outsourced in order to be complaint with the target at the end of June 2021 and there is a potential for a further 200 scans to be outsourced (300 in total) should demand continue to increase.

CT continues to grow at 8% per year. For the last 18 months additional appointments have been squeezed in, however current capacity is now insufficient.

Adult CT is showing 70.5% compliance at month end February which has improved from 57.7% at month end January for MoH reporting. The number of adult CT patients on the waiting list waiting longer than 42 days was 0 at month end February decreasing from 2 at month end January with the total waiting increasing from 306 at month end January to 414 at month end February.

Paediatric CT is showing 91.2% compliance at month end February which has improved from 82.5% at month end January for MoH reporting. The number of paediatric patients on the waiting list waiting longer than 42 days was 0 at month end February decreasing from 6 at month end January with the total waiting decreasing from 36 at month end January to 30 at month end February. We are now scheduling 3 adult patients per day on the Starship CT scanner to assist with reducing the Adult CT waitlist.

USS:

There is an internal target (95%) as we are mindful of the importance of patient access to service and safe waitlist management.

Performance against this target has improved from 62.8% at month end January to 79.3% at month end February for MoH reporting.

The number of adult USS patients on the waiting list waiting longer than 42 days has decreased significantly from 191 at month end January to 52 at month end February with the total waiting increasing slightly from 744 at month end January to 764 at month end February.

Paediatric USS is showing 97.3% compliance at month end February compared with 93.0% at month end January for MoH reporting. The number of Paediatric USS patients on the waiting list has decreased from 1 at month end January to 0 at month end February with the total waiting slightly increasing from 15 at month end January to 42 at month end February.

Recovery plans across MRI, CT and Ultrasound remain in effect with week by week reduction in patients waiting longer than 6 weeks and also reduction in the total waiting.

Pathology and Laboratory Medicine

Laboratory Demand Stewardship

LabPlus provide over 1000 different types of laboratory test, delivering at total of 4.6 million tests per annum at an average direct test cost of $6. Studies typically identify a significant number of hospitalized ordered tests are repeated, over-utilised and simply unnecessary and could be eliminated. The laboratory service is implementing three key initiatives to reduce unnecessary testing:

- The implementation of electronic ordering to optimise ordering decisions. A detailed business cases is in development
- The development of dashboard reporting to support referring services identify areas of over ordering based on standard testing patterns for hospitalised patients
- The development of a clinical governance to provide diagnostic stewardship for new test development

Leadership redesign

Consultation for a proposed redesign of the scientific and technical leadership structure has commenced. A decision on this proposal is due 3 May. The proposal is based on the principle creating a structure that can accelerate the adoption of new technology and ways of working for improved efficiency and clinical effectiveness.

COVID19 Testing

LabPlus continues to play an important role in the regional COVID19 testing programme. Current daily demand averages 1000 tests and surges to 3000 in peak periods, while achieving TAT of 24hrs. A new high throughput analyser is current currently being installed to further enhance test efficiency and service resilience. In addition, the service is planning an expansion of molecular laboratory space to cope with further surges.

Laboratory Space

With the rapid expansion of molecular work (including COVID testing) and equipment, coupled with more stringent health and safety and hazardous substances regulations, the laboratory space has reached capacity. This is likely to result in corrective actions issued by IANZ at the next inspection. The laboratory is working internally to provide solutions to space constraints, by re-purposing meeting rooms and staff tea-rooms, however options for expansion beyond the current footprint will be required in 3-5 year time horizon.

Anatomical Pathology (Community)

Increasing inbound specimen volume to Anatomic Pathology Services continues to outstrip our reporting capacity and catch-up opportunities are becoming successively more difficult. This is leading to a delay in turnaround times of up to 5 days. Clinically urgent cases are being prioritised in addition to exploring additional capacity, including further referral of cases to outside labs. Overseas pathologists are recruited into vacancies but have not yet arrived.

Diagnostic Genetics

Recent changes in key personnel and significant changes in type, volume and complexity has resulted in delays to reporting in some sections of diagnostic genetics. In addition global supply of reagents has impacted TATs in molecular genetics in February. Recruitment plans will help stabilise the service in part however job sizing indicates the need for and workforce expansion to keep pace with the rapid growth in demand and complexity for this service.

Adult Community and Long Term Conditions

Prepared by: Jackson Cutting (General Manager, Adult Community and Long Term Conditions)
Input by: Dr Jo Lambert (Senior Medical Officer, Sexual Assault Assessment and Treatment Service), Dr Anne Laking (Senior Medical Officer and Service Lead Clinician, Sexual Assault Assessment and Treatment Service)
Speaker: Sam Titchener (Director, Adult Community and Long Term Conditions)

Kuputaka: Glossary

Acronym/term	Definition
CLTC	Community and Long Term Conditions
Hinengaro	Mental and emotional wellbeing
Kaimahi	Worker, Employee, Staff member
Mahi	Work
Mātauranga Maori	Māori knowledge
Pūmanawa Tāngata	The name for the People Plan for Te Toka Tumai
Rangatahi	Youth, younger generation
Rōpū	Group
Taha tinana	Physical manifestations of illness
Taha wairua	The spiritual dimension

1. Te Tiriti o Waitangi in Action

Tē tōia, tē haumatia. Nothing can be achieved without a plan, workforce and way of doing things.

