TE TOKA TUMAI
Auckland DHB

Hospital Advisory Committee Meeting

Wednesday, 17 February 2021

8:30am

Marion Davis Library

Building 43
Auckland City Hospital
Grafton

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Published 3 February 2021

Agenda
Hospital Advisory Committee
17 February 2021

Venue: Marion Davis Library, Building 43
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 **Karakia**

1. Attendance and Apologies

Members:

Executive Staff: Debbie Holdsworth, Karen Bartholomew

2. Register and Conflicts of Interest

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

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

8.35am **3. Confirmation of 18 November Minutes 2020**

4. Action Points 18 November 2020 - Nil

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

5.1 Provider Arm Operational Update

5.2 Financial Update

	5.3	Director Equity Update – Child Health (Michael Shepherd and John Beca)
	5.4	Director Equity Update – Mental Health (Hineroa Hakiaha and Tracy Silva Garay)
	5.5	Director Equity Update – Women's Health (Rob Sherwin)
9.45am	**6.**	**RESOLUTION TO EXCLUDE THE PUBLIC**

Next Meeting:	Wednesday, 21 April 2021 at 8.30am A+ Trust Room, Clinical Education Centre Level 5, Auckland City Hospital, Grafton

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

Karakia

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

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

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of life

To the ancient realms of the Creator

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

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

Well Being to All.

Attendance at Hospital Advisory Committee Meetings

Members	12 Feb 2020	18 March 2020	22 April 2020	3 June 2020	15 July 2020	26 August 2020	7 October 2020	18 Nov 2020	17 Feb 2021
William (Tama) Davis (Chair)	1	1	c	c	c	c	1	1	
Joanne Agnew (Deputy Chair)	1	1	c	c	c	c	1	1	
Michelle Atkinson	1	1	c	c	c	c	1	1	
Doug Armstrong	1	1	c	c	c	c	1	1	
Bernie O'Donnell	1	1	c	c	c	c	x	x	
Michael Quirke	1	1	c	c	c	c	1	1	
Peter Davis	1	1	c	c	c	c	1	1	
Zoe Brownlie	1	1	c	c	c	c	1	1	
Fiona Lai	1	1	c	c	c	c	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	26.11.2020
Michael QUIRKE	Chief Operating Officer – Mercy Radiology Group Convenor and Chairperson – Child Poverty Action Group Director of Strategic Partnerships for Healthcare Holdings Limited	27.05.2020
Teulia 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) Senior Lecturer Researcher – University of Auckland Director Researcher – Moana Research	01.10.2020

Heather CAME	Primary Employer – Auckland University of Technology Contractor – Ako Aotearoa Acting Co-President – Public Health Association of New Zealand Fellow – Health Promotion Forum 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	23.11.2020

Minutes
Hospital Advisory Committee – Provider Equity Meeting
18 November 2020

Minutes of the Hospital Advisory Committee – Provider Equity meeting held on Wednesday, 18 November 2020 in the Marion Davis Library, Building 43, Auckland City Hospital, Grafton commencing at 8:30am

Committee Members Present	**Auckland DHB Executive Leadership Team Present**	
William (Tama) Davis (Chair)	Ailsa Claire	Chief Executive Officer
Jo Agnew (Deputy Chair)	Joanne Gibbs	Director Provider Services
Doug Armstrong	Justine White	Chief Financial Officer
Fiona Lai	Dr Mark Edwards	Chief Quality, Safety and Risk Officer
Michael Quirke	Sue Waters	Chief Health Professions Officer
Michelle Atkinson	**Auckland DHB Senior Staff Present**	
Peter Davis	Jo Brown	Funding and Development Manager Hospitals
Zoe Brownlie	Nigel Robertson	Interim Director, Perioperative Services
	Marlene Skelton	Corporate Business Manager
	Kay Sevillano	EA to Board Chair and Governance Administration
	(Other staff members who attend for a particular item are named at the start of the minute for that item)	

Karakia

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

1. APOLOGIES

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

The following apologies were received from members of the Executive Leadership team: Dame Naida Glavish, Chief Advisor Tikanga ADHB/WDHB, Dr Margaret Wilsher, Chief Medical Officer, Margaret Dotchin, Chief Nursing Officer, Meg Poutasi, Chief of Strategy, Mel Dooney, Chief People Officer, Shayne Tong, Chief of Informatics, Dr Debbie Holdsworth, Director of Funding Auckland and Waitemata DHBs, and Karen Bartholomew, Director of Health Outcomes Auckland and Waitemata DHBs.

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

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

3. CONFIRMATION OF MINUTES 7 OCTOBER 2020 *(Pages 9-18)*

Resolution: Moved Jo Agnew / Seconded Fiona Lai

That the minutes of the HAC meeting held on 7 October 2020 be approved.

Carried

4. ACTION POINTS

There were no action points to review.

5. PERFORMANCE REPORTS

5.1 Provider Arm Operational Update *(page 19-22)*

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

The work carried out by Emma Wiley, Consultation and Co-Design Manager and Vanessa Duthie, Māori Patient and Whānau Experience Lead, in the Adult Medicine Directorate was acknowledged. Their analysis contains a number of themes that will be carried across other directorates. A number of these themes will also be brought forward as work on the development of Key Result Areas (KRAs) continues for both the People Plan and the Business Plan, with the Board having approved the strategy.

The work currently undertaken by Kāiarahi Nāhi rōpū and the Pacific Care Navigation team will be audited after 6 months. The teams are 4 months into their work with significant improvements evident in the different specialities they are working in, particularly in the 3 large clinical areas, General Surgery, Orthopaedics and Ophthalmology. The Auckland DHB is making significant progress towards equivalent waiting times regardless of ethnicity.

The Ministry of Health has yet to confirm the go-live date for Bowel Screening services at the Auckland DHB. The Ministry were seeking clarification around recruitment of staff into key posts for this service, for which the Auckland DHB has provided relevant information.

Taiao Ora, Ward 51 officially opened on 16 November 2020. Patients have since been admitted to the ward.

There were no transplants during the level 4 COVID-19 lockdown However ,Transplants numbers have now recovered with kidney transplants in particular, having hit record high numbers.

COVID-19 work continues across the region and the 2 major risks faced by the Auckland DHB are around staffing deployments to border work and ARPHS (providing surge staffing while maintaining optimal hospital services for patients), and ongoing supply issues (international deliveries and logistics).

This year's Summer Plan will be a challenge due to the unpredictable nature of numerous events (e.g. internal movements, resurgence of COVID-19, etc).

Performance has slowly improved in terms of waiting times and details of this have been

noted in the September figures for ESPI-2 and ESPI-5. The Orthopaedic department waiting times have improved when compared to the position over the last 5 years. Although the Orthopaedic department's waiting list has room for improvement, activity numbers for September and October 2020 have exceeded that from the same time last year. However, activity overall still falls behind plan, which will be discussed further in the Financial Update.

The following was raised in discussion:

Stuart McGowan, Clinical Director, and the new Operations Manager of the Orthopaedics department were credited with leading the team's performance improvement. The Orthopaedics leadership team introduced important changes to the directorate such as an improved pooling of lists, better management of outsourcing of volumes, and tracking of short notice patients to fill waiting lists. Stuart McGowan is retiring in December 2020 and recruitment for his replacement is ongoing.

The Kāiarahi Nāhi rōpū and the Pacific Care Navigation team have reached out to 500 Māori and 700 Pasifika patients on waiting lists to date. The navigators continue to reach out to all Māori and Pasifika patients, many of whom are complex cases and have experienced issues accessing hospital services.

In 6 months, the size and skills mix of the navigation team will be evaluated. It was recognised that input from other allied health specialists, especially social workers, might be of benefit to the team going forward. At present, there are 20 navigators, 10 of whom are with Kāiarahi Nāhi and the other 10 are with the Pacific Care Navigation team.

The navigation team is comprised of senior nurses and their role is to challenge the existing system. If they are successful in working with clinicians, this will result in broader and more sustainable changes to the delivery of healthcare across the directorates.

Under the current Ministry of Health guidelines, the Auckland DHB receives funding for electives that have been carried out, and does not receive payment if electives are not delivered. There is no longer a system of fines when the DHB is unable to meet elective targets.

There is significant fixed cost needed to drive all acute work. In order to utilise this resource efficiently, the Auckland DHB needs to deliver as much planned care work as possible. The revenue from planned work and acute work makes up total cost. The Audit Committee is preparing a paper on the financial advantages of contracting with other providers through the funder, which will be shared.

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

Carried

5.2 Financial Update *(Pages 23-32)*

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

The budget is on track year to date (YTD) with minimal variance, if COVID-related expenses are excluded. The impact of COVID is significant during the month of September. There was an unfavourable result of $5.6m, of which $5m is attributed to COVID-related expenses. This has created an unfavourable variance of approximately $530K, which sits at approximately $710K year-to-date.

At the Committee's request, financial reports now include columns that reflect forecast figures. Auckland DHB's financial forecast is on track until the end of the year, excluding any possible further impacts of COVID.

There are FTE pressures around staff not taking annual leave and reduced staff turnover, which has resulted in a residual of 42 unfavourable FTE. Measures to manage these risks are being undertaken.

The Auckland DHB is sitting at approximately 94% of volume expectations, which creates financial risk in terms of revenue for IDF and planned care. Further, there is risk around Pacific contracts for non-resident work.

It was noted that a correction be made on page 26 of the Financial Report submitted to the committee. Where it states that, "The Provider Arm resulted for the year to date is $18.3m unfavourable", the figure should be $12.5 not $18.3m.

The following was raised in discussion:

Due to COVID activity, a number of FTEs for ARPHS response work have been coded as management and corporate costs to separate these from expenses that are sitting in provisional services (where COVID expenses are charged).

The Auckland DHB has received payments from the Ministry of Health for COVID-related expenses and the appropriation of funds is underway. Estimates from November until the end of the year are also being prepared.

Under the multi-collective employment agreement, staff can accrue up to 2 years of annual leave. Those with over 2 year's annual leave are asked to prepare a leave plan. Staff are being encouraged to take leave and refresh after a challenging year. Leave is built into the nurses' rosters as part of CCDM requirements. However, leave management differs according to clinical area due to varying circumstances and to ensure planned care work continues. Clinical Directors are working with their specialty leads to establish an appropriate leave plan suited to their directorate. Junior doctors adhere to specific leave provisions through MECA. The Medirota system is also being utilised, which provides notification when staff are surplus to roster, enabling them to take leave.

That the Hospital Advisory Committee:

1) **Note the correction on page 26 of the HAC report. Where it states, "The Provider Arm resulted for the year to date is $18.3m unfavourable", the figure should be $12.5m not $18.3m**
2) **Receives the Financial Update for November 2020.**

Carried

5.3 Director Equity Update – Cancer and Blood *(pages 33-39)*

Dr George Laking, Te Whakatōhea, Medical Oncologist, Kaihautū – Pou Ārahi, Dr Richard Sullivan, Director Cancer & Blood, Dr Ingo Lambrecht, Ngāi Tiamani, whāngai nā Ngāti Whātua and Troydyn Raturaga, (Ngāti Whātua, Ngāpuhi) Business Manager Provider Services and HR, were present to provide an update on Māori wellbeing in the Cancer and Blood directorate. This is in line with the Auckland DHB's commitment to Te Tiriti o Waitangi and health equity.

Dr Laking asked that the report be taken as read outlining as follows:

The report (Te Pou Ārahi) outlines the establishment of a structure in the Cancer and Blood directorate. The purpose is to advance the transformation of services by developing the capability and skills to work with Māori. The report also outlines work undertaken to develop capability in line with the Key Result Area 2 (KRA2) of the Pūmanawa Tāngata (the People Plan), which is to "Uphold Te Tiriti o Waitangi as our framework to eliminate racism, build culturally safe practice and achieve health equity".

Dr Laking discussed the membership, noting the absences of Tame Hauraki (Ngāti Whātua, Ngāpuhi, Ngāti Whānaunga), the newly appointed Kaumātua for Te Pūriri O Te Ora, and Kadin Latham (Ngāi Tahu) Project Coordinator.

The directorate is also involved in work relating to the Key Result Area 3 (KRA3) of the People Plan. This is around growing and developing Kaimahi Māori, by expanding the Māori workforce and promoting staff education. Their efforts in Tino Rangatiratanga, Ōritetanga and Te Ritenga were mentioned, including the intention to practice mihi whakatau and pōwhiri in the directorate to welcome new staff and whānau.

The following was raised in discussion:

The cultural changes being introduced to the Cancer and Blood directorate have had positive feedback. There is strong support and engagement from the directorate leadership team, branch staff and SLT. Kaimahi Māori (Māori workforce) have been brought into the directorate for the first time, resulting in Maori comprising about 4% of the workforce. The suggested optimum number of Māori in the directorate should be between 16% to 20% to match the directorate's workforce with the needs of the community.

It is important to address significant gaps in patient health outcomes for Māori and Pasifika groups to be able to provide world-class healthcare services. This is made possible when the practice of medicine reflects the diverse and unique requirements of the community that the Auckland DHB serves. The drive to change the way healthcare is provided does not pose as a risk at this time, but instead there is growing momentum and engagement from the wider organisation for this to happen.

Aspergillus/Fungal spore mitigation measures are being undertaken to ensure the safety of immune-compromised patients. There is a risk that spore counts will increase as the demolition of Building 13 commences. The Haematology service will relocate from Building

8 to the Rangitoto ward to mitigate the risk of infection. The move is a short-term solution until February/March 2021. It is uncertain when the Haematology services will be able to return to Building 8, and there is also concern that the Rangitoto ward may be needed for other purposes after March. The date for the demolition of Building 7 in 2021 is yet to be confirmed, which is another risk to be managed. Patients and whānau passing through the cut and cover tunnel during demolition is also a health risk so instructions will be provided to ensure they use a particular path to avoid the demolition area. A risk matrix is in place to manage the directorate's responsibility as a provider. This move has drawn a fair amount of media attention that is being managed.

Tama Davis, Committee Chair concluded the discussion by referring to the quote of Tā Apirana Ngata mentioned in the report and reflected as follows:

"It (change) speaks to the mention of springtime but also tapping into skillset regardless of where it exists within our community, to get the best outcomes for those who are most in need. Apirana's toki was a call to the changing environment within the Māori and pakeha development of our communities, and it was about thriving in the days destined for you. Taking a hold of new technologies (which at that time was pakeha technologies), understanding what that is, how we bring that into the world of oneness that we share, and moving forward as one people, elevating the uniqueness of us a New Zealand nation here in Aotearoa, while understanding that the many lenses and many perspectives allow us to drive with a colourful vision to the future."

That the Hospital Advisory Committee receives the Director Equity Update – Cancer and Blood for November 2020.

Carried

5.4 Director Equity Update – Surgical Services *(pages 40-47)*

Dr Rob Sherwin, Director Women's Health (presenting on behalf of Duncan Bliss, General Manager Surgical and Perioperative Services) and Rebecca Stevenson, General Manager Surgical Services were present. Dr Sherwin asked that the report be taken as read highlighting as follows:

The work of the navigators has delivered significant benefits given the reduction in waiting times for Māori and Pasifika patients. There is positive change around employment and retention of Māori staff, and a commitment from the directorate has been made to embed the gold standard of Māori patient and whānau experience and care.

Planned care volumes for Auckland DHB domicile patients are approximately 100% for adult surgery. The acute volumes have been impacted since COVID as reflected in ED attendances. There was 106% expected acute activity before COVID. The numbers have since decreased, and activity going forward is being monitored.

Planned care recovery funding targeted for specific services will be operationalised in due course. Plans for recruitment to make this possible are underway.

The leadership structure is under review and there is ongoing consultation and engagement with perioperative and surgical staff. A review group will consolidate staff

feedback after which results and recommendations will be submitted to the leadership team.

DNA rates have also reduced for Māori and Pacific patients due to the provision of Telehealth services and assistance from the navigators. ESPI-2 and ESPI-5 compliance (see page 46) also shows a reduction in long waiters.

The following was raised in discussion:

ESPI-5 performance has remained static due to increased referral volumes following the first COVID lockdown. Referrals had decreased significantly during the lockdown. The directorate has increased delivery of services to address the 4-month backlog.

The different clinical areas have had a positive experience utilising the equity adjuster waiting tool. This has resulted in very little disparity between Māori, Pasifika and patients of other ethnicities. There is staff confidence in the tool as longest waiting patients who are most at risk can now be prioritised, resulting in positive patient outcomes.

That the Hospital Advisory Committee receives the Director Equity Update – Surgical Services for November 2020.

Carried

5.5 Director Equity Update – Perioperative *(pages 48-58)*

Dr Nigel Robertson, Interim Director Perioperative Services asked the report be taken as read highlighting the following:

The work undertaken by Kāiarahi Nāhi rōpū is significant as patients are now receiving the appropriate attention and care they require.

Language is important to culture. The use of Te Reo Māori at the Auckland DHB is significant as it marks the ability for a culture to express itself.

The directorate has taken initiative to reach out to iwi-based primary care providers to foster the development of the front-end perioperative pathway, as the Directorate is aware there are systemic issues, especially for Māori. This is in tandem with the development of perioperative medicine as a speciality in itself, and has resulted in an integrated view of the patient journey from referral from primary care, and back to primary care after treatment.

Incidences of change in Tikanga Māori are as follows:

1) The use of forensic instruments processed through CSSD that was identified as inappropriate has now been changed.
2) There have been challenges in dealing with COVID patients in the operating rooms (OR) while ensuring the safety of both patients and staff. However, there has also been an uptake in OR productivity.