Adult Community and Long Term Conditions (CLTC) acknowledge it is at the beginning of a journey to ensure we honour and uphold Te Tiriti o Waitangi. We have a significant amount of work to undertake before all the services we provide are fit for purpose for whānau Māori. Reflecting on the opening proverb, the Directorate Leadership Team is committed to developing a cohesive plan which delivers on our commitments under Te Tiriti. It is our intent that our workforce reflects the communities we serve and that we embed a way of doing things in CLTC that it underpinned by Mātauranga Māori. We are pleased to share some of the work we have started on our journey and the purposeful direction we will take in the future. Within the broad range of services delivered by CTLC there are a number of Services which have progressed further in their journey to deliver on our commitments to Te Tiriti o Waitangi. Within this update is our intent to showcase the Pōhutukawa Clinic (Adult Sexual Assault Assessment and Treatment Service -SAATS) as an example of where we want to be as a Directorate in the future.

- **Kāwanatanga (Governance)**

We are committed to establishing the role of a Māori Health Lead who will be part of the Directorate Leadership Team. The Māori Health Lead will be a decision maker within the Directorate and be provided with dedicated time, resources and operational space to undertake the necessary mahi. It is our intent that the Māori Health Lead will be supported by a Māori rōpū consisting of kaimahi from within the Directorate and key business partners who share a Māori world view. Given the early stages in our Directorates' journey we intend to focus on services where we have received patient feedback and the outcome data indicates a need for reinvention to be fit for purpose for whānau Māori. These services are the Diabetes Service, the Auckland Regional Sexual Health Service and components of Reablement and Community services which support transitions from home to

supported living and on to aged residential care. These areas will form part of our Directorate Business Plans and are seen as key areas of opportunity for service design by Māori for Māori.

- **Tino Rangatiratanga (Autonomy; Self-Determination)**

Critical to Tino Rangatiratanga is the recognition that true autonomy can only be realised with actual decision making authority. In a health setting one of the ways this is reflected is through control over care pathway design and review. It is the intent of CLTC to undertake a critical pathway review in services where significant inequity of outcomes exists. This review will occur under the oversight of the Māori Health Lead and be informed by consumer representatives. Of particular focus in the year ahead is a review of locations for the delivery of regional outpatient clinics in the Auckland Sexual Health service and satellite clinics for the Auckland Diabetes Service.

Community Services has set up a Māori network meeting. This is the Directorates' first step towards building a decision making body driven by kaimahi Māori in shaping services design for whānau Māori. The Community Service has also commenced the implementation of the Intermediate Care Service Change. This change is being undertaken to ensure improved access to home based care options and to reduce inpatient hospital stays. One of the changes includes extended opening hours of the service which enables flexibility for whānau to support transitions of patients back to their homes. It also gives whānau confidence that older adults are safe and supported outside of an inpatient hospital setting in the initial period post discharge. We have engaged consumer and a kaimahi Māori representative in the Steering Group to support this work.

- **Ōritetanga (Equity)**

Within our Pūmanawa Tāngata aspirations is a commitment to develop our workforce to better represent the community we serve. We are currently part of a pilot programme in partnership with the Recruitment Team to ensure that all Māori candidates who are shortlisted for roles are offered pre-interview advice to ensure the best possible opportunity to share their story and lived experience. We intend to undertake a programme of up-skilling of leaders around how to interview in a way that recognises a candidates' lived service and experience, rather than framing an interview through a Pākehā/non-Māori structure and values system. We actively support the Rangatahi cadetship programme with a robust learning experience provided across the Directorate. In the past two internship programmes, Rangatahi have undertaken placements within a number of services across the Directorate. We have received positive feedback as to the value of the range of experience in CLTC in shaping their career journey in health.

The Directorate will make Māori Health, treatments and outcomes a standing agenda item for all clinical governance meetings at both Directorate and Service level. This deliberate action recognises that improvements to Māori Health outcomes must form part of strategic clinical decision making and can result in improvements for all health outcomes. Currently the Hospital Palliative Care and the Auckland Regional Pain Service (TARPS) have embedded Te Whare Tapa Whā in their care delivery. It is the intent of the Directorate Leadership team to leverage the success of these services in ensuring our care models incorporate a recognition of the importance of balance between treating the physical manifestations of illness (taha tinana) and taha wairua (spiritual wellbeing), whānau participation and hinengaro (mental and emotional wellbeing).

The Pōhutukawa Clinic is developing resources in conjunction with other Māori Health/support organisations including Tu Wahine, Te Rau Ora and Te Whāriki Takapou. A key leader in this work is

Dr Jo Lambert who is part of the Kahui Hononga hui, which meets regularly to discuss Māori Health issues and offer support to Māori employees. Part of this role has also been supporting a Pōhutukawa Clinical Nurse Specialist in her studies towards a Diploma in Health Science specialising in Māori Health.

The Community Services Needs Assessment and Service Co-ordination (NASC) team have undertaken to incorporate education on the Meihana method as part of all NASC on-boarding and on-going training. This will support the InterRAI needs assessment process to be culturally appropriate and responsive to Māori needs.

- **Te Ritenga Māori (Protection of Customs and Practices)**

The Directorate acknowledges there is a long journey to fulfil our obligations to uphold Te Ritenga. As a starting point we have ensured karakia forms part of directorate leadership level meetings and a number of service level meetings. It is the Directorate's intent to seek to replicate the achievements in services such as the Pōhutukawa Clinic in terms of ensuring Ritenga Māori is practiced in all parts of the patient experience.

In the Pōhutukawa Clinic (SAATS), Tikanga Māori is embedded in all parts of the patient experience for forensic services, using the Pōwhiri model of welcome and care with all service users, independent of ethnicity. Introductions, food, tapu space (forensic room) and offer of shower (cleansing) to bring back to noa, are integral to the care pathway within the Pōhutukawa Clinic. Tikanga Māori is considered when changing clinical and non-clinical environments. We store and refrigerate patient and staff food separately from changing areas or where scrubs are kept. Coloured pillows designate head or body use only. A karakia is offered to patients who identify this as something important at their initial welcome, before or during examinations and at closing. The clinic is blessed regularly by Te Toka Tumai Kaumātua, to assist in their commitment to ensure that this is a place of safety and healing for all.