The following was raised in discussion:

There are no unusual workforce drivers in CSSD at present. An operations manager was

appointed this year to assist the leadership in the service. Operating rooms (OR) have a large number of overseas trained nurses and has been significantly impacted during the year. This has since been offset by a great reduction in staff resignations resulting in a slight under recruitment of nursing staff. Anaesthetic technician FTE figures are the best it has been in many years.

The directorate is embarking on a project to improve workforce flexibility and increase the scope of practice of nursing and allied staff in ORs. This will result in having registered nurses who are also fully trained anaesthetic assistants, and anaesthesia technicians capable of scrubbing for surgery and looking after patients. The last intake for the diploma course at AUT commences on semester 2 next year. Staff will gain level 7 qualification, which is beneficial for both the hospital's workforce and individual professional development.

There has been an increase in incidents reported in CSSD. (CSSD processes 466,000 instruments per month, 41,000 of which are trays or packs of instruments). There were 15 Datix reports in October, 10 of which were related to trays from external sources. Two-thirds of reports were around instruments from outside the hospital facility. There were 5 "near misses" of staff-related incidents reported but no one was harmed.

Implants removed from patients are returned directly to the patient (should they so wish) in a suitable, sealed receptacle.

That the Hospital Advisory Committee receives the Director Equity Update – Perioperative Services for November 2020

Carried

5.6 Patient and Whānau Voice – Report *(pages 59-62)*

Dr Mark Edwards explained that this is the second presentation made by the Patient and Whānau Centered Care Council (PWCCC) to the committee, to further explain the general structure and function of the PWCCC. The council will regularly participate at HAC meetings next year and will be reporting to a work plan, which is currently in development.

Jane Drumm, Co-Chair, Patient and Whānau Centered Care Council asked that the paper be taken as read and highlighting as follows:

The focus of the paper is to illustrate the council's journey so far, what patient whānau care looks like, and how the council can work towards a Te Tiriti o Waitangi-based framework. The Terms of Reference prioritise recruitment of Māori to the Council, and work that is underway with other Councils across the country to ensure best outcomes for patients and whānau.

Iani Nemani, Patient and Whānau Advisor, Patient and Whānau Centered Care Council (PWCCC) provided a brief background on his family's journey from Tonga to New Zealand, and his hospital experience at Counties Manukau and Auckland. He expressed aspiration for equitable health services to be provided for all people, especially those who face challenges in accessing health care. The Council will strive to make this possible by being the vehicle for change, promoting diversity (not just ethnicity) in order to address equity.

The Council will also act as bridge builder between forums, boards, Māori, etc, facilitating challenging conversations as well as sharing patient stories across the organisation.

The following was raised in discussion:

Vanessa Duthie, Māori Patient and Whānau Experience Lead explained that the new Māori champions of patient and whānau experience are hosting expert speakers to enable cross-cultural sharing and learning. Speakers from cross-cultural backgrounds with interest in improved patient experience and equitable health outcomes are invited to monthly council meetings. A Pasifika speaker attended a recent session, and an Asian community representative has been invited to attend in the new year. Trans-gender and health experts will also be invited to participate.

A draft framework outlining the strategic direction of the Auckland DHB and how the Treaty of Waitangi will impact the work of the PWCCC will be presented to the committee by approximately March 2021. All ethnicities who are likely to be patients of the hospital will be included in the framework.

That the Hospital Advisory Committee:

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

Resolution: Moved Jo Agnew / Seconded Zoe Brownlie

Carried

6. GENERAL BUSINESS

Nil

7. RESOLUTION TO EXCLUDE THE PUBLIC *(Pages 63-64)*

Resolution: Moved Tama Davis / Seconded Jo Agnew

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

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
1. Karakia Attendance and Apologies	N/A	N/A
2. Conflicts of Interest	As per that stated in the open agenda	That the public conduct of the whole or the relevant part of the meeting would be likely to result

		in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3. Confirmation of Confidential Minutes 7 October 2020	**Commercial Activities** **Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public** [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4. Confidential Action Points	**Commercial Activities** **Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public** [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.1 Women's Health Review – Verbal Update	**Privacy of Persons** **Information relating to natural person(s) either living or deceased is enclosed in this report.** **Commercial Activities** **Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was 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]
6.1 Major Risk & Issues – Verbal Report	**Commercial Activities** Information contained in this report is related to commercial	That the public conduct of the whole or the relevant part of the meeting would be likely to result

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

The meeting closed at 10.30am.

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

Chair: _____ Date: _____

Tama Davis

Provider Arm Operational Exceptions Report

Recommendation

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

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

He tau hou
Titiro whakamuri
Kōkiri whakamua
A New Year
Look back and reflect
So that you can move forward

Kuputaka : Glossary

Acronym/term	Definition
ARPHS	Auckland Regional Public Health Service
MIQF	Managed Isolation and Quarantine Facility
NRHCC	Northern Region Health Coordination Centre
Te Papakāinga Atawhai o Tāmaki	Auckland City Hospital
Te Toka Tumai	Auckland DHB

1. Exceptions Report

The Executive Leadership Team highlights the following exceptions for the February 2021 Hospital Advisory Committee Meeting.

- Since the establishment of the Kaiārahi Nāhi rōpū and Pacific Care Navigation Service, over 1500 Māori and 1500 Pacific patients have been engaged and supported as they progress through planned care journeys from the point of being waitlisted for surgery. Currently 500 Māori and 470 Pacific patients and their whānau are being actively supported by the services. Since the return of the Navigators from supporting the regional COVID-19 response, the number of tamariki and their whānau supported has increased markedly. The Kaiārahi Nāhi Principles of Care and future service blueprint have been drafted and are currently under review. The Pacific Model of Care and a future service blueprint has been finalised and is now being used when working with services. A process of formal evaluation of the care navigation approach is currently underway. Planning has commenced to engage earlier in the patient journey from the point of referral and entering the DHB planned care system.
- The wider Planned Care Portfolio, of which the care navigation service is part of, is a complex system of integrated activity spanning improvement projects, digital innovations and operational initiatives across many services and directorates within Te Toka Tumai. The initiatives will deliver or enable benefits for the DHB recovery plans and improve equity. Examples of initiatives within the Planned Care Programme include:
    - Equity focussed work including Care Navigation and the development of a supporting digital tool for care navigators.
    - Extending hours in clinics and operating theatres in prioritised services.

- Implementation of the Outpatients Toolkit, which enables services to select best-fit new models and modes of care delivery. Services currently in implementation (Orthopaedics, ORL and General Surgery) are demonstrating benefits and tracking at or above Price Volume Schedule uplift targets for First Specialist Assessments and Follow Up appointments. We will be commencing work with other priority services (Cardiology and Vascular) over the next few weeks.
- Use of the Surgical Integrated Operations Centre, an operational management framework designed to maximise use and utilisation of operating theatre sessions. This framework, for example, makes it easier to identify in advance if an operating theatre may go unused by one service enabling another service to use the session. This means more patients can have their surgery within our existing operating theatre capacity. Based on the success of this framework last year at Greenlane (5-6% increase utilisation) there is a desire to scale this concept to our Te Papakāinga Atawhai o Tāmaki, Auckland City Hospital based theatre suites and developing supporting digital tools, starting with Level 8.
- Continued introduction of Telehealth services.

- The Board has recently endorsed an engagement plan to work in partnership with iwi and to consult with key internal and external stakeholders, to develop and implement a programme of work aimed at achieving equity across Maternity Services in the Women's Health Directorate. This supports the Board and Executive Leadership Team's strategic priority to eliminate inequities across the organisation. Inequities exist across Women's Health Services, including maternity, gynaecology and fertility. This engagement plan focuses, in the first instance, on addressing inequities in maternity services that are experienced across the maternity journey from preconception, through pregnancy and in the postnatal period. This prioritisation recognises the current impact of capacity issues in this part of the Directorate. Over the next few months the Women's Health Leadership Team, supported by the Board and the Executive Leadership Team will be sharing information and seeking feedback about problem statements and potential focus areas related to eliminating inequities within maternity services. They will also be seeking input from whānau and key stakeholders within Te Toka Tumai and externally, who are involved in the delivery of Maternity services. Most importantly, they will be working closely with our Māori leadership and iwi forums to ensure a partnership approach is adopted to identify problems and develop and implement solutions. The engagement plan will be launched at a Directorate-wide Women's Health Meeting on 1 March 2021. At this meeting the Board Chair and Chief Executive Officer will provide an overview of the Board's strategic priority to eliminate inequity. Executive and Women's Health leadership representatives will also present a summary of potential problem areas contributing to inequities in Women's Health Service. This meeting will be followed up with a series of meetings and workshops with representatives from key stakeholder groups.

- A Surgical and Perioperative review was initiated following the resignations of both the Director of Surgical Services and Perioperative Services. The timing of the resignations provided a unique opportunity to conduct a review that could inform the future shape of the directorates and improve the outcomes and experiences of patients on the surgical pathway and the employee experience. The purpose of the review was to gather feedback from across both directorates, and to use those insights to make recommendations for future planning and design. A

comprehensive data gathering process included input from over 200 employees through individual discussions and facilitated workshops as well as a review of recent patient feedback. Based on the data gathered, there is a strong sense that Te Toka Tumai employees come to work with a great sense of purpose and pride in their work and that they have chosen their careers primarily to deliver high quality patient care. Consistent themes emerged indicating opportunities to strengthen the culture and improve the collaboration and communication, across the Surgical and Perioperative Directorates, with a shared vision and a collective focus on patient centered care. Additional opportunities included patient centered pathway improvements and greater flexibility and team-orientated resourcing. There was a strong desire expressed to see greater leadership development and the ability of leaders to enable change and strengthen team culture. The discovery process has role modelled culture change by being participative and transparent. Recommendations will be prioritised in January/ February and we will commence the design phase in February with consultation on any proposed change in April.

- Transplant volumes total 61 heart, lung and liver and 79 renal transplants, totalling 140 transplants year to date.
- The Ministry of Health DHB performance report for December 2020 has included an analytics report which focuses on recent trends in the DHB workforce planning and forecasting. This report will be utilised to analyse our workforce resourcing drivers, workforce planning and forecasting, and workforce mix and trends.

COVID-19

- Te Toka Tumai continues to manage the impacts of COVID-19 on our hospitals and provider services. The COVID-19 response team remains in place to coordinate activity and respond to any increased community transmission. The team continues to work closely with the Northern Region Health Coordination Centre (NRHCC) and the other DHBs in the region to ensure regional consistency where appropriate.
- An appropriate screening tool is in use to identify patients presenting with higher index of suspicion or with COVID-19 symptoms, which support the appropriate clinical management of patients and use of personal protective equipment. Although the level of community transmission is very low, a number of patients continue to be identified with symptoms each day and are managed as such until test results and other clinical information is available. Since the last update, one patient (who was a recent returnee to New Zealand) was confirmed COVID-19 has been cared for within Te Papakāinga Atawhai o Tāmaki, Auckland City Hospital.
- There are daily admissions from managed isolation and quarantine facilities (MIQFs) for a range of (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.
- There continues to be a small number of people deployed to MIQFs and Auckland Regional Public Health Service (ARPHS) to support the on-going activities of both of those services. Prior to Christmas surge response staff were identified and trained to support ARPHS as required – these are all people working within the provider arm. Te Toka Tumai continues to work with NRHCC to understand the likely on-going demand for staff and balancing that against the need to maintain hospital and community services. Support was offered to Northland DHB following the identification of a positive case in their catchment.

- Planning for the vaccine roll-out is in early stages, working with the Ministry of Health and NRHCC. A high-level sequencing framework has been developed for Te Toka Tumai employees to support a staged roll-out plan.
- 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.

Summer 2020/21

- Midnight occupancy during December 2020 was significantly higher than previous years – Te Papakāinga Atawhai o Tāmaki, Auckland City Hospital (excluding maternity services) saw an increase of 7.8%, equivalent to 46 beds, compared to December 2019. A small (0.07 day) increase in length of stay was observed, accounting for 2.5% increase in occupancy. Early January 2021 also saw acute demand exceed previous years, however this has now settled to be comparable to last year.
- Due to the timing of Christmas, routine planned care continued to Christmas Eve, with most services continuing to provide acute and urgent care over the Christmas/New Year period.
- Fewer beds were reduced compared to previous years as part of the summer plan. This was due to forecasted higher demand, continuation of planned care recovery and the need to maintain a contingency workforce for any COVID-19 community transmission.

2. Ministry of Health Planned Care Performance Dashboard

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

ESPI Performance

- ESPI 5 performance has improved slightly between October and November 2020. ESPI 2 has deteriorated between October and November 2020, however still within the Ministry of Health plan.
- November 2020 ESPI 2 position is 5.3% noncompliant, compared with 5.3% noncompliant at the end of October 2020.
- November 2020 ESPI 5 position is 12.7% noncompliant, compared with 13.5% noncompliant at the end of October 2020.
- We have completed 10,057 planned care interventions year to date in November 2020 against a plan of 10,415 (97%).

2020/21 Planned Care – Year to Date performance

- For November 2020, the Auckland Provider delivered below plan by 239 planned care interventions which was 97% of plan.
- November 2020 activity was slightly lower than October 2020 activity.
- Outpatient volumes continue to recover to plan following the impact of the August 2020 COVID-19 impact.

Financial Performance

Consolidated Statement of Financial Performance - December 2020

Provider	Month (Dec-20)			YTD (6 months ending Dec-20)		
$000s	Actual	Budget	Variance	Actual	Budget	Variance
Income						
Government and Crown Agency sourced	10,881	10,071	811 F	63,651	60,721	2,930 F
Non-Government & Crown Agency Sourced	8,634	8,752	(118) U	53,268	53,010	258 F
Inter-DHB & Internal Revenue	1,818	1,565	252 F	9,120	8,851	270 F
Internal Allocation DHB Provider	131,495	130,465	1,030 F	775,338	782,789	(7,451) U
	152,828	**150,853**	**1,975 F**	**901,377**	**905,370**	**(3,993) U**
Expenditure						
Personnel	123,486	98,312	(25,173) U	611,110	579,576	(31,534) U
Outsourced Personnel	2,965	1,559	(1,406) U	17,313	9,354	(7,959) U
Outsourced Clinical Services	3,930	3,685	(245) U	24,361	21,872	(2,489) U
Outsourced Other	6,201	6,106	(96) U	36,501	36,634	133 F
Clinical Supplies	28,986	25,732	(3,254) U	169,612	165,258	(4,354) U
Infrastructure & Non-Clinical Supplies	15,004	18,243	3,239 F	108,694	109,449	756 F
Internal Allocations	805	805	() U	4,828	4,828	0 F
Total Expenditure	**181,376**	**154,441**	**(26,935) U**	**972,418**	**926,970**	**(45,448) U**
Net Surplus / (Deficit) including Abnormal Items	(28,548)	(3,588)	(24,959) U	(71,041)	(21,600)	(49,442) U
Abnormal Items						
Covid-19 Net Impact on Bottom Line	2,663	0	(2,663) U	25,904	0	(25,904) U
Holidays Act Impact on Bottom Line	20,000	0	(20,000) U	20,000	0	(20,000) U
BAU Net Impact on Bottom Line	**(5,885)**	**(3,588)**	**(2,296) U**	**(25,137)**	**(21,600)**	**(3,537) U**

Consolidated Statement of Personnel by Professional Group – December 2020

Employee Group $000s	Month (Dec-20)			YTD (6 months ending Dec-20)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical Personnel	44,142	34,907	(9,235) U	218,402	208,333	(10,069) U
Nursing Personnel	43,093	32,107	(10,986) U	208,876	193,684	(15,192) U
Allied Health Personnel	19,024	16,218	(2,806) U	94,617	91,731	(2,886) U
Support Personnel	3,254	2,893	(361) U	17,174	16,552	(622) U
Management/ Admin Personnel	13,973	12,187	(1,786) U	72,041	69,276	(2,764) U
Total (before Outsourced Personnel)	**123,486**	**98,312**	**(25,173) U**	**611,110**	**579,576**	**(31,534) U**
Outsourced Medical	1,246	1,039	(207) U	7,724	6,231	(1,493) U
Outsourced Nursing	134	66	(68) U	1,408	399	(1,010) U
Outsourced Allied Health	138	60	(78) U	681	359	(322) U
Outsourced Support	34	26	(8) U	240	156	(84) U
Outsourced Management/Admin	1,413	368	(1,045) U	7,259	2,209	(5,050) U
Total Outsourced Personnel	**2,965**	**1,559**	**(1,406) U**	**17,313**	**9,354**	**(7,959) U**
Total Personnel	**126,450**	**99,871**	**(26,579) U**	**628,423**	**588,930**	**(39,493) U**

Consolidated Statement of FTE by Professional Group – December 2020

FTE by Employee Group	Month (Dec-20)			YTD (6 months ending Dec-20)		
	Actual FTE	Budget FTE	Variance	Actual FTE	Budget FTE	Variance
Medical Personnel	1,550	1,536	(13) U	1,555	1,536	(19) U
Nursing Personnel	4,013	4,010	(3) U	4,081	4,040	(42) U
Allied Health Personnel	2,014	2,025	11 F	2,015	2,032	17 F
Support Personnel	527	531	4 F	532	531	(1) U
Management/ Admin Personnel	1,546	1,554	8 F	1,531	1,554	23 F
Total (before Outsourced Personnel)	**9,649**	**9,656**	**7 F**	**9,714**	**9,692**	**(21) U**
Outsourced Medical	39	29	(10) U	40	29	(10) U
Outsourced Nursing	1	3	3 F	1	3	3 F
Outsourced Allied Health	5	2	(3) U	6	2	(4) U
Outsourced Support	10	0	(10) U	11	0	(11) U
Outsourced Management/Admin	186	23	(163) U	170	23	(147) U
Total Outsourced Personnel	**241**	**58**	**(183) U**	**227**	**58**	**(169) U**
Total Personnel	**9,890**	**9,714**	**(175) U**	**9,941**	**9,750**	**(190) U**

Consolidated Statement of FTE by Directorate – December 2020

Employee FTE by Directorate Group (including Outsourced FTE)	Month (Dec-20)			YTD (6 months ending Dec-20)		
	Actual FTE	Budget FTE	Variance	Actual FTE	Budget FTE	Variance
Adult Medical Services	1,100	1,075	(25) U	1,072	1,041	(31) U
Adult Community and LTC	519	501	(18) U	572	560	(12) U
Surgical Services	938	899	(39) U	932	902	(30) U
Women's Health	381	389	8 F	386	389	3 F
Child Health	1,393	1,362	(30) U	1,403	1,362	(41) U
Cardiac Services	560	555	(5) U	571	564	(8) U
Clinical Support Services	1,418	1,406	(12) U	1,405	1,399	(6) U
Patient Management Services	471	459	(12) U	471	462	(9) U
Perioperative Services	769	811	42 F	787	810	23 F
Cancer & Blood Services	417	410	(7) U	416	412	(4) U
Operational - Others	16	2	(14) U	30	6	(24) U
Mental Health & Addictions	762	806	44 F	776	806	30 F
Ancillary Services	1,146	1,039	(108) U	1,120	1,039	(81) U
Total Personnel	**9,890**	**9,714**	**(175) U**	**9,941**	**9,750**	**(190) U**

Month Result

The Provider Arm result for the month is $25.0M unfavourable. This result is driven by the impacts of Covid-19 ($2.7M) combined with a $20.0M increase in the provision for Holidays Act liability. The underlying BAU result is $2.3M unfavourable.

Overall volumes are reported at 105.7% of base contract for the month - this equates to $6.3M above the month contract. This favourable contract position equates to a $3.0M reduction in the YTD washup liability for planned care and IDF funding, which has been recognised in the month's result.

Total revenue for the month is $2.0M (1.3%) favourable. Variances relating to Covid-19 were $2.0M favourable, with BAU close to budget. The key BAU variances are as follows:

- Provision for planned care and IDF revenue washup $3.0M favourable – reflecting increased volumes in December and therefore a reduction in the YTD washup position.
- New MOH funding for the Integrated Primary Mental Health Initiative $1.5M favourable.
- Retail Pharmacy revenue $0.6M favourable (partly offset by additional cost of goods sold).
- Capital Charge income $3.5M unfavourable due to MOH claw-back on capital charge funding to reflect the reduction of capital charge rate from 6% to 5%. The variance is offset by a reduction in capital charge expenditure.
- Other Income $0.6M unfavourable reflecting additional revenue assumed for budget initiatives not yet received.
- Public Health (base services excluding Covid-19) income $0.3M unfavourable primarily due to deficit support from Auckland metro DHBs not received.

Total expenditure for the month is $26.9M (17.4%) unfavourable. Variances relating to Covid-19 were $4.7M unfavourable and the increase in the provision for Holidays Act liability was $20.0M

unfavourable, leaving the underlying BAU variance $2.2M (1.4%) unfavourable. The key variances are as follows:

- Personnel/Outsourced Personnel costs $26.6M (26.6%) unfavourable, with the Covid-19 impact $3.6M unfavourable, Holidays Act remediation $20.0M unfavourable and the BAU variance $3.0M unfavourable. Excluding unbudgeted Covid FTE, total FTE are 28 over budget, equating to approximately $0.2M of this variance. The majority of the BAU variance reflects lower annual leave booked during December when compared to the planned phasing, however it is expected there will be an improvement in this position in January.
- Clinical Supplies $3.2M (12.6%) unfavourable. Covid-19 costs were $0.9M unfavourable. Excluding these costs, the underlying Clinical Supplies variance is $2.3M unfavourable, in line with volumes significantly higher than budget for the month of December.
- Infrastructure & Non Clinical Supplies $3.2M (17.8%) favourable, with the key variance being Capital Charge $3.5M favourable due to the reduction in the capital charge rate from 6% to 5% (offset by a reduction in capital charge income).

Year to Date Result

The Provider Arm result for the year to date is $49.4M unfavourable. This result is primarily driven by the impacts of Covid-19 ($25.9M) combined with an increase of $20.0M in the provision for Holidays Act liability. The underlying BAU result is $3.5M unfavourable.

Overall volumes (for total Auckland DHB and IDF Funders) are reported at 97.6% of the seasonally phased contract, equating to $17.8M below contract. This unfavourable contract position equates to a $14.0M washup liability for planned care and IDF funding, which has been provided for in the year to date result.

Total revenue for the year to date is $4.0M (0.4%) unfavourable, with a net $1.9M unfavourable of this variance attributable to Covid-19, and BAU $2.1M unfavourable. The key variances are as follows:

- Provision for planned care and IDF revenue washup - $14.0M unfavourable – reflecting significantly reduced volumes during the Covid-19 resurgence period, with continuing lower acute volumes following the return to alert level 1.
- Non Resident revenue $5.2M unfavourable – primarily reflecting reduced Pacific contract cases as a result of Covid-19.
- Capital Charge income $3.5M unfavourable due to MOH claw back on capital charge funding to reflect the reduction of capital charge rate from 6% to 5%. The variance is offset by a reduction in capital charge expenditure.
- Other Income $3.1M unfavourable reflecting additional revenue assumed for budget initiatives not yet received.
- Public Health (base services excluding Covid-19) income $1.1M unfavourable due to deficit support from Auckland metro DHBs not received.
- MOH side contract income $13.3M favourable due to additional laboratory income for high volumes of Covid-19 testing.
- Retail Pharmacy revenue $4.1M favourable (mostly offset by additional cost of goods sold).
- New MOH funding for the Integrated Primary Mental Health Initiative $1.5M favourable.
- Research Income $1.3M 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 larger donations for key projects.

- ACC income $0.7M favourable reflecting additional volumes in services such as Reablement and surgery.

Total expenditure for the year to date is $49.4M (4.9%) unfavourable. Nearly all of this variance is attributable to additional costs arising from Covid-19 ($25.9M) and the increase in the provision for the Holidays Act liability ($20.0M), with the underlying BAU variance $3.5M unfavourable. The key variances are as follows:

- Personnel/Outsourced Personnel costs $39.5M (6.7%) unfavourable with the key variances as follows:
  - Unbudgeted Covid-19 related expenditure of $16.7M.
  - Increase in the provision for Holidays Act liability $20.0M unfavourable
  - Excluding unbudgeted Covid FTE, total FTE are 43 over budget, equating to approximately $2.3M of this variance.
  - The balance of the variance primarily reflects lower annual leave taken than the phased plan, however it is expected there will be an improvement in this position in January.
- Outsourced Clinical Services $2.5M (11.4%) unfavourable, with the key variances as follows:
  - Unbudgeted Covid-19 related expenditure of $0.7M (for laboratory send-away 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 $0.5M unfavourable variance which will correct during the year.
  - Additional MRI outsourcing $0.3M unfavourable for which additional one off MOH funding has been received.
  - Additional outsourcing in Ophthalmology in order to meet contract $0.5M unfavourable.
- Clinical Supplies $4.3M (2.6%) unfavourable. This variance is primarily due to Laboratory consumable costs which are $3.7M unfavourable for the cost of Covid-19 tests. Excluding these costs, the underlying Clinical Supplies BAU variance is $0.6M (0.3%) unfavourable, in line with overall volume performance below contract.
- Infrastructure & Non Clinical Supplies $0.8M (0.7%) favourable, with the key variances being:
  - Unbudgeted Covid-19 related expenditure of $2.6M unfavourable
  - Cost of Goods Sold $3.6M unfavourable for retail pharmacy, offset by additional retail revenue for the year to date.
  - Capital Charge $4.2M favourable due to the reduction in the capital charge rate from 6% to 5%
  - Interest & Finance Charges $0.3M favourable.
  - All Other Operating Expenses such as Professional Fees, Training, Travel & Accommodation $2.4M favourable.

FTE

Total FTE (including outsourced) for December were 9,889 which is 175 higher than budget. The key drivers of the FTE over budget are unbudgeted FTE for Covid-19 (147 FTE) and over appointment of RMOs (24 FTE).

Volume Performance

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

		Dec-2020				YTD (6 months ending Dec-20)			
		$000s				$000s			
Directorate	**Service**	**Cont**	**Act**	**Var**	**Prog %**	**Cont**	**Act**	**Var**	**Prog %**
Adult Community & LTC	Ambulatory Services	1,313	1,585	273	120.8%	9,293	10,206	913	109.8%
	Community Services	1,718	2,124	406	123.6%	11,834	13,027	1,193	110.1%
	Diabetes	520	573	53	110.1%	3,444	3,816	373	110.8%
	Palliative Care	39	39	0	100.0%	234	234	0	100.0%
	Reablement Services	1,265	1,326	61	104.8%	11,917	12,401	484	104.1%
	Sexual Health	318	506	188	159.2%	2,069	3,252	1,184	157.2%
Adult Community & LTC Total		**5,173**	**6,153**	**981**	**119.0%**	**38,790**	**42,936**	**4,146**	**110.7%**
Adult Medical Services	AED, APU, DCCM, Air Ambulance	2,945	2,960	15	100.5%	17,107	16,841	(267)	98.4%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	13,599	15,418	1,819	113.4%	88,238	86,294	(1,944)	97.8%
Adult Medical Services Total		**16,544**	**18,378**	**1,834**	**111.1%**	**105,345**	**103,135**	**(2,211)**	**97.9%**
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	9,823	10,741	917	109.3%	65,626	66,213	588	100.9%
	N Surg, Oral, ORL, Transpl, Uro	10,745	12,139	1,395	113.0%	70,330	69,111	(1,220)	98.3%
	Orthopaedics Adult	4,867	5,047	181	103.7%	31,269	30,028	(1,241)	96.0%
Surgical Services Total		**25,435**	**27,927**	**2,493**	**109.8%**	**167,225**	**165,352**	**(1,873)**	**98.9%**
Cancer & Blood Services	Cancer & Blood Services	11,954	11,706	(248)	97.9%	72,259	71,029	(1,230)	98.3%
	Genetics	289	298	9	103.2%	2,006	2,211	205	110.2%
Cancer & Blood Services Total		**12,243**	**12,004**	**(239)**	**98.1%**	**74,264**	**73,240**	**(1,025)**	**98.6%**
Cardiovascular Services		**13,028**	**12,645**	**(383)**	**97.1%**	**86,180**	**79,618**	**(6,563)**	**92.4%**
Children's Health	Child Health Community Services	2,860	2,699	(161)	94.4%	19,137	14,541	(4,596)	76.0%
	Child Health Medical	5,850	5,929	79	101.4%	39,857	35,485	(4,372)	89.0%
	Child Health Surgical	9,610	10,767	1,156	112.0%	66,365	63,814	(2,551)	96.2%
Children's Health Total		**18,320**	**19,395**	**1,075**	**105.9%**	**125,358**	**113,840**	**(11,518)**	**90.8%**
Clinical Support Services		**3,598**	**3,865**	**267**	**107.4%**	**23,745**	**23,836**	**91**	**100.4%**
DHB Funds		**9,747**	**9,431**	**(316)**	**96.8%**	**59,591**	**60,034**	**443**	**100.7%**
Perioperative Services		**15**	**8**	**(7)**	**53.5%**	**102**	**60**	**(42)**	**58.8%**
Public Health Services		**155**	**155**	**0**	**100.0%**	**929**	**929**	**0**	**100.0%**
Support Services		**102**	**102**	**0**	**100.0%**	**614**	**614**	**0**	**100.0%**
Women's Health Total		**7,252**	**7,888**	**636**	**108.8%**	**49,750**	**50,477**	**726**	**101.5%**
Grand Total		**111,612**	**117,953**	**6,341**	**105.7%**	**731,894**	**714,069**	**(17,825)**	**97.6%**

2) Total Discharges for the YTD (6 Months to December 2020)

		Cases Subject to WIES Payment		All Discharges			Same Day discharges		Same Day as % of all discharges	
		Inpatient								
Directorate	**Service**	**2020**	**2021**	**Last YTD**	**This YTD**	**% Change**	**Last YTD**	**This YTD**	**Last YTD**	**This YTD**
Adult Community & LTC	Ambulatory Services	1,257	1,367	1,279	1,379	7.8%	1,200	1,324	93.8%	96.0%
	Community Services	0	4	0	13	0.0%	0	8	0.0%	61.5%
	Reablement Services	0	0	1,149	1,070	(6.9%)	61	48	5.3%	4.5%
Adult Community & LTC Total		1,257	1,371	2,428	2,462	1.4%	1,261	1,380	51.9%	56.1%
Adult Medical Services	AED, APU, DCCM, Air Ambulance	7,691	7,877	7,881	7,948	0.9%	5,424	5,605	68.8%	70.5%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	10,892	10,292	11,088	10,409	(6.1%)	1,857	1,825	16.7%	17.5%
Adult Medical Services Total		18,583	18,169	18,969	18,357	(3.2%)	7,281	7,430	38.4%	40.5%
Cancer & Blood Total		2,766	2,373	3,229	2,663	(17.5%)	1,737	1,283	53.8%	48.2%
Cardiovascular Services Total		4,259	4,323	4,438	4,445	0.2%	1,135	1,181	25.6%	26.6%
Children's Health	Child Health Community Services	1,662	1,028	1,669	1,031	(38.2%)	125	107	7.5%	10.4%
	Child Health Medical	6,226	5,933	6,854	6,747	(1.6%)	4,792	4,930	69.9%	73.1%
	Child Health Surgical	5,573	4,986	5,919	5,235	(11.6%)	2,500	2,064	42.2%	39.4%
Children's Health Total		13,461	11,947	14,442	13,013	(9.9%)	7,417	7,101	51.4%	54.6%
Clinical Support Services Total		0	0	9	0	0.0%	8	0	88.9%	0.0%
DHB Funds Total		824	1,168	827	1,168	41.2%	638	935	77.1%	80.1%
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	9,803	9,251	10,563	9,880	(6.5%)	5,857	5,218	55.4%	52.8%
	N Surg, Oral, ORL,	6,356	6,198	6,811	6,596	(3.2%)	2,777	2,658	40.8%	40.3%
	Orthopaedics Adult	2,452	2,556	2,555	2,657	4.0%	435	523	17.0%	19.7%
Surgical Services Total		18,611	18,005	19,929	19,133	(4.0%)	9,069	8,399	45.5%	43.9%
Women's Health Total		10,784	10,146	11,188	10,467	(6.4%)	4,122	3,854	36.8%	36.8%
Grand Total		**70,545**	**67,501**	**75,450**	**71,717**	**(4.9%)**	**32,660**	**31,571**	**43.3%**	**44.0%**

3) Caseweight Activity for the YTD (6 Months to December 2020 (All DHBs))

		Acute							Elective							Total						
		Case Weighted Volume			$000s				Case Weighted Volume			$000s				Case Weighted Volume			$000s			
Directorate	Service	Con	Act	Var	Con	Act	Var	Prog %	Con	Act	Var	Con	Act	Var	Prog %	Con	Act	Var	Con	Act	Var	Prog %
Adult Community & LTC		**654**	**681**	**27**	**3,624**	**3,774**	**150**	**103.8%**	**58**	**22**	**(36)**	**319**	**122**	**(197)**	**28.9%**	**711**	**703**	**(9)**	**3,943**	**3,896**	**(47)**	**97.8%**
Adult Medical Services	AED, APU, DCCM, Air Ambulance	2,132	2,171	39	11,824	12,037	214	101.8%	0	0	0	0	0	0	0.0%	2,132	2,171	39	11,824	12,037	214	101.8%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	10,946	10,179	(768)	60,701	56,443	(4,258)	93.0%	17	0	(17)	94	0	(94)	0.0%	10,963	10,179	(785)	60,795	56,443	(4,352)	92.8%
Adult Medical Services Total		**13,079**	**12,349**	**(729)**	**72,525**	**68,480**	**(4,045)**	**94.4%**	**17**	**0**	**(17)**	**94**	**0**	**(94)**	**0.0%**	**13,096**	**12,349**	**(746)**	**72,619**	**68,480**	**(4,139)**	**94.3%**
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	5,047	5,206	159	27,988	28,870	882	103.2%	3,898	3,760	(138)	21,615	20,848	(767)	96.5%	8,945	8,966	21	49,604	49,718	115	100.2%
	N Surg, Oral, ORL, Transpl, Uro	5,218	5,372	154	28,933	29,787	854	103.0%	3,941	3,668	(273)	21,854	20,338	(1,516)	93.1%	9,159	9,039	(119)	50,787	50,125	(662)	98.7%
	Orthopaedics Adult	3,264	3,234	(30)	18,102	17,935	(167)	99.1%	1,976	1,650	(325)	10,955	9,150	(1,805)	83.5%	5,240	4,884	(356)	29,057	27,085	(1,972)	93.2%
Surgical Services Total		**13,529**	**13,812**	**283**	**75,023**	**76,592**	**1,568**	**102.1%**	**9,815**	**9,077**	**(737)**	**54,425**	**50,337**	**(4,088)**	**92.5%**	**23,344**	**22,890**	**(454)**	**129,448**	**126,929**	**(2,519)**	**98.1%**
Cancer & Blood Services		**3,390**	**3,088**	**(302)**	**18,801**	**17,126**	**(1,674)**	**91.1%**	**0**	**0**	**0**	**0**	**0**	**0**	**0.0%**	**3,390**	**3,088**	**(302)**	**18,801**	**17,126**	**(1,674)**	**91.1%**
Cardiovascular Services		**8,723**	**8,039**	**(684)**	**48,372**	**44,579**	**(3,794)**	**92.2%**	**5,159**	**4,567**	**(592)**	**28,605**	**25,324**	**(3,282)**	**88.5%**	**13,882**	**12,606**	**(1,276)**	**76,977**	**69,902**	**(7,075)**	**90.8%**
Children's Health	Child Health Community	1,954	1,113	(840)	10,835	6,174	(4,661)	57.0%	0	0	0	0	0	0	0.0%	1,954	1,113	(840)	10,835	6,174	(4,661)	57.0%
	Child Health Medical	4,548	3,796	(752)	25,222	21,050	(4,173)	83.5%	30	37	8	166	208	42	125.6%	4,578	3,833	(745)	25,388	21,258	(4,130)	83.7%
	Child Health Surgical	5,994	5,562	(432)	33,236	30,842	(2,394)	92.8%	3,813	3,747	(66)	21,143	20,776	(367)	98.3%	9,806	9,308	(498)	54,379	51,618	(2,761)	94.9%
Children's Health Total		**12,496**	**10,471**	**(2,025)**	**69,293**	**58,065**	**(11,227)**	**83.8%**	**3,843**	**3,784**	**(59)**	**21,309**	**20,984**	**(325)**	**98.5%**	**16,339**	**14,255**	**(2,083)**	**90,601**	**79,050**	**(11,552)**	**87.2%**
Women's Health Services		**5,176**	**4,973**	**(203)**	**28,703**	**27,577**	**(1,126)**	**96.1%**	**1,186**	**1,208**	**22**	**6,575**	**6,698**	**123**	**101.9%**	**6,362**	**6,181**	**(181)**	**35,278**	**34,275**	**(1,003)**	**97.2%**
DHB Funds		**135**	**0**	**(135)**	**749**	**0**	**(749)**	**0.0%**	**1,046**	**1,165**	**119**	**5,799**	**6,459**	**660**	**111.4%**	**1,181**	**1,165**	**(16)**	**6,548**	**6,459**	**(89)**	**98.6%**
Grand Total		**57,182**	**53,414**	**(3,768)**	**317,090**	**296,194**	**(20,896)**	**93.4%**	**21,122**	**19,823**	**(1,299)**	**117,126**	**109,924**	**(7,202)**	**93.9%**	**78,304**	**73,237**	**(5,067)**	**434,216**	**406,117**	**(28,099)**	**93.5%**
Excludes caseweight Provision																						