We continue to normalise the use of Te Reo Māori in both the clinical and non-clinical spaces. Te Reo is encouraged in formal and informal written correspondence with a number of service level weekly staff communications being entitled Kia Mārama, a name endorsed by our Chief Advisor Tikanga, Māori Health. We welcome new kaimahi with a mihi whakatau in a number of services and will work to build confidence in practice across the Directorate in the coming year. We are also working with kaimahi to incorporate Māori Health as part of future professional education and will ensure research decisions are informed by a need to address inequity in outcomes.

2. Eliminate inequity

We are steadfast in our desire to institute a number of deliberate, practical measures to reduce (with a view to eliminate) inequity. Our strategy can be broken down into three parts. Firstly, our people understand what inequity means; secondly we can identify drivers of inequity in patient outcomes and thirdly we work with Māori to design and deliver interventions to eliminate inequity.

As a first stage, all people leaders within the directorate are required to complete equity training as part of the Management Development Programme by June 2021. At present 47% of people leaders have completed the module along with 11 senior kaimahi with a number of staff in progress to be completed by end of financial year.

Work is underway to ensure all new business intelligence reports include ethnicity measures and we are working to update legacy reports over the course of the next 12 months to ensure we can see where inequity is occurring.

We have commenced a review of outpatient clinic locations following patient feedback regarding barriers to access. Initially there will be a focus on the Auckland Sexual Health Service, Adult Community Services and the Diabetes Services. The intent is to transition additional services to the DHB Point Chevalier site and relocate the West Auckland sexual health clinic from New Lynn to the Henderson Central Business District by the end of 2021.

We are committed to review all care pathways in the next two years to understand the drivers of inequality and intervene to address these. Presently there is inconsistent application of prioritisation methodology where priority risk ratings are increased for Māori and Pasifika patients across the Directorate. Significant work needs to be completed to understand the efficacy of this broad "one-up" type adjuster both in Specialist Outpatient Services and community services.

- *Diabetes - Care Co-ordinator and a fit for purpose service*

A role was designed and implemented in the Diabetes service in 2019, the purpose of the role was to support Māori and Pasifika patients across the care pathway which in turn would improve health outcomes and reduce inequities.

An internal evaluation has been completed of the Diabetes Care Co-ordinator role with significant improvement in the number of healthy days experienced by the patients as evidenced in a 57% reduction in hospital admissions for the patient group over the reviewed period.

This dedicated non-clinical role works closely with Māori and Pasifika aged under 25 living with Diabetes. The Co-ordinator is purposed to support the service to better engage with both the patients and whānau across the care pathway. The Care Co-ordinator works closely with Fale Wha group in Diabetes to ensure service development incorporates both a Pasifika and Māori world view.

As part of improving the delivery of diabetes services to whānau Māori, the Clinical Nurse Specialist Kaiārahi Nāhi have presented at monthly service meetings. This engagement has supported the wider team to understand that all members of the service have a role to play in making the service fit for purpose for Māori. This workforce development will be further supported through all staff in the Diabetes Service completing unconscious bias education this year.

The Diabetes Service is also trialling provision of diabetic retinal screening on Saturdays to improve and support access for services. This has been well received by patients and has resulted in increased attendance when compared with weekday offerings. Further investigation will be undertaken in the coming months to determine if this should become a standard part of the Diabetes Service care delivery model.

- *Pōhutukawa Clinic (SAATS) - Service development*

One of the Pōhutukawa Clinics' main goals is to improve access to therapeutic medical examinations after an alleged recent or past sexual assault or abuse. The service is aware of a significant unmet need for these types of examinations and this unmet need is most prevalent in Māori and Pasifika ethnicities. The service is currently focusing on training all Pōhutukawa Clinic Nurses to perform these complex assessments with a future goal being to offer nurse-led clinics in the community.

In liaison with Medical Sexual Assault Clinicians Aotearoa (MEDSAC), New Zealand Police and the Ministry of Health, the service is currently engaged in the development of a non-fatal strangulation pathway to offer expert forensic and therapeutic medical care to patients who have been strangled and not sexually assaulted. This care pathway is in its early development phase and will support holistic care for priority patients and be informed by the principles of Te Whare Tapa Whā.

3. People, Patients and Whānau at the Centre

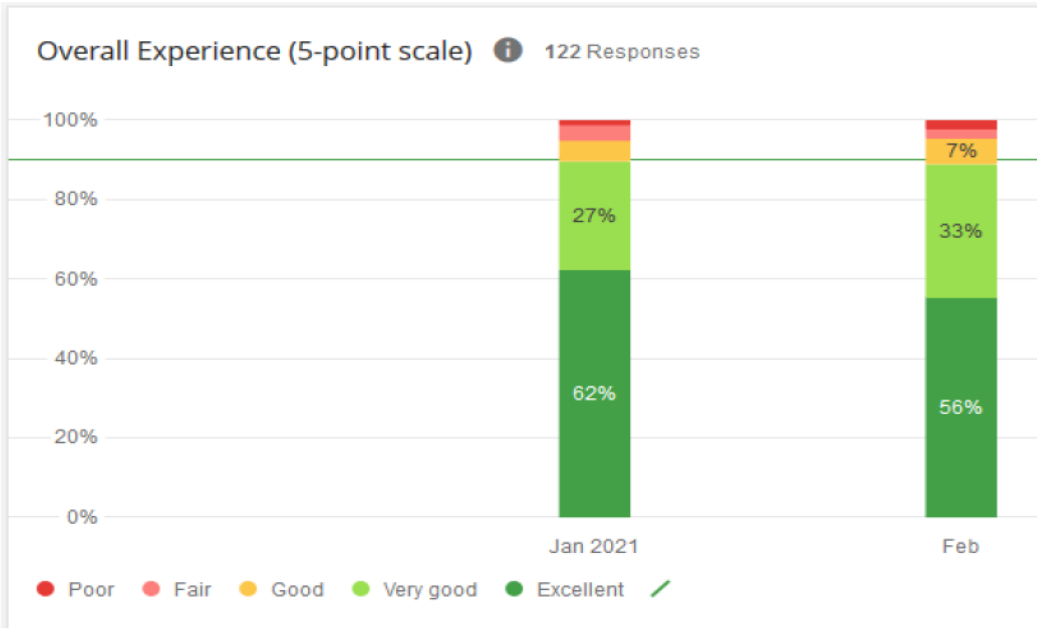
- *Community Services – Engaging with patients and whānau*