Acute Services

The December quarter continued to experience the tail of the impact of Covid-19 lockdowns and consequent reductions in infectious diseases. YTD the acute performance to contract is 93% (compared to 87% in September). However, performance to contract for the same period last year was 101% of contract, and actual acute caseweight delivery is down by over 2,500 WIES when compared to pre-Covid-19.

- While acute medical discharges are still lower than the same period last year by about 250 discharges per month, there has been a big increase between the September and December quarters. The average number of monthly discharges last year was just over 5,100. The monthly rate for September YTD was 4,680 and for December YTD it increased to 4,870. The biggest increases between the two quarters were in paediatric services with Paediatric ED and General Paediatrics increasing by over 130 discharges per month. Adult ED also saw an increase of 50 discharges per month, while all other medical services were only slightly down on last year. Average WIES has dropped by 3.5% compared to the same period last year because of a drop in long stay high WIES cases. This is predominantly in paediatrics. ALOS is similar to last year.
- Acute surgical discharges have also improved since the September quarter and are now 6% lower than the same period last year. Again the big increases between September and December quarters were in paediatric specialities, particularly Paediatric ORL and Paediatric Orthopaedics. However, there have been increases across most services. There has been a slight drop off in average WIES, but it is still 7% higher than the same period last year and the ALOS is also up by 6%.
- Obstetric numbers have again increased slightly and are now 11% lower than the same period last year, although actual birth numbers are still sitting at 10% lower than the same period last year. Average WIES is the same as last year.

Elective Services

Elective discharges are now nearly 94% of contract. Discharges are up 2% more than the same period last year and average WIES is up 1%.

4) Non-DRG Activity (ALL DHBs)

		Dec-2020				YTD (6 months ending Dec-20)			
		$000s				$000s			
Directorate	**Service**	**Cont**	**Act**	**Var**	**Prog %**	**Cont**	**Act**	**Var**	**Prog %**
Adult Community & LTC	Ambulatory Services	766	889	122	115.9%	5,350	6,351	1,001	118.7%
	Community Services	1,718	2,124	406	123.6%	11,834	12,986	1,152	109.7%
	Diabetes	520	573	53	110.1%	3,444	3,816	373	110.8%
	Palliative Care	39	39	0	100.0%	234	234	0	100.0%
	Reablement Services	1,265	1,326	61	104.8%	11,917	12,401	484	104.1%
	Sexual Health	318	506	188	159.2%	2,069	3,252	1,184	157.2%
Adult Community & LTC Total		**4,627**	**5,457**	**830**	**117.9%**	**34,847**	**39,040**	**4,193**	**112.0%**
Adult Medical Services	AED, APU, DCCM, Air Ambulance	910	919	9	101.0%	5,284	4,803	(480)	90.9%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	4,694	5,449	755	116.1%	27,443	29,851	2,408	108.8%
Adult Medical Services Total		**5,604**	**6,368**	**764**	**113.6%**	**32,727**	**34,655**	**1,928**	**105.9%**
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	2,296	2,622	326	114.2%	16,022	16,495	473	103.0%
	N Surg, Oral, ORL, Transpl, Uro	2,997	3,029	32	101.1%	19,543	18,985	(558)	97.1%
	Orthopaedics Adult	321	576	255	179.4%	2,212	2,943	731	133.0%
Surgical Services Total		**5,614**	**6,227**	**612**	**110.9%**	**37,776**	**38,423**	**646**	**101.7%**
Cancer & Blood Services	Cancer & Blood Services	8,785	9,121	336	103.8%	53,458	53,903	445	100.8%
	Genetics	289	298	9	103.2%	2,006	2,211	205	110.2%
Cancer & Blood Services Total		**9,074**	**9,420**	**345**	**103.8%**	**55,463**	**56,113**	**650**	**101.2%**
Cardiovascular Services		**1,303**	**1,414**	**110**	**108.5%**	**9,203**	**9,716**	**513**	**105.6%**
Children's Health	Child Health Community Services	1,312	1,353	41	103.1%	8,302	8,367	65	100.8%
	Child Health Medical	2,110	2,374	264	112.5%	14,469	14,227	(242)	98.3%
	Child Health Surgical	1,853	1,907	55	102.9%	11,986	12,196	210	101.8%
Children's Health Total		**5,275**	**5,634**	**359**	**106.8%**	**34,757**	**34,791**	**33**	**100.1%**
Clinical Support Services		**3,598**	**3,865**	**267**	**107.4%**	**23,745**	**23,836**	**91**	**100.4%**
DHB Funds		**8,866**	**8,922**	**57**	**100.6%**	**53,044**	**53,575**	**532**	**101.0%**
Perioperative Services		**15**	**8**	**(7)**	**53.5%**	**102**	**60**	**(42)**	**58.8%**
Public Health Services		**155**	**155**	**0**	**100.0%**	**929**	**929**	**0**	**100.0%**
Support Services		**102**	**102**	**0**	**100.0%**	**614**	**614**	**0**	**100.0%**
Women's Health Total		**2,116**	**2,502**	**386**	**118.2%**	**14,472**	**16,201**	**1,729**	**111.9%**
Grand Total		**46,349**	**50,073**	**3,723**	**108.0%**	**297,678**	**307,952**	**10,273**	**103.5%**

Outpatient activity has continued to improve and is now over 100% of contract. The non DRG wash up is $0.3M favourable to ADHB reflecting strong Oncology service delivery this year.

Starship Child Health

Prepared by: Emma Maddren (General Manager)
Speaker: John Beca, Director of Child Health (Surgical) and Michael Shepherd, Director of Child Health (Medical and Community)

Kuputaka : Glossary

Acronym/term	Definition
CED	Children's Emergency Department
NICU	Neonatal Intensive Care Unit
ORL	Otorhinolaryngology (ear nose and throat)
PICU	Paediatric Intensive Care Uni
WNB	Was Not Brought

1. Te Tiriti o Waitangi in Action

- **Kāwanatanga**

Starship Child Health acknowledges the need to embed Māori governance structures into all aspects of the directorate's function and leadership and that there is significant progress to be made here. Starship has some existing and emerging governance activities, particularly at service level which require coordination and development.

Sonny Niha (Te Orewai, Ngāti Hine, Ngāpuhi) was appointed to the role of Starship Kaumātua in mid 2020. Sonny continues to be part of He Kāmaka Waiora and works closely with Starship to improve the outcomes and experiences for Māori tamariki, rangitahi, whānau and staff.

The appointment of Toni Shepherd to the Maori Health Lead, a member of the Starship Senior Leadership Team took place on 11 January. Toni Shepherd is of Kai Tahu and Waitaha descent and has worked with Starship clinically for 12 years. An initial area of focus for the Māori Health Lead will be the establishment of a Māori Advisory Board for Starship. This will provide much needed reflection, guidance and expertise to inform key priorities and actions across Starship.

- **Tino Rangatiratanga**

Haumaru Hononga

Haumaru Hononga (Safety in Partnership) is a group first established within Puawaitahi (child protection multi-agency centre with Te Puaruruhau (Starship Child Protection), Police and Oranga Tamariki) in 2019. The purpose of Haumaru Hononga is twofold:

1. To improve outcomes and experiences of Māori who visit Puawaitahi;
2. To help implement the 'promote equity by respecting diversity' elements of the Puawaitahi Strategic Plan work stream within the work plan, including assisting with oversight of Tikanga and helping to enhance cultural practice in the building.

The tikanga reflects the mana of the local mana whenua, Ngāti Whātua, and is described in the Te Toka Tumai and Waitematā DHB Tikanga Best Practice Guidelines. Responsibilities include:

- To provide a collective voice on matters of tikanga in the workplace and actively support it's consistent use.
- To provide a safe and supportive point of engagement for efforts to build cultural accountability and cultural capacity.
- To be advocates for tamariki and rangatahi Māori service users.
- To create the opportunity for a collective voice for staff from minority and marginalised groups working at Puawaitahi.
- Identifying other initiatives to strengthen and support cultural safety within Puawaitahi.

Key initiatives led by Haumaru Hononga since its inception include:

- **Advocating for and securing dedicated Kaumātua (0.2FTE) and a Kaiāwhina (1.0FTE)** to provide additional capability and capacity to other teams across Puawaitahi to increase successful engagement with tamariki and rangatahi experiencing abuse. Our Kaiāwhina provides support and liaison to Māori tamariki and rangatahi, working closely with our Puawaitahi Kaumātua. The role is hosted by Te Rūnanga o Ngāti Whātua (Te Hā Oranga) to help form links with Iwi based services and connections, as well as improve the visibility of Puawaitahi and provide a communication and reporting line to Te Hā Oranga.
- **Developing and implementing Puawaitahi Cultural Safety Guidelines.** The Guidelines comprise six key principles with underpinning practice points. It is anticipated that as a result of implementing these principles, the awareness and confidence of the workforce will be raised and that staff will demonstrate consideration of wider cultural needs and expectations. Guidelines specific to Puawaitahi will also help to identify and frame bespoke training needs for staff from each of the three statutory agencies working together in this unique setting. These guidelines are the starting point to ensure that the environment and practices at Puawaitahi reflect the identities, languages and cultures of the children who attend.

- **Ōritetanga**

Starship Child Health has committed to an equity programme which will be guided by an equity statement and equity profiles in development for each of the more than 20 Child Health services. Initial work in this area (commenced in mid-2020) has informed both the existing health equity actively at Starship (detailed below) and the identification of additional areas of focus, particularly at the level of individual services and groups of services.

- **Te Ritenga**

Appointment of a dedicated Kaumātua, Sonny Niha, to Starship Child Health in July 2020 was an important step in having increased access to Māori customary protocols within Starship Child Health services. There is now a much greater emphasis on welcoming new staff to the organisation, acknowledging and welcoming staff promoted internally and bringing formality to a range of meetings and fora across the directorate.

2. Eliminate Inequity

Starship Child Health has a range of directorate wide and service-specific equity initiatives. The most significant system-wide initiatives are summarised below:

Development of service-level equity profiles. This work began in mid 2020 and requires all services within Starship Child Health to create a profile of health equity for the service to identify and resolve inequities. This work has important links to Te Toka Tumai-wide work such as the planned care equity programme. The equity profiles are structured around the key domains of access, timeliness, clinical care delivery, outcomes and patient and whānau experience. The pathways and outcomes programme within Starship Child Health, funded by Starship Foundation, is an important area of work to actively resolve inequities.

Patient focused booking. This project, funded by Starship Foundation, has been active for two years and has extended to most medical and surgical services across Starship Child Health. This project invites whānau to contact scheduling teams to negotiate times to be seen in clinic and actively supports whānau to attend at times that suit them. It also provides an opportunity for whānau to receive more information about the purpose of the visit, to coordinate multiple visits on one day and to identify any questions or concerns they might have about their appointment. A comprehensive evaluation of patient focused booking is planned for 2021, supported by funding from the Ministry of Health.

Was not brought (WNB). This work is addressing the significant rates of Starship patients not being brought to appointments. Specific actions include accurate reporting for individual services and clinic locations, greater understanding of the factors which prevent whānau from attending appointments, specific interventions for patient groups, close alignment to patient focused booking, accurate information on whānau we work with and a WNB scheduler to engage with and support whānau to attend appointments when there are challenges. Transport, clinic locations and inter-DHB work are important areas of focus also.

Kaiārahi Nāhi and Pacific Care Navigators. This Te Toka Tumai-wide initiative has been actively implemented in Starship with emphasis on paediatric general surgery, paediatric Otorhinolaryngology (ORL), paediatric orthopaedics and paediatric dentistry. This work is supporting whānau and tamariki and identifying systemic barriers and improvements which will link with other components of the equity programme.

Priority whānau and tamariki project. This two year project has focused on achieving significant and enduring changes for Starship Child Health tamariki and whānau. Key areas of progress include: improved inter-agency working including memoranda of understanding, role clarification, shared information and training, implementation of the neglect of medical care guidelines, psychosocial assessment tool implementation, escalation pathways (internal and multiagency), wellbeing group for Starship staff, engaging effectively with Māori training and appointment to Whānau Liaison role with Ronald McDonald House funding.

Pathways and outcomes programme. Starship has completed the development of six pathways with three implemented. Impacts include reduced inpatient bed days for children with cellulitis by approximately 50% (20 bed days per month), reduction in late cancellations for elective surgery (pilot programme), improved care coordination and planning for spinal surgery patients with resulting reduction in median length of stay. A standardised outcome measurement strategy has been aligned with pathway development and service equity review to increase visibility of inequities, impact of quality improvement through pathway development on equity and to enable data analysis to be more efficient and relevant.

2021 priority areas for the programme include trialling a regional pathway model for planned paediatric ORL surgical services, short stay surgical pathways, acute orthopaedic presentations and prevention and rehabilitation for preventable paediatric respiratory conditions.

3. People, Patients and Whānau at the Centre

Child Health has made progress in the following target areas of the Pūmanawa Tāngata Plan:

People Plan Area	Target Activity	Progress
1. Strengthen our organisational culture and values	• SMOs receive quality multi-source feedback 2-3 yearly, which informs development and support • All managers complete Just Culture training by 30 June 2021	• Trial of multi-source feedback survey near completion in Blood & Cancer service. Roll out in PICU and CED to start in February 2021 • 37 Child Health leaders completed / registered for Just Culture training
2. **Uphold Te Tiriti o Waitangi** - our framework to eliminate racism, build culturally safe practice and achieve health equity	• We understand what a culturally safe environment means for our kaimahi • Education to support shift from cultural competence to cultural safety	• Continued roll out of Engaging Effectively with Māori (64 attendees in Q2) • Equity conversations with all service leaders/ equity focus in all services • Appointment of Māori Health Lead who will further inform this work
3. Grow and develop ngā kaimahi Māori	• Recruitment of Māori candidates to reflect population • Increase Māori leadership within Child Health • Develop Māori Health staff support structures (building on Community/Te Puaruruhau)	• Māori leadership increased through appointment of Māori Health lead and new Safekids Director • 100% of Māori candidates hired in November 2020 • Starship Community developed plan to support Māori kaimahi
4. Create a healthy workplace - through Kia Ora tō Wāhi Mahi	• Increase wellbeing activity at a local level through support and promotion • Increase AL usage	• Wellbeing group surveyed teams across CH and identified how teams are supporting wellbeing and further support needed • Developed Starship Wellbeing Hippo as platform for sharing resources and ideas • Analysis of nursing leave data • Messaging re importance of taking leave/summer plan to optimise leave opportunities. Vacancies in many areas and/or volumes continue to be barrier in reducing leave balances
5. Deliver a workforce that is fit for the future - attracting the best and growing our people	• Establish an IT/Data community of practice	• Member of IT/ data group identified/ liaison with HI to provide support
6. Make it easier to work here - improving our people's experience	• Open and responsive to feedback	• Listening and responding to feedback through various channels
7. Significant Directorate programmes of work (outside of People Plan)	• Review of Pain Service • PICU expansion and atrium refurbishment	• Completed Phase 1 of change project with consultation on integration of acute and chronic pain services • Funding approval for PICU expansion

4. Digital Transformation

Digital transformation is a key priority for Starship Child Health and there is considerable focus during 2021 on the following:

- Ensuring digitally accessible clinical pathways accessible locally, nationally and internationally. The first step is complete around digital publication of pathways and further work is being done around how we can digitise some of the processes within individual pathways.
- Electronic prescribing for outpatients is now live and being further embedded within the directorate.
- Electronic lab ordering is also now live and being embedded.
- Further emphasis on enabling and supporting virtual work across medical, surgical and community services. This includes access to video-enabled equipment and processes to enable easier access for patients, whānau and clinicians.
- Participation in the Regional Community Collaborative Care initiative. This work is seeking to replace the existing clinical record in the community and mental health setting. Close collaboration with Northland and other Northern Region DHBs will ensure consistency in underlying principles and approach. This is a particularly important initiative for Starship Community Services over the next 12-18 months.