Through a consultation and change process we have extended the Rapid Community Access Team (RCAT) hours to ensure the service is better aligned with the needs of patients and their whānau.

The Rapid Community Access Team is an intensive nursing, physiotherapy and occupational therapy team providing support in the home for complex patients with acute health care needs. The RCAT team engages with patients and whānau during the acute phase until such time that the patient is once again safe to be supported by primary care or community services such as district nursing. In this service nurses may visit multiple times a day and work in a multi-disciplinary framework with Allied Health professionals to ensure all equipment is in place to support transition from hospital to home. The Allied Health staff within RCAT undertake early intensive rehabilitation with patients and seek to quickly establish goals of rehabilitation that are patient centric and practical in a patient's residential environment.

To complement this, the Adult Community Service has embedded weekly multi-disciplinary team case conferences which include opportunities for whānau, Primary Care and external agencies to participate care planning for the patient. The Community Services now has a patient experience survey utilising the DHB portal after a significant period in development. The survey has had significant uptake from patients with initial feedback offering rich insight into what we are doing well and also areas for improvement:

Figure 1 – Community Service Patient Experience 2021 YTD



Data 1 January – 28 February

CBU: **Adult Community Services, Mobility Solutions, NASC - OLDER PEOPLE**

- *Reablement (Older Peoples Health) – Support when whānau can't be there*

A key focus of the Reablement service has been enhancing the Companion Volunteer programme through investment in new resources, increased access to portable electronic devices, bimonthly training for volunteers and improved activity provision on weekends. Availability of wireless devices and video conferencing to connect with whānau was driven in part by the challenges posed by visitor and travel restrictions associated with the pandemic. The use of videoconference to include whānau unable to attend family conferences supporting care decisions for older adults is now part of business as usual and one of the real positives to come out of a challenging year in older people health.

- *Regional Immunology Service – Delivering care closer to home*

We are piloting an immunology outpatient clinic at Māngere Bridge using the Regional Sexual Health facilities. This pilot was initiated from patient feedback, particularly from Māori and Pasifika patients in Counties Manukau DHB, around barriers to access at the Auckland City Hospital site. The success of this initiative will be reviewed in 6 months to gain an understanding if this change has allowed the service to better engage with the regional community it serves. This initiative is not only enabling care closer to home for Māori but also using our existing resources wisely so that external clinic leases are fully utilised.

4. Digital Transformation

- *Digital Health Services*

The Auckland Sexual Health Service (ASHS) is undertaking a significant change to how it interacts with patients through a number of work streams. These include an upgrade of the external facing website to allow self-booking options for clients via the Cliniko tool and the embedding of a self-directed care navigation tools within the website. The ASHS team are working closely with consumer groups to ensure their digital presence is fit for purpose and has strong links to primary care and specialist community partners. Across the Directorate the use of electronic prescribing and lab test requests has been well received along with a significant transition to telehealth where clinically appropriate.

- *Workforce and Business systems*

We have invested in portable devices to ensure they are available for all clinical staff working in community settings. The ability to have patient information and clinical tools at the click of a button offers significant benefits to the quality and efficiency of care provision. This change however has posed some challenges in terms of ensuring all devices are fully fit for purpose and are able to provide access to all clinical systems. The Directorate is working closely with the HIT team to address these issues as part of the Windows Ten system upgrade programme.

The Directorate has successfully implemented the Meditrota electronic rostering tool in all medically led services. This tool offers visibility of rostering patterns, clinic room utilisation, information on cancelled sessions and allows the service to better tailor the services it provides to meet patient need.

5. Resilient Services

- *Community Services and Reablement – Supporting hospital occupancy and flow*

Community Services has worked hard to build organisational awareness of the alternatives within the community to an inpatient hospital stay and options to support care in the community earlier following an acute event. The community team is now fully engaged with capacity planning meetings and is undertaking in-reach and complex discharge support activities across a number of services.

The Community Intermediate Care team has robust support from a Geriatrician to ensure transitions from hospital to an interim care placement and then home are managed effectively and are sustainable. Allied Health in-reach to Reablement and Ward 51 is a further measure to support earlier safe discharge to the community. The success of this is demonstrated in a significant improvement in the provision of intensive rehabilitation in a non-hospital setting with calendar year to date results meeting the MOH target for community stroke rehabilitation in Jan/Feb 2021.

- *Reablement Services (Older Peoples Health) pathway development*

The Reablement service has successfully embedded the first phase of the frailty model of care which involves a Frailty nurse, Registrar and Geriatrician presence in the Clinical Decision Unit. This team is purposed with identifying options to support the patient in the community and seek alternatives to an inpatient admission. Half of the patients cared for in CDU under this pathway in the past 12

months have been transitioned to a non-hospital setting with the remainder transitioning directly to Reablement without the need for an admission to Adult Medical Services. For patients who are admitted to the Reablement Service there are benefits in terms of continuity of care and early intervention from Social Workers, Geriatricians and Community Services Needs Assessment to facilitate the earliest practicable discharge back to normal place of residence.

The second phase of the frailty pathway redevelopment involves the phased implementation of an Acute Care of the Elderly Pathway and fractured hip (Neck of Femur NOF) pre-operative pathway within Reablement Services. This pathway development offers significant benefit in terms of continuity of care provision, reduced length of stay and more effective engagement with community services.

- *CLTC - Working closely with Primary Care*

A number of services have robust engagement programmes with primary care to support specialised education and training. Of particular note is the education programme delivered by the Transgender Health Key Worker who has worked closely with Primary Care to develop educational and communication material to support understanding of this care pathway in General Practice. In the coming year enhanced engagement and the use of virtual service delivery will be a key part of a number of services business plans.

- *Endocrinology - Fracture Liaison Service – a new approach*

The Fracture Liaison Service (FLS), previously managed through the Reablement Service, has transitioned to the Endocrinology Service as part of a service redesign. The change is premised on taking a more tactical approach to treatment provision where, rather than intervening in an inpatient setting post significant fracture, the reinvented service utilises data searches from Health Intelligence and a "Fracture Liaison Algorithm" to identify patients with fragility fractures who require bone densomitry scanning and intervention. This method is viewed as clinical best practice, is supported by ACC as partner in the FLS and offers a sustainable mechanism to identify patients who will benefit most from the Fracture Liaison Service. This is also an approach endorsed by the Health aging strategy.

- *Dermatology – Sustainable skins pathway*

The Dermatology Service is working closely with Surgical Services and Primary Care to increase utilisation of the GP with a special interest (GPSI) skin lesion removal programme. Currently there are barriers to utilising the GPSI service which have resulted in unsustainable pressure on the Dermatology Service and in some cases high cost provision for low cost need. Initial patient experience feedback has indicated that consumer preference if for care closer to home which will be a primary focus of this project. The refreshed skin lesion pathway is intended to be implemented mid 2021 with an objective of 80% of skin lesions being removed in primary care.

6. Financial Sustainability

The Directorate has developed a financial sustainability plan for the 20/21 and 21/22 financial years with a focus on reducing waste in equipment and consumables management, effective resource allocation and ensuring that ACC revenue is fully captured and recovered. The benefits of this

programme of work are starting to yield benefits in a forecast favourable year in position of approximately $0.5M.