5. Resilient Services

Paediatric Intensive Care Unit (PICU) and atrium redevelopment. This $40m project funded jointly by the Ministry of Health and Starship Foundation will enable much needed increased bed capacity and support services for PICU, related clinical services and spaces for Starship whānau. Central Government approval of the funding for this project was confirmed in late December. Procurement and programming activity is currently in progress with building commencement expected in the latter part of 2021.

Regional otorhinolaryngology (ORL) project. This work was commenced in 2020 under the vulnerable services programme. A modest funding contribution from the Ministry of Health is enabling the development of a regional equity profile, waitlist and consideration of a series of options for improving access to services and outcomes for Auckland Metro tamariki. This work is supported by the Northern Regional Alliance.

Service reviews. An external review of the Starship Pain service was commissioned in 2020, funded by Starship Foundation. The review was aimed at ensuring tamariki and whānau receive equitable and appropriate access to services and addressed several long term challenges impacting the service. A phased redesign of the service is now in progress.

6. Financial Sustainability

STATEMENT OF FINANCIAL PERFORMANCE
Child Health Services

Reporting Date Dec-20

($000s)	MONTH			YEAR TO DATE (6 months ending Dec-20)		
	Actual	Budget	Variance	Actual	Budget	Variance
REVENUE						
Government and Crown Agency	1,100	1,057	43 F	5,714	6,473	(758) U
Funder to Provider Revenue	17,930	20,191	(2,260) U	124,340	136,581	(12,241) U
Other Income	1,252	1,506	(253) U	6,856	9,033	(2,177) U
Total Revenue	**20,282**	**22,754**	**(2,471) U**	**136,911**	**152,087**	**(15,177) U**
EXPENDITURE						
Personnel						
Personnel Costs	16,020	14,685	(1,334) U	90,153	86,993	(3,160) U
Outsourced Personnel	133	131	(2) U	783	786	3 F
Outsourced Clinical Services	180	232	53 F	1,290	1,395	105 F
Clinical Supplies	3,019	2,717	(302) U	19,285	18,439	(846) U
Infrastructure & Non-Clinical Supplies	419	421	2 F	2,363	2,510	147 F
Total Expenditure	**19,770**	**18,186**	**(1,583) U**	**113,874**	**110,123**	**(3,752) U**
Contribution	**512**	**4,567**	**(4,055) U**	**23,037**	**41,965**	**(18,928) U**
Allocations	1,042	911	(130) U	6,015	6,030	15 F
NET RESULT	**(529)**	**3,656**	**(4,185) U**	**17,022**	**35,935**	**(18,913) U**

Paid FTE

	MONTH (FTE)			YEAR TO DATE (FTE) (6 months ending Dec-20)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	282.7	274.9	(7.8) U	286.6	274.9	(11.8) U
Nursing	774.5	758.3	(16.2) U	782.2	758.3	(23.9) U
Allied Health	214.9	213.6	(1.3) U	217.7	213.6	(4.0) U
Support	0.3	0.3	0.0 F	0.3	0.3	0.0 F
Management/Administration	109.6	111.3	1.7 F	108.8	111.3	2.5 F
Total excluding outsourced FTEs	**1,382.0**	**1,358.4**	**(23.7) U**	**1,395.6**	**1,358.4**	**(37.3) U**
Total :Outsourced Services	10.7	3.9	(6.8) U	7.8	3.9	(3.9) U
Total including outsourced FTEs	**1,392.7**	**1,362.3**	**(30.5) U**	**1,403.4**	**1,362.3**	**(41.1) U**

Comments on major financial variances

The Child Health Directorate position is $18.9M unfavourable for December year to date.

December Year to Date revenue is $15.2M unfavourable and total expenditure variance is at $3.7M unfavourable.

Inpatient WIES for the December month is 4% higher than last year and 5% higher than contract.

Inpatient WIES for December Year to Date is 11% lower than last year and 13% lower than contract this year.

Full Year FTE for Employed/Contracted Employees is 41.1 FTE unfavourable.

Key factors impacting on December year to date performance are as follows:

1. Revenue $15.2M unfavourable:

- Funder to Provider revenue is currently reported at as $12.2M unfavourable due to reduced inpatient volumes associated with COVID. Acute volumes are particularly low (84%, $11.0M unfavourable), which is driving almost all of the funder revenue deficit. December volumes were quite strong though at 105% and elective volumes are almost at budget levels (99% YTD). However the positive impact for December is not included in the financial result.
- Non resident revenue is $1.6M unfavourable (-63%) due to COVID and the associated border restrictions, and donation revenues are $1.2M unfavourable, although they often vary over the course of the year. However both of these revenue streams are likely to see some continuation of these trends over the year.

2. Expenditure $3.7M unfavourable:

- Personnel costs $3.2M unfavourable. Cost per FTE is 0.9% unfavourable ($0.8M U) which is driven primarily by the increase in leave balances of $1.06M over the first half of the financial year. Staffing levels are 37.3 FTE unfavourable ($2.4M U). In general the variance is driven by FTE variances rather than price issues, albeit that there is continued pressure on reducing leave. Neonates, general paediatrics and eating disorders are the clinical areas under pressure.
- Clinical supply costs are $846k unfavourable. PCT costs are $360k unfavourable but are offset by revenue; Implants $630k unfavourable (mainly orthopaedics $500k but also neurosurgery $230k) although this is closer to $750k on a volume adjusted basis. Current analysis suggests that key drivers are increased spinal volumes, higher use of implants, increased levels of vagal nerve stimulator surgeries and a shortfall in budgeted cost. Blood costs are $110k unfavourable and 105% to last year in spite of activity 11% lower. Similarly, Disposable Instruments in theatre are 25% higher than last year on similar volumes.
- Infrastructure costs are $147k favourable. This reflects primarily low bad and doubtful debt expenditures but is otherwise at budget levels overall.

3. FTE: 43.3 FTE unfavourable:

- Year to date employed FTE was 37.3 unfavourable and total FTE, including outsourced, was 41.1 unfavourable.
- RMO FTE is approximately 6.5 FTE unfavourable with the majority of this through over-appointments. The senior medical staff variance is approximately 5.3 FTE unfavourable – of which approximately 4.0 FTE have unbudgeted revenue funding, and 1.3 FTE unbudgeted across several other services.
- Nursing is 24FTE unfavourable – primarily in Ward 25/Eating Disorders (17 FTE unfavourable), due to increased recruitment of Health Care Assistants and impact of services in the Eating Disorders service; together with the impact of Neonatal Intensive Care Unit (NICU) (9 FTE unfavourable) which continues to see pressure on staffing.
- Allied Health is 4.0 FTE unfavourable with approximately half of it due to funded over appointments and the other half due to over-appointments in sleep technicians and dietitians.
- The focus for 20-21 is to build on pathway development; clinical supply cost containment, productivity and recovery of elective surgery. In addition on-going oversight of employee costs, including vacancy and recruitment processes; and leave will continue to be managed pro-

actively in order to mitigate cost pressures. However the current adverse position is very much driven by the low acute patient activity which is largely driven by COVID impacts.

7. Scorecard and Exceptions

Auckland DHB - Child Health

HAC report for December 2020

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

Safety

Metric		Actual	Target	Previous
Medication errors with major harm	PR215	0	Lower	0
Nosocomial pressure injury point prevalence (% of in-patients)	PR097	6.3%		6.3%
Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	PR185	4.22%		3.8%
Number of falls with major harm	PR199	0	Lower	0
Number of reported adverse events causing harm (SAC 1&2)	PR084	0	Lower	0
Unviewed/unsigned Histology/Cytology results >=30 days	PR596	13	Lower	5
% Hand hygiene compliance	PR195	89.42%	>=80%	91.98%
Central line associated bacteraemia rate per 1,000 central line days	PR087	2.88	<=1	1.94
Number of Central line associated bacteraemia reported	PR600	3		3
Reported Medication/Fluid Incidents causing moderate/severe harm	PR486	0		0
Reported Medication/Fluid Incident rate reported per 1,000 bed days	PR415	6.18		8.44
Good Catches	PR334	21		20
Unexpected PICU admissions	PR374	17		15
Paediatric Code Blue Calls	PR335	3		7
% PEWS score documented	PR355	97.5%	>=95%	97.5%

Patient-centred

Metric		Actual	Target	Previous
% WNB rate for outpatient appointments - Māori	PR057	14.63%	<=9%	15.98%
% WNB rate for outpatient appointments - Pacific	PR058	15.99%	<=9%	16.89%
% WNB rate for outpatient appointments - All Ethnicities	PR056	7.84%	<=9%	8.42%
% WNB rate for outpatient appointments - Deprivation Scale Q5	PR338	13.83%	<=9%	14.53%
% Very good and excellent ratings for overall inpatient experience	# PR154	87.02%	>=90%	88.33%
% Very good and excellent ratings for overall outpatient experience	# PR179	90.6%	>=90%	86.52%
% Very good and excellent ratings for coordination of care after discharge	# PR493	54.55%	>=90%	50%
% Response rate to ADHB patient experience inpatient survey	# PR315	17%	>=25%	16%
Electronic Discharge Summary completion – Child Health	PR439	97.03%	>=95%	97.42%
Child Health Nursing Family Feedback	PR376	98.94%	>=90%	97.27%

Timeliness

Metric		Actual	Target	Previous
(MOH-01) % CED patients with ED stay < 6 hours	PR016	90.77%	>=95%	94.14%
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Māori	PR329	43	Lower	36
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Pacific	PR330	42	Lower	40
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Total	PR328	277	Lower	241
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Deprivation Scale Q5	PR332	94	Lower	83
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Māori	PR323	21	Lower	21
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Pacific	PR324	16	Lower	13
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Total	PR327	83	Lower	103
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Deprivation Scale Q5	PR326	33	Lower	31
Median acute time to theatre (decimal hours) - Starship	PR034	7.92		6.92

Effectiveness

Metric		Actual	Target	Previous
28 Day Readmission Rate - Māori	# PR079	6.32%	<=10%	5.36%
28 Day Readmission Rate - Pacific	# PR080	9.38%	<=10%	7.32%
28 Day Readmission Rate - Total	# PR078	8.53%	<=10%	8.67%
28 Day Readmission Rate - Deprivation Scale Q5	# PR322	7.17%	<=10%	8.98%

Efficiency

Metric		Actual	Target	Previous
Elective day of surgery admission (DOSA) rate	PR048	61.15%	TBC	61.29%
% Day Surgery Rate	PR052	59.73%	>=52%	50.92%
Average LOS for WIES funded discharges (days) - Acute	PR219	4.34	<=4.2	4.53
Average LOS for WIES funded discharges (days) - Elective	PR220	1.3	<=1.5	1.2
% Adjusted Session Theatre Utilisation	PR198	83%	>=85%	84.06%
Average Occupancy	PR444	92.88%	90%	89.79%
Inpatient Median LOS	PR437	2.15		2.09
Inpatients with LOS over 30 days (discharged)	PR438	20		12
FSA to FU Ratio – Child Health	PR440	0.25		0.25
Laboratory cost per bed day ($) - Child Health	PR441	R/U		81.31
Radiology cost per bed day ($) - Child Health	PR442	R/U		115.52
Antibiotic cost per bed day ($) - Child Health	PR443	R/U		24.99
% of patients discharged on a date other than their estimated discharge date	PR375	19.83%		18.47%
PICU Exit Blocks	PR333	3	Lower	14

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 December 2020
R/U	Result Unavailable

Antibiotic cost per bed day ($) - Child Health

Laboratory cost per bed day ($) - Child Health

Radiology cost per bed day ($) - Child Health

Results Unavailable

Atypical acute paediatric demand profile. Starship Child Health experienced significant reductions in demand across some services during 2020, consistent with the demand across other tertiary children's hospitals internationally. The most notable impact was in General Paediatrics, ORL, Orthopaedics and Respiratory. These appear to result from a combination of the COVID lockdown periods in March / April and August / September and the reduced mixing and activity within the community during the period from March 2020. Temporary reductions in demand were experienced in some services such as Children's Emergency Department (CED) and NICU although activity in these areas has since increased dramatically with CED experiencing very high presentations from November onwards and NICU at or over 100% for much of the latter part of 2020.

Elective surgical recovery. The COVID lockdown periods significantly impacted the delivery of elective services during 2020. Recovery plans were submitted to the Ministry of Health in July and updated in October 2020. These plans note the significant and continued disruptions to the health system, not all of which are predictable (supply chain, reliance on Starship for delivery of regional and national work, workforce impacts).

Sustainable commissioning plan for tertiary paediatric services. Application of the current activity based funding model to Starship is not serving the New Zealand population well and it is recommended that a capacity funding approach be explored. The current activity based funding results in:

- Lack of emphasis and influence on equity of access and equity of outcomes,
- Large unpredictable Inter-district flow costs related to high cost individual patients leaving other DHBs vulnerable, especially smaller DHBs,
- Lack of incentive for non-inpatient models of care,

- Lack of centralisation of specialised services where this would improve outcomes, improve efficiency and reduce overall cost, and increase sustainability of the workforce,
- Difficulty planning and delivering relatively small services with vulnerable workforces due to unpredictable revenue.

Starship Child Health is working closely with the executive leadership team to explore an approach to capacity funding and recognises the opportunity to significantly improve inequities, increase efficiency and ensure the long term safety and sustainability of tertiary paediatric services.

Mental Health Directorate

Prepared by: Hineroa Hakiaha (Ngāti Awa, Ngāi Tūhoe, Ngāti Maniapoto, Ngāi Tahu; co-Director), Tracy Silva Garay (co-Director); Alison Hudgell (General Manager)
Speaker: Hineroa Hakiaha and Tracy Silva Garay (Co-Directors)

Kuputaka : Glossary

Acronymn/term	Definitions
CTO	Community Treatment Order
IPS	Individual Placement and Support
Kaimahi	Worker
MHACS	Mental Health and Addiction Additional Crisis Support
MHEA	Mental Health Emergency Alternative
NGO	Non-Government Organisation
Tāngata whai i te ora	People seeking wellness
Tūtakitakitanga	Meet and greet

1. Te Tiriti o Waitangi in Action

"Kua tawhiti ke to haerenga mai, kia kore haere tonu. You have come too far, not to go further. He tino nui rawa ou mahi, kia kore e mahi nui tonu. You have done too much, not to do more." Tā James Henare – Ngati Hine 1998

Te Tiriti o Waitangi and mental health has long been a conversation with non-Māori and honouring its obligations as a Titiri partner. In 1987 James Henare shared that "the Treaty, then was not just a political and legal covenant but also a spiritual one... because of the Treaty, Māori believe right to this day that they are equal partner and yet they know from experience that is not so."

Here in Mental Health and Addictions, we are not going to wait another 30 years to honour Te Tiriti; Te Tiriti is going to be the tool that will support our service to eliminate institutional racism, racism and discrimination, unconscious bias, social injustice and unfair health care treatment at all levels. We recognise our shortcomings and are prepared to make changes and do things differently for those that we serve in our community.

According to Whakamaua, the Māori Health Action Plan 2020-2025, Ōritetanga - Article 3, when expressed in mana terms is Mana Tangata. This refers to fairness and justice and equity. Te Ritenga - The Declaration, when expressed in mana terms is Mana Māori. This refers to cultural identity and integrity, active inclusion and protection of Matauranga Māori. As there is so much of Te Tiriti that we would like to implement within our mahi as the Mental Health Directorate, and to remain true to ensure that the integrity of the its mana is maintained, we will implement and focus on Article 3 (Mana tangata) and the Declaration (Mana Māori) of Te Tiriti. It will take 6-12 months to prepare, then a period for implementation into practice, followed by ongoing monitoring of its effectiveness within the services and how kaimahi are coping with changes.

Ōritetanga – Mana Tangata: To accomplish fair and just behaviour and services, we need a workforce that is culturally capable to work for tāngata whai i te ora and their whānau. This includes needing a workforce that is tailored to meet Māori aspirations for wellbeing. Therefore, the

Mental Health Directorate is in the process of organising training for staff within the directorate that will ensure confidence, courage and being effective in their wāhi mahi/work space. Kaimahi will require an environment that is equally conducive to practice with tāngata whai i te ora and access to the right tools to provide quality care.

Ritenga Māori – Mana Māori: In order to accomplish this part of Te Tiriti, we will tie it into the Mana Tangata training and mahi. This is to ensure that kaimahi interactions and engagement with tāngata whai i te ora are effective and efficient, and that both are safe during these processes of whanaungatanga and tūtakitakitanga. Therefore, the training will be tailored specifically for staff of Mental Health and Addictions.

2. Eliminate Inequity

Our Māori whānau living in Tāmaki Makaurau are part of the inequitable health statistics of Aotearoa. To effectively tip the balance of inequities for Māori wellbeing we have to be proactive in the next 6-12 months and into the future to tackle our structures which relate to our processes and procedures. The successful recruitment of an Equity Lead person is one of the key ways we will start to effectively deal with inequities within the Mental Health and Addictions Directorate.