Figure 2 - CLTC Financial Sustainability Plan

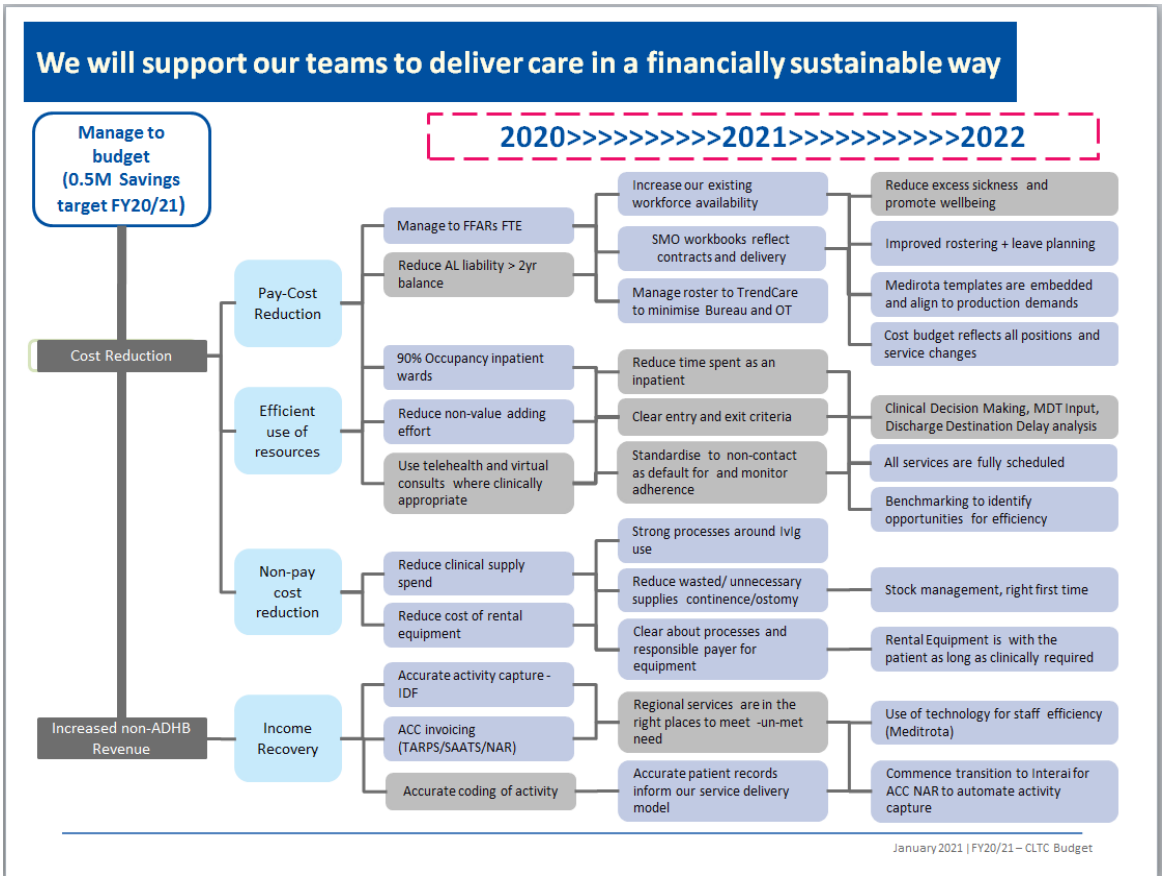


Figure 3 – CLTC Statement of Financial Position Feb 2021

Auckland DHB - Adult Community and LTC

Statement of Financial Performance for February 2021

($000s)	MONTH			YEAR TO DATE (8 months ending Feb-21)		
	Actual	Budget	Variance	Actual	Budget	Variance
REVENUE						
Government and Crown Agency	1,238	1,326	(87) U	11,080	10,607	473 F
Funder to Provider Revenue	6,771	6,335	436 F	55,969	53,416	2,554 F
Other Income	9	18	(9) U	92	145	(53) U
Total Revenue	**8,018**	**7,679**	**339 F**	**67,141**	**64,168**	**2,973 F**
EXPENDITURE						
Personnel Costs						
Medical	1,315	1,263	(52) U	11,621	11,013	(608) U
Nursing	1,835	1,880	46 F	16,558	16,879	321 F
Allied Health	816	768	(48) U	8,002	7,162	(840) U
Support	0	0	0 F	0	0	0 F
Management/Adminstration	325	337	12 F	2,805	2,883	78 F
Savings	0	0	(0) U	0	0	(0) U
Total Personnel Costs	**4,291**	**4,248**	**(43) U**	**38,985**	**37,936**	**(1,049) U**
Outsourced Personnel	29	55	25 F	481	438	(43) U
Outsourced Clinical Services	80	117	36 F	1,075	932	(143) U
Clinical Supplies	934	934	(0) U	8,738	8,004	(734) U
Infrastructure & Non-Clinical Supplies	156	147	(9) U	1,264	1,201	(63) U
Total Expenditure	**5,490**	**5,500**	**10 F**	**50,543**	**48,511**	**(2,032) U**
Contribution	**2,528**	**2,179**	**349 F**	**16,598**	**15,657**	**942 F**
Allocations	441	466	26 F	4,045	4,051	5 F
NET RESULT	**2,087**	**1,712**	**374 F**	**12,553**	**11,606**	**947 F**

Paid FTE

	MONTH (FTE)			YEAR TO DATE (FTE) (8 months ending Feb-21)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	81.3	73.6	(7.7) U	82.5	77.4	(5.0) U
Nursing	245.1	253.9	8.8 F	271.9	278.5	6.6 F
Allied Health	124.2	115.7	(8.5) U	142.0	129.5	(12.4) U
Support	0.0	0.0	0.0 F	0.0	0.0	0.0 F
Management/Administration	57.3	57.1	(0.3) U	56.9	57.7	0.7 F
Savings	0.0	0.0	0.0 F	0.0	0.0	0.0 F
Total excluding outsourced FTEs	**507.8**	**500.3**	**(7.5) U**	**553.2**	**543.2**	**(10.1) U**
Total :Outsourced Services	3.6	2.1	(1.5) U	3.1	2.1	(1.0) U
Total including outsourced FTEs	**511.4**	**502.4**	**(9.0) U**	**556.3**	**545.2**	**(11.1) U**

Comments on Major Financial Variances

The result for the Adult Community and Long Term Conditions (ACLTC) Directorate for the year to date 28 February 2021 is $947k favourable to budget.

This is primarily due to favourable funder to provider wash up revenue driven by volume performance across almost the entire directorate (except for the Community Service which is paid on contract). This is partially offset by personnel costs and clinical supplies.

Volumes

The volumes for the year to date February are 4.9% above contract or $2,497k F (after wash up adjustments). As the wash up is done monthly in arrears only the YTD January variance of $2,338k F is recognised in the result. The over performance in February of $159k F will be recognised in March.

Total Revenue - $2,973k Favourable YTD – this is mainly due to

- Funder to provider revenue wash-up $2,554k F. This is volume driven and is washed up monthly in arrears (YTD February volumes are 4.9 % above contract),
- Government and Crown Agency Income of $473k F - mainly ACC revenue.

Expenditure including allocations $2,027k Unfavourable YTD

The main drivers of the unfavourable expenditure variance are:

- **Personnel costs (including outsourced) $1,006k U** - primarily due to
  - Medical $608k U - mainly RMO over allocation and SMO above budget to meet volume demands,
  - Allied Health $840k U - this unfavourable variance is partly attributed to the
    - Needs Assessment Service Coordinator (NASC) roles being budgeted in nursing but more allied health staff have been appointed to posts (5FTE U - these roles are interchangeable.
    - FTE vacancy targets (5.6 FTE U) not being achieved due to high volumes and patient demand this a target was set as a means of offsetting additional services provide as part of ACC NAR

Overall clinical personnel costs are driven by a 4.9 % increase in volumes across the Directorate and are partially offset by an increase in annual leave taken over the year and increased ACC revenue in Reablement and the Community Services

- **Clinical Supplies $734k U –** primarily driven by an increase in volumes across the Directorate and an understated budget assumption for blood products. Key variances are in
    - Blood products $412k U mainly in Dermatology, Immunology and Rheumatology,
    - Pharmaceuticals cost $125k U for Rheumatology and Reablement.

FTE 11.4 FTE unfavourable - primarily due to

Medical personnel 5.0 FTE U- mainly over budget due to volume demands across the Directorate and approved but unbudgeted FTE to support enhanced pathways.

Nursing personnel 6.6 FTE F – mainly due to vacancies in the Community Services offset by Allied Health roles (see below),

Allied Health personnel 12.4 FTE U – primarily due to Community Service - Needs Assessment Service Coordinator (NASC) roles budgeted in nursing but more allied health staff have been appointed to posts 5FTE U and unachieved vacancy assumption 5.6 FTE U

Forecast

The full year forecast is $563k favourable to budget.

7. Directorate Scorecard

Auckland DHB - Adult Community & Long Term Conditions

HAC report for February 2021

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 - 12 month average (% of in-patients)	PR185	2.4%		1.2%
Number of falls with major harm	PR199	0	Lower	2
Number of reported adverse events causing harm (SAC 1&2)	PR084	1	Lower	3
% Hand hygiene compliance	PR195	92.34%	>=80%	87.15%

Patient-centred

Metric		Actual	Target	Previous
% Patients cared for in a mixed gender room at midday - Adult	PR175	12.57%	<=2%	5.86%
% hospitalised smokers offered advice and support to quit	PR129	100%	>=95%	85.71%
% DNA rate for outpatient appointments - Māori	PR057	22.73%	<=9%	23.4%
% DNA rate for outpatient appointments - Pacific	PR058	29.59%	<=9%	24.59%
% DNA rate for outpatient appointments - All Ethnicities	PR056	13.27%	<=9%	12.68%
% DNA rate for outpatient appointments - Deprivation Scale Q5	PR338	21.71%	<=9%	19.36%
% Very good and excellent ratings for overall inpatient experience	# PR154	84.6%	>=90%	100%
% Very good and excellent ratings for overall outpatient experience	# PR179	91.20%	>=90%	90.9%

Timeliness

Metric		Actual	Target	Previous
% of inpatients on Reablement Services Wait List for 2 calendar days or less	PR023	100%	>=80%	99.35%
% Discharges with Length of Stay less than 21 days (midnights) for Reablement	PR193	77.12%	>=80%	80.88%
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Māori	PR329	1	Lower	4
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Total	PR328	9	Lower	24
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Deprivation Scale Q5	PR332	4	Lower	10

Effectiveness

Metric		Actual	Target	Previous
28 Day Readmission Rate - Māori	# PR079	0%	<=6%	0%
28 Day Readmission Rate - Pacific	# PR080	6.25%	<=6%	0%
28 Day Readmission Rate - Total	# PR078	1.32%	<=6%	3.01%
28 Day Readmission Rate - Deprivation Scale Q5	# PR322	0%	<=6%	5%

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 February 2021

- *Exceptions*

Managing gender mixing in rooms has been particularly challenging due to high hospital occupancy in February 2021.

Due to COVID level changes in February increase in Did Not Attract (DNA) rate was reflected across all ethnicities particularly in diabetic retinal screening which accounts for a significant proportion of all DNA and is the focus of a regional model redesign. We expect to see improvement in the DNA rate with some of the service redesign which has focus on ensuring services are provided at locations/access hours that meet needs of the population being served.

Table 1 – DNA Rates YTD Ambulatory Services

All Specialist Out Patient Services						
	Jan	Jan DNA	Jan POP	Feb	Feb DNA	Feb POP
All	12.68%	244	1924	13.46%	281	2088
Māori	23.40%	33	141	22.88%	35	153
Other	9.20%	136	1478	9.14%	146	1598
Pacific	24.59%	75	305	29.67%	100	337
All Excluding Diabetes						
	Jan	Jan DNA	Jan POP	Feb	Feb DNA	Feb POP
All	9.63%	144	1496	9.22%	148	1605
Māori	19.00%	19	100	15.31%	15	98
Other	7.80%	97	1243	6.96%	93	1336
Pacific	18.30%	28	153	23.39%	40	171

There is an on-going focus in place on inpatient experience within the Reablement service. Patient and Whānau experience sessions are being held weekly by senior team members to capture in the moment voice of customer to address concerns during a patients inpatient stay.

It is important to note that the ESPI non-compliance reflected a data integrity issue related to the scheduling of The Auckland Regional Pain Service follow-ups as opposed to actual non-compliance with ESPI2.

- *Improvement*

There are a number of opportunities to improve the Directorate level HAC reporting for CLTC particularly the re-admission data set which currently excludes Reablement Services.

Similarly, the effectiveness of community Service in re-admission avoidance and provision of care closer to home; it is proposed this type of data will be reflected in the future scorecard as opposed to the current data set.

Patient and Whānau Voice – Te Tiriti o Waitangi based framework for Patient and Whānau Centred Care at Te Toka Tumai Auckland DHB

Recommendation

That the Hospital Advisory Committee:

1. **Receives the Patient and Whānau Voice – Te Tiriti o Waitangi based framework for Patient and Whānau Centred Care at Te Toka Tumai Auckland DHB report dated 21 April 2021.**
2. **Notes the "ORITE" reflection framework for patient and whānau centred care.**

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

Kuputaka : Glossary

Acronym/term	Definition
CEC	Consumer Experiences Council (formerly known as the Patient and Whānau Centred Care Council)
ORITE	The acronym for the set of questions in the Te Tiriti o Waitangi based framework for patient and whānau centred care at Te Toka Tumai Auckland DHB.

1. Executive Summary

Te Toka Tumai Auckland DHB has refreshed its strategy and two pillars it will focus on are Te Tiriti in Action, and, People, patients and whānau at the centre. The Consumer Experiences Council (formerly Patient and Whānau Centred Care Council) exists to support and guide patient and whanau centred care at Te Toka Tumai Auckland DHB.