2.1 Community Treatment Order Project

The Community Treatment Order (CTO) project is looking at three key priority areas to address inequities:

1. Access to free medication
2. Tāngata whai i te ora and whānau empowerment
3. Staff training Mental Health Act

All three priority areas had developed workstream plans for the 2020-2021 financial year with completion aimed for June 2021. However, due to the impacts of COVID-19 this work was put on hold for over 6 months. A new timeline has been developed with work starting early in the new year and running through until June 2022.

The whānau empowerment and engagement work will begin on 17 February, called “Kōrero Mai”. This is for whānau and tāngata whai i te ora to gain a greater understanding of the CTO process to enable greater empowerment of tāngata whai i te ora to make informed choices. The hui will also be an opportunity to share information on the project and seek their feedback which will inform the next steps of the project, including removing potential tāngata whai i te ora off the Mental Health Act. There will be staff training around the CTO, the power of decision making for tāngata whai i te ora care and where this should sit.

3. People, Patients and Whānau at the Centre

Specialist mental health and addiction services are essential for the health of people with complex or enduring mental health and addiction issues. Strengthening these services will involve improving seamless access to care between hospitals, general practices and community services. It will include

determining how to best use a range of forms of support, such as peer support, group therapies and telemedicine.

The voices and stories of people with lived experience of specialist services, and their whānau, will be important in influencing decision-making to implement changes.

3.1 The Mental Health and Addictions Transitions Pilot

The Mental Health and Addictions Transitions Pilot will strengthen and improve the responses of Mental Health Services when discharging tāngata whai i te ora from inpatient services and establishing community support packages.

The Pilot is targeted at adults with complex mental health and addiction and other needs requiring specialist mental health services to gain and maintain wellbeing in a community setting.

The Pilot will offer a transition programme for tāngata whai i te ora leaving acute mental health inpatient services, to ensure they receive housing support, ongoing mental health and addictions support, and other wraparound support according to their individual needs. This will involve tāngata whai i te ora being supported into housing in the community with holistic care provided by a multi-disciplinary workforce (a mix of clinical and non-clinical workers, including peer and cultural support workers) who can actively provide support, and connect the person to other support as needed.

The Pilot is targeted at 70 tāngata whai i te ora over a 4 year period and will include any or all of the following:

- Flexible home-based services, tailored to meet the unique needs of individuals in scope for this initiative,
- Provision of housing through access to the public and private market/social or supported housing,
- Provision of mental and physical health services, and
- Provision of broader support services.

This pilot is instrumental in the achievement of this aspirational goal and of addressing the urgent issues of people stranded, or likely to be, in inpatient services despite no longer clinically requiring that level of services due to being homeless with no suitable accommodation to be discharged to.

The pilot requires a focus on equity and a culturally appropriate approach and environment. A co-design process involving Māori and tāngata whai i te ora, along with other sectors, involved in homelessness and housing will take place.

3.2 Housing Specialist Role

This role arose out of an engagement in 2017 with our services and Non-Government Organisation (NGO) providers following challenges with discharging people with complex needs who were clinically ready, but without suitable housing, to the community. In 2020 it was agreed to initiate a one year pilot of a Housing Specialist role to facilitate discharges of this cohort from inpatient mental health facilities. This role complements the more recent Mental Health and Addictions Transitions Pilot in that there will be people who may not be prioritised or fit the Transition pilot criteria, but who can be supported by the Housing Specialist.

The Housing Specialist is co-located with the Assertive Community Outreach Service and will work collaboratively within Te Whetū Tāwera, Buchanan Rehabilitation Service and with the Taylor Centre

which covers the CBD (therefore have demand from among those experiencing homelessness in Auckland Central), to identify and support transitions to long term housing and support options for tāngata whai i te ora with complex housing needs.

The role of the Housing Specialist will be to provide housing navigation support to tāngata whai i te ora, whilst integrated with specialist mental health services. Key functions of the role include:

- Accepting referrals from clinical staff for people who have been assessed as being able to live independently,
- Assessing the housing needs of tāngata whai i te ora e.g. configuration, location affordability, eligibility for Housing First,
- Supporting tāngata whai i te ora to get on the housing register and/or to maximise income and accommodation benefits,
- Sourcing housing solutions from the public, community and private market or working with agencies that provide this function and supporting people to move in.

An evaluation will determine the efficacy of this approach and if successful, will provide evidence for a further business case to ensure sustainable funding for this initiative.

3.3 NGO Partner Role for the Intensive Support Pilot Te Whetū Tāwera

During the August COVID-19 response we saw increased pressure on Te Whetū Tāwera beds and decreased capacity in CMHC teams, along with high volumes of available NGO contracted support hours. This resulted in NGOs being engaged to explore how support hours might be used differently to provide some more intensive support for up to 10 days to enable the discharge of people with their own accommodation from Te Whetū Tāwera. The focus was threefold;

- Working proactively with tāngata whai i te ora and whānau to identify support needs on discharge,
- Navigation to support resources, particularly informal and natural supports,
- Providing knowledge and expertise on social supports to the Multi-disciplinary team in the CMHC,
- Providing short term brief support interventions.

Subsequently, and due to the success of this intervention during COVID and ongoing availability of NGO support hours, it was agreed to have a 0.5 FTE NGO partner position for one year to support tāngata whai i te ora, whānau and clinicians to continue with this approach. In addition the NGO partner will identify gaps in knowledge and understanding about community resources and will seek to broker introductions and develop relationships between them and Te Whetū Tāwera. Where identified supports cannot be provided from existing formal or informal supports, the NGO partner will identify and report that gap.

3.4 Mental Health and Addiction Additional Crisis Support Role and Experience in Adult Emergency Department

The Ministry of Health has funded a Mental Health and Addiction Additional Crisis Support (MHACS) role to help strengthen and improve the responses of Emergency Departments (and other locations people may present in crisis) to individuals presenting with mental health needs or in distress.

As part of the development of this role, engagement took place with a range of staff involved in Adult Emergency Department (Emergency Department and mental health clinicians, security, orderlies and administration staff) as to their experience and needs in working with people presenting in mental health and addiction crisis. Five hui with Māori and Pacific tāngata whai i te ora and others with recent experience of presenting to the Adult Emergency Department in crisis were set up to be facilitated by our consumer leadership team. Unfortunately these were cancelled due to the Auckland level 3 COVID lockdown and previous consultation feedback was utilised.

The support includes a mental health nurse educator role to build the capability and confidence of staff working in the Emergency Department and other locations people present in crisis. The role is intended to support the professional development and capability of clinical, non-clinical and administration staff who interact with individuals (and their whānau or support people) presenting with mental health needs or in distress.

The MHACS nurse educator will be an expert in Mental Health and Addictions and experienced in supporting and developing the clinical, cultural and professional skills of health workers. The role could provide education, support and supervision but will not be a direct clinical role (or carry a clinical caseload).

It is anticipated that the professional development of staff will occur flexibly and be tailored to meet the needs of the Emergency Department (and other locations where people present in crisis), taking into account the needs of different occupational groups and roster patterns.

3.5 Increasing Access to Employment Support for New Zealanders with Lived Experience of Mental Health and Addiction Issues

People with lived experience of mental health and addiction issues want to work, but levels of employment participation remain significantly lower than for people without mental health and addiction issues. This is particularly the case for people accessing specialist mental health and addiction services who are four times more likely to be unemployed.

For example, large numbers of people with mental health and addiction issues have lost contact, often for many years, with the labour market. This is evident from the high numbers of people with mental health and addiction issues (diagnosed and undiagnosed) claiming welfare benefits.

For most people, being in employment is good for health and wellbeing, and is far better for a person's health and wellbeing than being unemployed. Staying at work or returning to employment are wellbeing goals for people and whānau. Therefore, quality support to achieve these employment aspirations should be an integral part of a transformed mental health and addiction system. To support people with mental health and addiction issues who face multiple barriers to returning to work, intensive employment assistance integrated with health treatment is needed.

Research over the past three decades, conducted in multiple countries including Aotearoa with tāngata whai i te ora, clinicians and other stakeholders, has identified, validated, and operationalised evidence-based practices which can address this employment inequity and meet peoples' employment aspirations. These evidence-based practices are collectively known as the Individual Placement and Support (IPS) approach to employment support. IPS practices are specifically designed to successfully support people who face multiple health and social barriers to employment, achieve their vocational aspirations.

When compared to the efficacy and effectiveness evidence for other psychosocial interventions in psychiatry, this evidence base is significantly advanced and well-established, and has been successfully replicated globally.

Te Toka Tumai has, for some time, funded 5 FTE IPS consultants who work in an integrated way with some of our Community Mental Health Centres. However this means there are some community based services that do not have access to IPS and, for those that do, there is an insufficient ratio of consultants to tāngata whai i te ora in service as per IPS fidelity.

Our Directorate has been working closely, as part of a national group, to develop a cross-government approach to enable a co-ordinated service delivery response so that peoples' health and employment needs are met at the same time, rather than sequentially. Evidence indicates that when employment and health services are integrated, more people are supported to successfully to remain in work and return to employment.

Subsequently the Ministry of Social Development (MSD) wants to pilot an Auckland metro response and intends to match the existing 13 IPS FTE in the Waitematā DHB pilot in Te Toka Tumai and Counties Manukau DHB. This will see an increase of 7 – 8 FTE IPS consultants across Te Toka Tumai as a pilot for one year starting 1 July 2021.

3.6 Quality, Safety and Risk

The Mental Health Directorate has initiated a process for making quality, safety and risk part of what we do all the time. An agreed framework and template supports our clinical and operational leaders from the seven service groups (covering 23 services) to share with the Directorate Leadership Team clinical, quality, safety and risk areas and issues on a regular basis (quarterly meetings).

The four key areas of focus are:

- Service Improvement,
- Governance and Assurance,
- Patient Experience,
- Key Result Areas.

3.7 Integrated Primary Mental Health Care Initiative

As part of the response to the RFP for this initiative, Te Toka Tumai and Waitematā DHB have received some funding for secondary mental health services to support primary care in an integrated way. Our Directorate Leadership Team has worked with Waitematā leadership to develop a joint plan for the enhancement of the current support provided to primary care. The funding is intended to cover:

- 1 FTE Nurse Educator / Clinical Coach who will work with the mental health credentialed nurses in primary care and provide on-going clinical supervision, training and coaching / mentoring where required. The role will create communities of practice so that nurses working closely together (practice areas or location) can come together to support each other and reduce burnout. A geo-mapping exercise will support this approach.
- 0.5FTE Senior Medical Officer phone line

- Strengthened health pathways to support transition of tāngata whai i te ora in specialist mental health services back to primary care.
- Explore the feasibility of increasing credentialed nurse sessions to 30 minutes as part of extended consultations, similar to extended GP consults.

4. Digital Transformation

4.1 Zoom Enabled Technology

Te Toka Tumai Mental Health Adult Acute Inpatient Service Te Whetū Tāwera is constantly at capacity. The ten adult mental health services, including CMHCs that refer the majority of service users for admission, have an increased demand for services and increased acuity which has contributed to further demand on beds at Te Whetū Tāwera. With the majority of community based service across a range of geographical locations, there has been fragmentation in terms of collaborative care planning across specialist and NGO services and with whānau. A significant contributing factor has been the lack of technology to assist this.

The impact is negative service user experience and outcome, increased pressure on the community mental health service groups, and increased risk to service users due to the inability to access the appropriate service in a timely manner.

A process improvement project commenced in 2019 to work through understanding the flow issues across adult inpatient and community services and to identify solutions by determining root causes of the problems. As noted above, one of the issues identified was the challenge with taking a consistent collaborative approach across services and with whānau for integrated care planning and the requirement for Zoom enabled technology to support a sustainable way of addressing this.

This is also an issue across our Child and Youth and Older Adult services.

A capital bid has been approved to address this for Adult services as phase 1 of this project and a business case is underway. The second phase, focusing on Child and Youth and Older Adult, will require a capital bid in 2021/22.

4.2 Telehealth Project

When Aotearoa went into Level 4 lockdown, the use of telehealth for service user consultations at Te Toka Tumai became key in facilitating the physical distancing required in the management of COVID-19.

The definition of telehealth is 'the use of information and communication technologies to deliver health care when patients and care providers are not in the same physical location'[1].

As the country moves out of more restrictive COVID-19 levels, and services start to return to their normal working practices, mental health services are looking to capitalise on the experience gained from using telehealth.

As an initial step, and through a short survey across 20 service users, the consumer leadership team gained feedback from tāngata whai i te ora and whānau using qualitative and quantitative methods.

[1] https://www.telehealth.org.nz/telehealth-forum/what-is-telehealth/

A survey was also conducted with clinical staff on their experience of telehealth, including what worked and areas for development. Subsequently a working group of clinicians, with consumer representation, have agreed that they will promote the use of Zoom as a consumer driven initiative. This aligns with the He Ara Oranga and Ministry of Health focus on Access and Choice.

Our Directorate is also involved in a national group set up to work on clinical standards and telehealth.

5. Resilient Services

5.1 COVID-19 Pandemic Response

To support the delivery of safe and flexible health care with our population in the COVID-19 pandemic response, the Mental Health Directorate has:

- Developed COVID contingency plans for our community and inpatient services,
- Audited and supported over 35 NGO led residential services for people with mental health and addiction issues,
- Developed an audit tool to ensure ongoing quality assurance so that services are COVID-19 ready should we be required to move up and down levels.

As a Directorate we have been actively involved in supporting the Homeless in Motels initiative developed in response to COVID and the Managed Isolation and Quarantine hotels. This includes developing pathways, and associated communications, for these services into specialist mental health services.

5.2 Agile and Rapid Adaption Programmes

During the COVID-19 Level 4 lockdown, and in order to support the Adult Emergency Department, the Directorate stood up a Mental Health Emergency Alternative (MHEA) located at Greenlane.

The intention was to safely divert those with mental health needs or dual diagnosis needs (and no physical needs) away from the Emergency Department, and the purpose of doing so was to:

- Reduce the risk of exposure to COVID 19 for patients and staff,
- Reduce cross contamination by staff who were visiting multiple sites,
- Allow the Emergency Department to focus on those with physical needs,
- Ensure that the Emergency Department had adequate capacity to cope with the global pandemic.

These were extra-ordinary measures implemented for the level 4 lockdown period with a planned review post lockdown. When the country moved out of Level 4, and on reviewing COVID-19 measures that made a positive difference to determine the viability and benefits of implementing them into business as usual, MHEA became a focus of attention.

The setting up of MHEA was deemed to have made a positive difference to tāngata whai i te ora, whānau and staff, and this model of care needed to be further explored. The assumption was that any design would take advantage of the benefits of safely reducing pressure on the Emergency

Department for mental health attendances and assessments, and ensure that any future model of care design is sustainable moving into business as usual. It would not, however, address the issue of flow which would need to have a focus on acute options.

Subsequently two sprints were set up, with the objective being to design and develop a model of care for the Mental Health and Addictions Directorate that allows for tāngata whai i te ora who require a timely specialist mental health assessment, and do not have medical needs, to be diverted from the Emergency Department into a low stimulus environment and a facility that fits with the environmental and health and safety needs.

As a follow on from the sprints, the next step is to develop a comprehensive Liaison Psychiatry model that covers a 24/7 period seven days a week. This is required to complement a Mental Health Emergency Alternative.

6. Financial Sustainability

Financial Results

Auckland DHB - Mental Health

Statement of Financial Performance for December 2020

($000s)	MONTH			YEAR TO DATE (6 months ending Dec-20)		
	Actual	Budget	Variance	Actual	Budget	Variance
REVENUE						
Government and Crown Agency	0	79	(79) U	644	475	169 F
Funder to Provider Revenue	10,846	10,838	8 F	64,587	65,029	(442) U
Other Income	37	61	(24) U	433	367	66 F
Total Revenue	**10,883**	**10,979**	**(95) U**	**65,663**	**65,871**	**(208) U**
EXPENDITURE						
Personnel Costs						
Medical	2,090	2,341	250 F	11,028	13,801	2,773 F
Nursing	3,405	3,226	(179) U	19,549	19,243	(306) U
Allied Health	1,956	2,153	197 F	11,376	12,020	644 F
Support	42	36	(6) U	224	205	(18) U
Management/Adminstration	444	434	(10) U	2,590	2,512	(78) U
Savings	0	0	(0) U	0	0	0 F
Total Personnel Costs	**7,937**	**8,189**	**253 F**	**44,767**	**47,781**	**3,015 F**
Outsourced Personnel	235	34	(201) U	1,717	206	(1,512) U
Outsourced Clinical Services	88	193	105 F	682	1,156	474 F
Clinical Supplies	138	112	(26) U	581	671	90 F
Infrastructure & Non-Clinical Supplies	380	399	19 F	2,605	2,399	(206) U
Total Expenditure	**8,777**	**8,927**	**150 F**	**50,351**	**52,212**	**1,861 F**
Contribution	**2,106**	**2,052**	**54 F**	**15,312**	**13,659**	**1,653 F**
Allocations	2,114	2,097	(17) U	12,731	12,601	(129) U
NET RESULT	**(8)**	**(46)**	**37 F**	**2,581**	**1,058**	**1,524 F**

Paid FTE

	MONTH (FTE)			YEAR TO DATE (FTE) (6 months ending Dec-20)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	87.7	107.4	19.7 F	85.6	107.4	21.8 F
Nursing	355.3	365.6	10.2 F	365.0	365.6	0.6 F
Allied Health	238.6	260.8	22.2 F	242.5	260.8	18.3 F
Support	7.4	7.2	(0.2) U	7.4	7.2	(0.2) U
Management/Administration	63.4	63.1	(0.3) U	64.9	63.1	(1.8) U
Savings	0.0	0.0	0.0 F	0.0	0.0	0.0 F
Total excluding outsourced FTEs	**752.5**	**804.0**	**51.5 F**	**765.3**	**804.0**	**38.7 F**
Total :Outsourced Services	9.6	2.0	(7.6) U	10.3	2.0	(8.3) U
Total including outsourced FTEs	**762.0**	**806.0**	**44.0 F**	**775.7**	**806.0**	**30.3 F**

Comments on Major Financial Variances

The Mental Health Directorate is $37k favourable to budget for the month of December and $1,524k favourable to budget YTD.