Patient and whānau centred care encourages the active collaboration and shared decision-making between patients, whānau, and providers.

The CEC identified that Te Tiriti o Waitangi, when applied to international best practice guidelines, lifts biculturalism and indigenous people's rights with respect to patient and whānau centred care.

Ōrite is the kupu Māori/Māori word for same, equal etc. ORITE is the acronym for the five questions intended by the CEC to influence organisational discourse about patient and whānau centred care towards honouring both Te Tiriti o Waitangi and international best practice.

A working group identified a low level of comfort or experience across Te Toka Tumai Auckland DHB to operationalise Te Tiriti o Waitangi based frameworks. Collaboration and iteration in the development and socialising of the ORITE framework for reflection will be critical to its uptake amongst staff.

2. Background

In November 2020, a paper was presented to the Hospital Advisory Committee /Provider Equity Committee outlining the need for a patient and whanau centred care framework fit-for-purpose in Aotearoa New Zealand's context of biculturalism, inequitable outcomes and Te Tiriti o Waitangi.

A Te Tiriti-based framework was proposed and endorsed, allowing further work to occur to develop the approach.

3. Response

Using a matrix of the articles (ngā wāhanga) of Te Tiriti o Waitangi alongside the Planetree framework, the Patient and Whānau Centred Care Council worked to understand how to guide patient and whānau centred care in Te Toka Tumai Auckland DHB and in Aotearoa New Zealand.

A paper seeking support for the approach from the Hospital Advisory Committee/Provider Equity Committee of the Board, Te Toka Tumai Auckland DHB was endorsed in November 2020.

The concept was further iterated at the Consumer Experiences Council planning workshop in November 2020.

The five guiding principles of the Planetree International framework and the four wāhanga/articles of Te Tiriti o Waitangi were then worked up into the CEC's new "ORITE" reflection framework for patient and whanau centred care.

A small working group undertook further development of the draft ORITE framework into a tool for testing and presentation to the Committee.

A low level of confidence or experience with operationalising a Te Tiriti o Waitangi based approach was reported from the working group. This helped identify a range of tactical responses that will support good engagement by staff with the ORITE framework: to clearly define terms used; to frame the elements into open ended and non-judgmental questions; and to cater to the need for staff in different work settings to have practical and accessible tools.

It became clear that an iterative approach to developing the framework to completion will also support a widely acceptable end result.

4. Conclusion

Generally, Te Toka Tumai Auckland DHB has widespread support at high-level, but very little experience and maturity in operationalising Te Tiriti o Waitangi based frameworks at service level. It will be important for the CEC to value journeying, reflection and improvement rather than compliance in the socialising of this framework amongst staff.

APPENDIX 1

ORITE reflection framework for patient and whānau centred care (version 3)

1. Introduction

Patient and whānau centred care is about deeply understanding the health care needs and preferences of people, and then meeting those to a high standard through encouraging the active collaboration and shared decision-making between patients, whānau, and providers.

The Consumer Experiences Council exists to support and guide patient and whānau centred care in Te Toka Tumai Auckland DHB.

Te Tiriti o Waitangi, when woven with international best practice guidelines, lifts biculturalism and indigenous peoples rights in the patient and whānau centred care space. This approach aligns with two pillars in the Organisational Strategy; Te Tiriti o Waitangi in Action, and, People, patients and whānau at the centre.

2. Approach

There are four Te Tiriti o Waitangi articles called wāhanga. Below is a way of thinking about each wāhanga in a reflective manner.

Te Tiriti o Waitangi

Wāhanga 1: Kawanatanga How are Māori involved in decision-making and governance of projects in this work?

Wāhanga 2: Tino Rangatiratanga How do you know whether this work advances Māori tino rangatiratanga?

Wāhanga 3: Oritetanga How do you know this work increases health equity?

Wāhanga 4: Te Ritenga How do you integrate wairuatanga in this work?

These work alongside the Planetree International 5 guiding principles to form the ORITE reflection framework for patient and whānau centred care at Te Toka Tumai Auckland DHB.

International best practice

Planetree International 5 guiding principles are:

Create organisational structures that promote engagement;

Connect values, strategies and actions;

Implement practices that support partnership;

Know what matters;

Use evidence to drive improvement.

The ORITE reflection framework for patient and whānau centred care

The intention of this framework is to encourage reflection by teams, services, departments and directorates on their approach to patient and whānau centred care. The questions are designed to acknowledge that improvement is a journey. Revisiting the framework with periodic reflection will support improvement over time.

The core elements form an acronym ORITE (ōrite is the Māori word for equal, same):

Organisational structures: In what ways do our systems and processes promote engagement with Māori patients and whānau, and with all patients and whānau?

Tip: Reflect on governance, service design, team structure, procedures, policies or routines.

Reconnect values, strategies and actions: How do our organisational values show up for Māori patients and whānau and for all patients and whānau, in engagement strategies and activities?

Tip: Reflect on Haere Mai Welcome, Angamua Aim High, Manaaki Respect, Tūhono Together

Implementation practices: How does the way we work reliably support partnership with Māori patients and whānau, and with all patients and whānau?

Tip: Reflect on institutional racism, biases, world-views, assumptions and norms.

Trust: How do our reasons or intentions for engaging link to what matters to Māori patients and whānau and to all patients and whānau?

Tip: Reflect on benefits across spiritual, physical, whānau and mental dimensions of health

Evidence: How is evidence used to drive improvement for Māori patients and whānau to the same levels achieved for all patients and whānau?

Tip: Reflect on the origin of knowledge systems, quality of data and sources of feedback used in the improvement process

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 17 February 2021	**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 Vulnerable Service Update	**Prejudice to Health or Safety** Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act

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