The driver of the favourable YTD variance remains lower medical and allied health personnel costs which reflect vacancies in SMO positions, Psychologists and Occupational Therapists.

Key drivers of the favourable YTD variance are

Total Revenue - $208k unfavourable. This is mainly due to the Funder to Provider revenue wash up for the CSW Service and is offset by savings in CSW operating expenditure (the CSW service was transferred to the Funder after the budget was set).

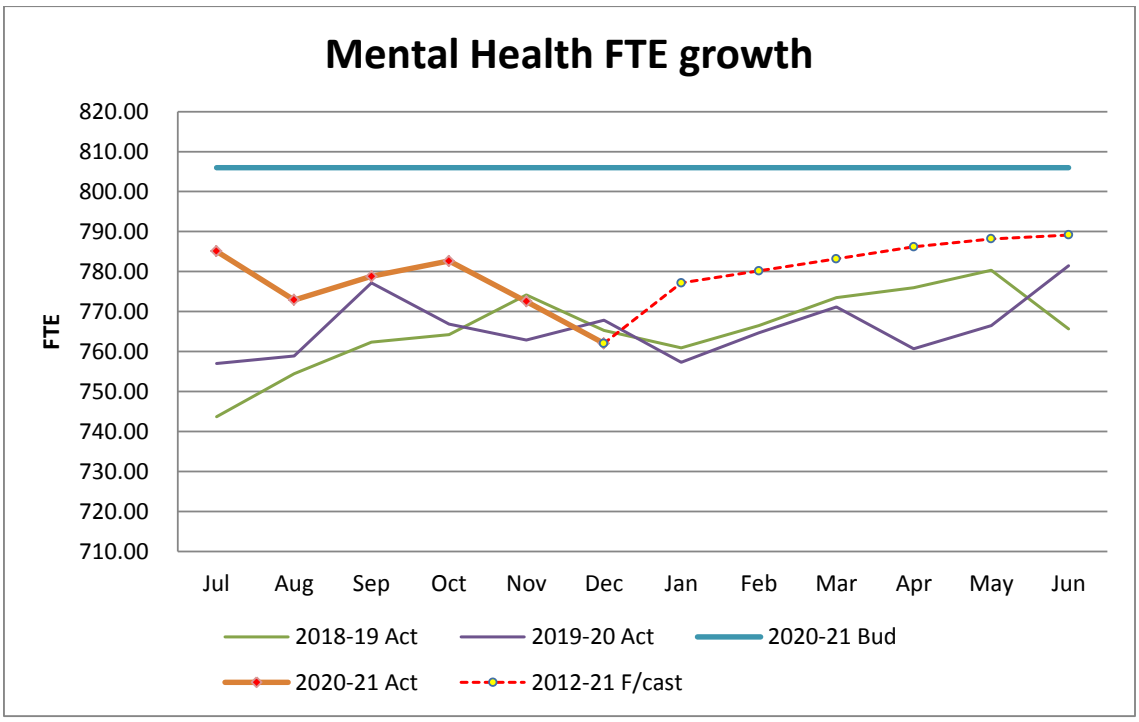
Total Expenditure (including allocations) - $1,732k favourable. This is primarily due to:

Personnel costs including Outsourced Personnel -$1,503k favourable mainly due to

- Medical Personnel costs $1,472k F – due to vacancies partially offset by outsourced medical costs to backfill vacant positions.
- Allied Health vacancies $520k F - mainly vacancies in Psychologists and Occupational Therapists.

YTD FTE – 30.3 FTE favourable

Overall the YTD FTE numbers have improved from previous years, but recruitment timeframes have increased as a result of travel restrictions due to the Covid-19 pandemic response.



7. Scorecard and Exceptions

Auckland DHB - Mental Health

HAC report for December 2020

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

Safety

Metric		Actual	Target	Previous
Medication errors with major harm	PR215	0	Lower	0
Nosocomial pressure injury point prevalence (% of in-patients)	PR097	0%		0%
Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	PR185	0.4%		0.5%
Number of falls with major harm	PR199	0	Lower	0
Number of reported adverse events causing harm (SAC 1&2) - excludes suicides	PR201	3	Lower	4
Unviewed/unsigned Histology/Cytology results >=30 days	PR596	0	Lower	0
Reduction in number of AWOLs from inpatient units	PR740	13	Lower	16
Discharges with face-to-face contact within 7 days of discharge	PR230	95.1%	>=95%	90.7%
Screening for Family Violence	PR741	62.52%	>=90%	53.22%
Reduction in physical assaults in acute inpatient units	PR742	12	Lower	11
Reduction in verbal threats and abuse in acute inpatient units	PR743	1	Lower	5

Patient-centred

Metric		Actual	Target	Previous
% hospitalised smokers offered advice and support to quit	PR129	85.71%	>=95%	95.83%
Seclusion episodes: Total	PR213	2	<=7	1
Seclusion episodes: Māori	PR761	0	Lower	0
Seclusion episodes: Pacific	PR762	2	Lower	0
Reduction in episodes of personal restraint	PR214	45	<=86	47
Family/Whānau engagement (Adult CMHS)	PR763	37.43%	>=30%	39.27%
Identifying clients who are parents	PR764	42.27%	>=40%	44.35%
Smoking screening and VBA: Community	* PR765	43%	>=95%	40.88%
Mental Health Act - Family consultation for S76 Reviews	PR779	53.7%	>=30%	60%

Timeliness

Metric		Actual	Target	Previous
3 week Waiting Times: 0-19 years - Total	PR223	62.9%	>=80%	65.6%
3 week Waiting Times: 0-19 years - Māori	PR785	70.45%	>=80%	72.78%
3 week Waiting Times: 0-19 years - Pacific	PR786	80.73%	>=80%	82.24%
3 week Waiting Times: 0-19 years - Asian	PR787	66.88%	>=80%	67.35%
3 week Waiting Times: 0-19 years - Other	PR788	56.19%	>=80%	59.86%
3 week Waiting Times: 65+ years - Total	PR227	76.9%	>=80%	75.1%
Section 76 Reviews Completed on Time: Māori	PR744	27.59%	100%	40.91%
Section 76 Reviews Completed on Time: Non-Māori	PR745	41.67%	100%	53.62%

Effectiveness

Metric		Actual	Target	Previous
Percentage of discharges with paired HoNOS assessments - inpatient	PR757	57.27%	>=80%	65.35%
% of people seen face-to-face with HoNOS assessment - community (90 day)	PR746	41.84%	>=80%	44.32%
Provider Arm Access - 0-19Y Total	PR205	2.74%	>=2.05%	2.74%
Provider Arm Access - 0-19Y Māori	PR202	4.17%	>=2.58%	4.29%
Provider Arm Access - 0-19Y - Pacific	PR758	1.86%	>=1.4%	1.86%
Provider Arm Access: 0-19Y - Asian	PR759	1.54%	>=1.12%	1.52%
Provider Arm Access: 0-19Y - Other	PR760	3.5%	>=2.8%	3.51%
28 day Acute Mental Health Re-Admission Rate - Māori	PR789	17.39%	<=10%	3.85%
28 day Acute Mental Health Re-Admission Rate - Pacific	PR790	11.11%	<=10%	9.09%
28 day Acute Mental Health Re-Admission Rate - Total	PR791	10.64%	<=10%	5.5%
28 day Acute Mental Health Re-Admission Rate - Deprivation Scale Q5	PR792	24.14%	<=10%	7.69%

Efficiency

Metric		Actual	Target	Previous
Discharge transition planning - inpatient	PR781	52.73%	>=95%	35.64%
Discharge transition planning - community	PR782	40.17%	>=95%	38.38%

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.
*	Quarterly

PR765 (Quarterly)

Actual result is for the period ending June 2019. Previous period result is for period ending March 2019.

Scorecard Commentary

7.1 Screening for Family Violence

While Mental Health remains below target, our results compare favourably with other Directorates.

7.2 Smokefree

Weekly reporting and monitoring is now in place and managed by the Smokefree Co-ordinator.

7.3 Waiting Times

Wait times remain a key issue for Child and Adolescent services. Since the end of the first lockdown and through the second lockdown, a surge in referral rates has seriously impacted waiting times. For instance, in some weeks, the referral numbers were more than 50% higher than the same weeks last year. As a consequence a service-wide project is underway and is actively working in a consultative approach with staff to look at improving flow into, and through, the service. The first part of this project is focused on the initial referral, triage and assessment phase, and how we can streamline our services. We continue to offer telehealth as an option for both initial assessment and ongoing intervention.

7.4 Section 76 Mental Health Act Reviews

The Director, Area Mental Health Services will be conducting a workshop this year to provide additional guidance around Section 76 review processes.

7.5 HoNOS Assessments

HoNOS is an outcomes assessment tool mandated for use in mental health services nationally. A project is underway to trial ways to integrate the use of this tool in multi-disciplinary team reviews as a way of fostering better uptake. Allied to this, reporting is being developed and trialled to provide more meaningful and useful HoNOS data for clinicians.

7.6 28 day Re-Admission Rate

The very high rates this month are at odds with our usual results which sit well below the 10% threshold. This was driven by high re-admission numbers at Te Whetū Tāwera for November. The results will be monitored.

7.7 Discharge Planning

This local reporting item aligns with a quarterly Ministry of Health report on wellness planning for current and recently discharged clients and fits with a directorate-wide focus on “connecting care” this year. The Ministry of Health reporting includes an audit of a sample of plans which is very useful in highlighting quality issues. While overall the targets have not been met, there is some variation among services. Where targets are not being met, service groups are undertaking a variety of initiatives to improve care planning. These include a focus on education (e.g. training around systems), integrating care planning into wider clinical processes, implementing a new template for collaborative care planning, and setting up clear systems for reviews, audit and monitoring.

Women's Health Directorate

Prepared by: Bridget Cooper (General Manager), Nicole Pihema {Ngāpuhi me Te Rarawa} Associate Director of Midwifery (Māori Health and Equity), Deb Pittam (Director of Midwifery)
Speaker: Rob Sherwin (Director)

Ko te waka o Te Wāhanga Hauora Wāhine tēnei e tuku mihi
Ki a koutou kua mau ringa ki te hoe
Ki te hunga katoa kua whakapono ki a matou
He mea nui to tātou iwi
He mea nui to tātou whenua
He mea nui to tātou Rangatiratanga
He koha katoa mai i ngā tūpuna
Kaua ēnei taonga e moumou
I tēra ka tere whakamua tātou kia tau tika
Ngā wawata kei roto i a tātou katoa

No reira ngā mihi nui

Whakataukī

"Kia mau ki te mana o te whānau, te hapū me te iwi"

The mana and tapu of other iwi or hapū must also be observed

Nā Ngāti Whātua

The Women's Health Directorate hold no bias toward iwi affiliations, and endeavour to actualise the above Whakataukī by ensuring that wāhine Māori are upheld in their aspirations and moemoeā (dreams/visions) for themselves and their pēpi.

1. Te Tiriti o Waitangi in Action

- **Kāwanatanga (Governance)**

Āhuru Mowai (Sheltered Haven) Maternity Framework

Annmarie Taiapa-Johnson (Kaiwhakahaere: Charge Midwife) has developed a Māori framework model of maternity care, through her postgraduate studies, that takes into consideration that maternity should be a protective space. She presented this framework to National Leaders in Midwifery in Christchurch on 9 December 2020, where it was well received. Te Toka Tumai Women's Health Leadership team will review this framework in January 2021, with a view to agreeing to next steps.

Perinatal Anxiety and Depression Aotearoa (PADA) Maternal Mental Health Network

In November 2020 several members of Te Manawa O Hine (Māori midwifery service) attended a wānanga at Ōrākei to gather information and network with leaders in the field of maternal mental health. The ability to support and assist whānau is often fraught and blocked by barriers. The rate

of maternal suicide for Wāhine Māori is three times that of non-Māori. Te Manawa O Hine is actively working to reduce barriers to care and in particular to increasing access to mental health support.

Mātauranga Māori (Māori Knowledge)

Through the generosity of scholarships available through Te Toka Tumai, we are supporting kaiwhakawhānau (midwives) to attend Te Reo classes in total immersion environments. This course is full-time, therefore we have enabled a flexible working environment to support staff to participate.

- **Tino Rangatiratanga (Autonomy)**

Kaiwhakawhānau Wānanga (Midwife Seminar/Workshop)

The first of three monthly wānanga occurred in November 2020 for kaiwhakawhānau. This included mihi whakatau at Te Whetu Tawera as many of our kaiwhakawhānau had yet to receive mihi whakatau as new staff members to Te Toka Tumai. Te Manawa O Hine went through a process of whakawhanaunga (getting to know one and other) to ensure that we reach the outcome of whanaungatanga (good relationships). We utilise this time to strategise, debrief and to maintain momentum to keep ourselves healthy and therefore to continue to work with whānau.

- **Ōritetanga (Equity)**

Maternity Information System

Te Manawa O Hine will commence training for use of the Badgernet Information System that is currently available for community based midwives in Aotearoa. The implementation of this system for Te Manawa O Hine will reduce barriers of access to information particularly for wāhine who transfer their care from Counties Manukau DHB. This will reduce delays in information sharing and will improve outcomes.

In addition, Te Manawa O Hine will benefit from the implementation of the Badgernet Global System that has received Board approval (See section 3: Digital Transformation)

- **Te Ritenga (Custom and Practice)**

Karakia (Prayers)

Kaiwhakawhānau are frequently encouraged to zoom into the Karakia sessions that Te Toka Tumai Kaumātua run. Karakia is an essential part of who we are and what we do. It is important that we normalise this practice and continue to promote its importance in Te Ao Māori me Te Ao Hurihuri.

Rongoā Māori (Māori treatments)

Part of the purpose of Te Manawa O Hine is to assist our kaiwhakawhānau to aspire to be all that they can be. This includes the continuation of traditions of our tūpuna (ancestors). We have held a one-day practical workshop to support and educate our team and student midwives how to source ‘muka’ which is used to tie off the iho/umbilical cord prior to its cutting and how to make Kawakawa Balm. This workshop was well received and we hope to have follow-up sessions in the New Year.

2. Achieving Equity

Te Ao Māori inhabits space that includes the worlds of many other different peoples. Inequities arise when the imbalance of power tips and forces different world views to collide. Multiple strategies for resolution should be used to integrate those worlds so that equity is achieved. With our commitment to the articles of Te Tiriti o Waitangi, it is important that the commitment is made to Tangata whenua by eliminating inequities which they face. This invariably will increase the overall health and wellbeing of all, irrespective of ethnicity or place of origin.

Engaging with Māori and Culture in Practice Programmes

The re-development of the previously taught Cultural Competency and Turanga Kaupapa Training has been undertaken. As part of this, Hone Hurihanganui will provide 'Engaging with Māori' education to all staff within Women's Health. The 'Engaging with Māori' program will be delivered over 3 x 3 hour workshops.

In addition, a newly developed 'Culture in Practice' program will commence in February 2021. This will encompass Turanga Kaupapa and Te Toka Tumai values and will explore how to apply these teachings in practice. Many cultural training programs lack knowledge application, particularly in the clinical setting. This program will close the gap in learning and will evolve in response to feedback. Culture in Practice is delivered over a 1 x 3 hour workshop. It is planned that Culture in Practice will be an on-going requirement for all Women's Health staff to complete on a regular basis. Feedback will be sought from all participants.

Culture in Practice Train the Trainers

We have engaged with Northland DHB and the Ngā Tatai Ihorangi program developer Koha Aperahama to provide training, support and mentoring to Māori midwives at Te Toka Tumai. It is expected that these midwives will provide a readily available source of education and be able to deliver the regular 'Culture in Practice' program for Women's Health staff.

3. Digital Transformation

The current maternity information system, Healthware is technically and functionally obsolete. A business case has been approved by the Board for the Badgernet Maternity Clinical Information System. A steering group will oversee the project, which is formed of six interdependent workstreams. The current expected 'go live date' for Badgernet is October 2021.

4. People, Patients and Whānau at the Centre

Recent appointments in the Women's Health Service include 13 midwives, including one return to practice Māori midwife. A subspecialist Gynaecological Oncology Surgeon will commence in the New Year, once registration and immigration requirements have been completed.

HR Report

Utilising the Pūmanawa Tangata Plan, the Women's Health Directorate progressed pieces of work in each of the plan areas for the period October to December 2020. This progress is summarised as follows:

People Plan Area	Target Activity	Progress	Outcome
Uphold Te Tiriti o Waitangi - our framework to eliminate racism, build culturally safe practice and achieve health equity	Promote Cultural Safety in Practice	Re-launch Cultural training including a Train-the-Trainer model to transfer skills. Focus of the training will be Te Tirirti, Cultural Safety and Tikanga on Birthing for the directorate.	The first training session has been planned to take place on Monday 22 February.
Grow and develop ngā kaimahi Māori	Grow, develop & retain Māori workforce.	Support Māori Midwife students through the provision of student scholarships. Nurture relationships with these students.	This work is on-going. We are confident that nurturing our Māori Midwife students in their tertiary studies will support their transition following their graduation into Te Toka Tumai.
Create a healthy workplace - through Kia Ora tō Wāhi Mahi	Understand individual causes of high sick leave and support employees to ensure their wellbeing is prioritised.	Engage employees with greatest sick leave taken. Review progress and update plans.	Over the past quarter, through engagement with the 11 Nurse, Midwife and HCA employees with the greatest amounts of sick leave taken in the past 12 months, 8 employees reduced the amount of sick leave taken, 2 took no further sick leave and only one employee took further sick leave. A large amount of sick leave was taken over the festive period. A plan to empower Line Managers to address this is being put in place.
Deliver a workforce that is fit for the future - attracting the best and growing our people	Midwife Recruitment	Continued focus on Midwife Recruitment including working with Recruitment on Auckland DHB Midwife brand.	Recruitment have conducted workshops on developing and employee Value Proposition for Midwifery and Women's Health. We have had five Core Midwives start in January with a further four due to start in February. In 2020 we appointed 19 Core Midwives in total.
	Support Development of Post Graduate Midwife qualification	Partner with tertiary institutions to pilot conversion from nursing to Midwifery programme.	AUT have confirmed they are able to provide a two-year Master's degree for Nurses to become Midwives. They are in the process of investigating whether this could be reduced to an 18 month programme.
Make it easier to work here - improving our people's experience	Support employee development by ensuring leaders have and capture Performance Conversations for every employee in the directorate.	Ensure all L2 and L3 employees have had a PC captured in Kiosk in the past year.	The number of employees who have had a performance conversation and where this has been captured in Kiosk increased from 44% to 50% over the quarter.
Significant Directorate Programme of Work (not part of People Plan)	Review of SMO AHOC MoU	Agree approach with Chiefs and agree principles with ASMS.	Engagement took place with ASMS to agree an approach to review the SMO After Hours On Call Memorandum of Understanding. The review will begin on 05 February.

5. Financial Sustainability

Financial Results

STATEMENT OF FINANCIAL PERFORMANCE

Womens Health Services

Reporting Date Nov-20

($000s)	MONTH			YEAR TO DATE (5 months ending Nov-20)		
	Actual	Budget	Variance	Actual	Budget	Variance
REVENUE						
Government and Crown Agency	211	214	(3) U	1,005	1,072	(66) U
Funder to Provider Revenue	7,829	7,798	31 F	41,143	42,498	(1,355) U
Other Income	252	176	76 F	1,014	880	134 F
Total Revenue	**8,292**	**8,188**	**104 F**	**43,163**	**44,450**	**(1,287) U**
EXPENDITURE						
Personnel						
Personnel Costs	4,054	4,202	148 F	20,265	20,375	110 F
Outsourced Personnel	100	87	(13) U	438	435	(2) U
Outsourced Clinical Services	93	113	21 F	463	564	101 F
Clinical Supplies	561	494	(66) U	2,624	2,685	62 F
Infrastructure & Non-Clinical Supplies	103	127	24 F	615	634	20 F
Total Expenditure	**4,910**	**5,024**	**114 F**	**24,404**	**24,694**	**291 F**
Contribution	**3,382**	**3,165**	**217 F**	**18,759**	**19,756**	**(996) U**
Allocations	839	802	(37) U	4,187	4,013	(174) U
NET RESULT	**2,543**	**2,363**	**180 F**	**14,572**	**15,743**	**(1,171) U**

Paid FTE

	MONTH (FTE)			YEAR TO DATE (FTE) (5 months ending Nov-20)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	73.3	71.6	(1.7) U	73.0	71.6	(1.4) U
Midwives, Nursing	261.1	265.3	4.2 F	262.5	265.3	2.8 F
Allied Health	10.0	9.5	(0.6) U	9.8	10.0	0.2 F
Support	0.0	0.0	0.0 F	0.0	0.0	0.0 F
Management/Administration	37.1	39.0	2.0 F	37.5	39.0	1.5 F
Other	0.0	0.0	0.0 F	0.0	0.0	0.0 F
Total excluding outsourced FTEs	**381.5**	**385.4**	**3.9 F**	**382.8**	**385.9**	**3.2 F**
Total :Outsourced Services	5.2	3.1	(2.1) U	4.5	3.1	(1.4) U
Total including outsourced FTEs	**386.7**	**388.5**	**1.8 F**	**387.2**	**389.0**	**1.8 F**

Te Kāwanatanga Pūtea o Te Manawa o Hine

Te Manawa o Hine service was established and commenced midway through the last financial year, so the financial year 2021 (FY2021) is its first full year of operation. From a Finance perspective its Kāwanatanga Pūtea operates under its own responsibility centre (RC) both *within* and *alongside* the Directorate. Te Manawa O Hine has a 7.0 FTE establishment and an operational (personnel, clinical, vehicle etc.) costs budget of $0.9m. Although the amount may not be fully used in FY2021 we will work to carry the same amount into the next budget round.

Comments on major financial variances (YTD)

The Directorate's YTD result is $1,171k U to budget. This reflects unfavourable PVS revenue variance due to Obstetrics lower birth numbers, offset by higher (favourable variance) general Gynaecology volumes. Further offset by overall costs that remain moderately favourable to budget.

Comment on Volumes (YTD)

Overall YTD Directorate CWD volumes stand at 96.4% of contract, with Specialist Neonates at 95.6%. Obstetric inpatient WIES are 9.9% under contract, and discharges are 11% lower than last year. Gynaecology acute WIES are 21% over contract and elective WIES are 13% over, this is also showing in the number of discharges being 232, or 11%, higher than the same period last year. Gynae-Oncology elective WIES are 20% under contract.

November 2020: Year-to-date- financial analysis:

1 Revenue $1,287k U YTD.

PVS revenues are $1,354k U from Obstetric CWD being $2,201k U from a combination of lower births and a higher average WIES, whilst general Gynaecology CWD volumes continue to be above contract by $929k F, or 18%.

In other revenue activity we have underperformance of Colposcopy to contract $37k U, offset by release of internal ACC self-insurance $88k F, and higher Fertility clinic bookings $69k F.

2 Expenses $117k F

Favourable expenditure variance is less than a half of 1% of $28m opex budget YTD.

- **Personnel** YTD $110k F

This is expected to be a timing difference and will unwind in the remainder of the year, and is inline with the total FTEs being 1.8 FTE F to budget.

- **Outsourced personnel** $2k U
- **Outsourced clinical services** $101k F

Due to underspend within Te Manawa o Hine, MQSP, and Calm Birth programmes, but these are due to timing/ phasing and these costs will be closer to budget in the remainder of the financial year.

- **Clinical supplies** $62k F

Blood products $93k F; which is all used by an over-run in the December month.

- **Infrastructure & Non-Clinical** $20k F;

Minor difference, from some unused budgets or due to timing for costs yet to be incurred.

- **Internal Allocations** total $174k F;

Includes Labs being $90k U, all from higher Gynaecology volumes, and Radiology $172k U (evenly split between Obstetrics and Gynaecology). There is a favourable offset by Nutrition charges of $76k F

6. Resilient Services

A business case has been written for the funding of a Newborn Transitional Care (NTC) service, jointly run by Women's Health and Newborn Services. The unit will consist of two six bed pods on levels nine and ten of Te Papakāinga Atawhai o Tāmaki, Auckland City Hospital. The NTC service is required to improve the safety and quality of care provided to mothers and babies at Te Toka Tumai in order to ensure better outcomes for late preterm infants. It is proposed the NTC service be implemented in July 2021 based on the recommendations set out in the business case.

7. Maternity Scorecard

All data are mothers	NZ average 2017		All births at NWH				Private Obstetrician				Self Employed MW				NW Community				NW High Risk			
MODE OF BIRTH		Q	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2019	Q1 2020	Q2 2020	Q3 2020
All births		N	1687	1599	1509	1551	486	455	463	435	713	659	658	724	363	345	250	271	103	115	115	98
Spontaneous vertex delivery	62.5	%	48.0	49.9	48.4	51.1	32.9	34.9	33.3	39.5	57.1	60.4	57.9	57.2	53.2	53.0	54.4	57.6	33.0	40.9	40.0	35.7
Instrumental Delivery	9.3	%	11.7	12.0	11.1	11.9	10.9	13.4	11.7	10.8	13.6	12.4	12.5	14.8	9.9	11.9	9.2	8.9	11.7	5.2	7.0	6.1
Caesarean Section	27.9	%	39.6	37.7	39.8	36.5	55.6	51.4	54.4	49.7	28.9	27.2	28.7	27.5	36.4	34.2	36.0	32.8	53.4	53.0	52.2	57.1
Women Registered with NW community		N	351	364	393	366																
Registration in the first trimester	72.3	%	63.0	61.3	59.0	62.3																
STANDARD PRIMIPARA OUTCOMES																						
All standard primip births		N	265	262	242	256	80	68	74	63	130	129	127	155	58	61	35	33				
Spontaneous vaginal birth	65.1	%	44.5	45.4	42.1	45.7	35.0	32.4	24.3	23.8	44.6	53.5	48.8	49.7	67.2	44.3	57.1	63.6				
Instrumental vaginal birth	16.3	%	23.8	24.4	21.1	28.5	18.8	25.0	21.6	28.6	26.2	24.8	25.2	31.6	15.5	24.6	5.7	18.2				
Caesarean section	17.6	%	31.7	30.2	36.8	25.8	47.9	42.6	54.1	47.6	29.2	21.7	26.0	18.7	17.2	31.1	37.1	18.2				
Induction of labour	7.6	%	33.6	33.6	40.1	35.9	40.0	57.4	52.7	50.8	35.4	23.3	30.7	29	22.4	29.5	40.0	33.3				
Standard primip vaginal births		N	181	183	153	190	37	39	34	33	92	101	94	126	48	42	22	27				
Intact lower genital tract (%)	27.7	%	6.1	7.1	8.5	12.6	5.4	2.6	11.8	15.2	5.4	7.9	6.4	11.1	6.3	7.1	9.1	14.8				
Episiotomy & no 3rd/4th degree tear	24.5	%	49.7	43.7	47.1	52.6	73.0	59.0	38.2	57.6	54.3	43.6	57.4	54.8	25.0	31.0	18.2	37.0				
3rd/4th degree tear without episiotomy	4.4	%	3.9	3.8	0.7	3.2	0.0	5.1	2.9	0.0	4.3	3.0	0.0	2.4	6.3	4.8	0.0	11.1				
Episiotomy & 3rd/4th degree tear	1.7	%	4.4	3.8	2.0	1.6	2.7	0.0	0.0	3.0	2.2	4.0	3.2	1.6	6.3	7.1	0.0	0.0				
Standard primip unassisted vaginal birth		N	118	119	102	117	20	22	18	15	58	69	62	77	39	27	20	21				
Episiotomy in **unassisted** vaginal birth		%	34.7	26.1	37.3	41.9	60.0	36.4	33.3	46.7	37.9	29.0	48.4	44.2	17.9	11.1	10.0	28.6				
3rd/4th degree tear in **unassisted** vag birth		%	6.8	5.0	2.0	4.3	0.0	0.0	5.6	0.0	6.9	5.8	1.6	3.9	10.3	7.4	0.0	9.5				
Standard primip assisted vaginal birth		N	63	64	51	73	17	17	16	18	34	32	32	49	9	15	2	6				
Episiotomy in **assisted** vaginal birth		%	90.5	87.5	72.5	74.0	94.1	88.2	43.8	72.2	88.2	87.5	84.4	75.5	88.9	86.7	100.0	66.7				
3rd/4thdegree tear in **assisted** vag birth		%	11.1	12.5	3.9	5.5	5.9	11.8	0.0	5.6	5.9	9.4	6.3	4.1	22.2	20.0	0.0	16.7				
MATERNAL MORBIDITY																						
Caesarean birth		N	668	604	600	566	270	235	252	216	206	179	189	199	133	119	90	89	54	61	60	56
Category 1 Caesarean section		%	8.1	7.0	7.0	5.5	4.8	2.6	3.6	2.8	11.7	11.2	12.2	9.5	8.3	8.4	7.8	3.4	7.4	8.2	3.3	5.4
General anaesthetic for caesarean section	8.2	%	5.4	5.3	4.5	4.1																
Blood transfusion with caesarean section	3.1	%	1.3	2.0	3.7	1.9																
All vaginal births		N	1019	998	909	986																
Blood transfusion with vaginal birth	2.2	%	2.1	2.0	2.8	2.5																

All data are babies	NZ average 2017	Q	All births at NWH				Private Obstetrician				Self Employed MW				NW Community				NW High Risk			
			Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2019	Q1 2020	Q2 2020	Q3 2020
All births (babies)		**N**	1709	1624	1528	1579	496	460	468	440	717	661	665	732	370	357	254	277	104	121	118	105
Preterm birth <37 weeks	7.5	%	9.6	10.2	10.4	10.6	7.1	6.5	5.8	6.8	7.0	7.4	8.6	8.5	10.8	10.4	9.8	10.1	25.0	28.9	31.4	32.4
Spontaneous preterm birth <37wks		%	5.6	6.2	5.9	5.5	3.8	4.6	2.8	4.5	4.2	5.3	5.4	4.6	6.5	6.7	6.7	5.1	9.6	10.7	12.7	8.6
Iatrogenic preterm birth <37wks		%	4.0	4.0	4.5	5.1	3.2	2.0	3.0	2.3	2.8	2.1	3.2	3.8	4.3	3.6	3.1	5.1	15.4	18.2	18.6	23.8
Admission to NICU		%	11.4	11.1	11.1	10.8																
Babies born at term (>=37wks)		**N**	1546	1459	1369	1412																
NICU + >=4hrs respiratory support	2.0	%	2.7	2.9	2.6	2.8																
SGA singleton babies (<10th CBC)		**N**	224	201	193	193	48	45	50	50	89	78	84	84	50	52	29	29	26	22	25	25
Detected SGA		%	37.5	48.3	44.6	48.0	31.3	37.8	40.0	40.0	40.4	46.2	47.6	51	34.0	48.1	34.5	48.7	57.7	77.3	56.0	50.0
SGA at term delivered < 40 wks		%	64.7	59.7	57.0	62.8	75.0	73.3	70.0	82.9	60.7	52.6	52.4	56.1	66.0	61.5	58.6	66.7	65.4	63.6	52.0	65.0

NOTES:

SGA= <10th customised birth weight centile, excluding multiple pregnancies

Detected SGA defined at admission to DU as suspected clinical with no scan or suspected and confirmed by scan

8. Scorecard and Exceptions

Auckland DHB - Women's Health

HAC report for December 2020

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

Safety

Metric		Actual	Target	Previous
Medication errors with major harm	PR215	0	Lower	0
Nosocomial pressure injury point prevalence (% of in-patients)	PR097	0%		0%
Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	PR185	0%		0%
Number of falls with major harm	PR199	0	Lower	0
Number of reported adverse events causing harm (SAC 1&2)	PR084	3	Lower	4
Unviewed/unsigned Histology/Cytology results >=30 days	PR596	33	Lower	20
% Hand hygiene compliance	PR195	87.5%	>=80%	80.7%

Patient-centred

Metric		Actual	Target	Previous
% hospitalised smokers offered advice and support to quit	PR129	95.59%	>=95%	98.44%
% DNA rate for outpatient appointments - Māori	PR057	14.69%	<=9%	16.94%
% DNA rate for outpatient appointments - Pacific	PR058	18.44%	<=9%	12.87%
% DNA rate for outpatient appointments - All Ethnicities	PR056	7.79%	<=9%	5.98%
% DNA rate for outpatient appointments - Deprivation Scale Q5	PR338	11.25%	<=9%	9.63%
% Very good and excellent ratings for overall inpatient experience	# PR154	75.5%	>=90%	82.8%
% Very good and excellent ratings for overall outpatient experience	# PR179	87.7%	>=90%	88.3%
% Very good and excellent ratings for coordination of care after discharge	# PR493	50%	>=90%	50%
% Response rate to ADHB patient experience inpatient survey	# PR315	20%	>=25%	15%
Number of CBU Outliers - Adult	PR173	215	<=300	194
Number of patient discharges to Birthcare	PR192	225	TBC	280
Breastfeeding rate on discharge excluding NICU admissions	# PR099	76.48%	>=75%	75.67%

Timeliness

Metric		Actual	Target	Previous
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Māori	PR329	2	Lower	3
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Pacific	PR330	0	Lower	1
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Total	PR328	8	Lower	16
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Deprivation Scale Q5	PR332	1	Lower	5
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Māori	PR323	4	Lower	4
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Pacific	PR324	3	Lower	4
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Total	PR327	34	Lower	35
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Deprivation Scale Q5	PR326	10	Lower	11

Effectiveness

Metric		Actual	Target	Previous
28 Day Readmission Rate - Māori	# PR079	6.8%	<=6%	4.8%
28 Day Readmission Rate - Pacific	# PR080	9.39%	<=6%	6.67%
28 Day Readmission Rate - Deprivation Scale Q5	# PR322	7.12%	<=6%	6.41%
Post Gynaecological Surgery 28 Day Acute Readmission Rate	# PR210	10.67%		5.24%

Efficiency

Metric		Actual	Target	Previous
Elective day of surgery admission (DOSA) rate	PR048	89.47%	>=68%	97.5%
% Day Surgery Rate	PR052	33.82%	>=50%	33.09%
Average LOS for WIES funded discharges (days) - Acute	PR219	1.69	<=2.1	1.77
Average LOS for WIES funded discharges (days) - Elective	PR220	1.49	<=1.5	1.51
HT2 Elective discharges cumulative variance from target	PR035	1.06	>=1	1.13
Inhouse Elective WIES through theatre - per day	# PR053	8.39	>=4.5	9.4

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 December 2020

Resolution to exclude the public from the meeting

Recommendation

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

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
1. Karakia Attendance and Apologies	N/A	N/A
2. Conflicts of Interest	As per that stated in the open agenda	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3. Confirmation of Confidential Minutes 18 November 2020	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4. Confidential Action Points - 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** 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]