AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Hospital Advisory Committee Meeting

Wednesday, 20 March 2019

1.30pm

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

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Published 14 March 2019

Agenda
Hospital Advisory Committee
20 March 2019

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

Time: 1.30pm

Committee Members	**Auckland DHB Executive Leadership**	
Judith Bassett (Chair)	Ailsa Claire	Chief Executive Officer
Pat Snedden (Board Chair) ex officio	Karen Bartholomew	Acting Director of Health Outcomes – Auckland & Waitemata DHBs
Jo Agnew	Margaret Dotchin	Chief Nursing Officer
Michelle Atkinson	Joanne Gibbs	Director Provider Services
Doug Armstrong	Dame Naida Glavish	Chief Advisor Tikanga – ADHB/WDHB
Dr Lee Mathias	Dr Debbie Holdsworth	Director of Funding – ADHB/WDHB
Gwen Tepania-Palmer	Chris Hutton	Acting Chief People Officer
	Riki Nia Nia	General Manager Māori Health
	Rosalie Percival	Chief Financial Officer
	Meg Poutasi	Chief of Strategy, Participation and Improvement
	Shayne Tong	Chief of Informatics
	Sue Waters	Chief Health Professions Officer
	Dr Margaret Wilsher	Chief Medical Officer
	Auckland DHB Senior Staff	
	Dr Vanessa Beavis	Director Perioperative Services
	Dr John Beca	Director Surgical, Child Health
	Jo Brown	Funding and Development Manager Hospitals
	Ian Costello	Director of Clinical Support Services
	Suzanne Corcoran	Director Participation and Insight
	Dr Lalit Kalra	Acting Director Community & Long Term Conditions
	Rachel Lorimer	Director Communications
	Mr Arend Merrie	Director Surgical Services
	Kieron Millar	Acting General Manager Commercial Services
	Auxilia Nyangoni	Deputy Chief Financial Officer
	Alex Pimm	Director Patient Management Services
	Anna Schofield	Director Mental Health and Addictions
	Dr Michael Shepherd	Director Medical, Children's Health
	Dr Barry Snow	Director Adult Medical
	Dr Robert Sherwin	Director Women's Health
	Dr Michael Stewart	Director of Cardiovascular
	Dr Richard Sullivan	Director Cancer and Blood
	Madeleine Willis	Committee Secretary
	(Other staff members who attend for a particular item are named at the start of the respective minute)	

Apologies Members:

Apologies Staff: Dame Naida Glavish, Chief Advisor Tikanga – Auckland and Waitemata DHBs and Mr Arend Merrie, Director Surgical Services.

Agenda

Please note that agenda times are estimates only

1.30pm	**1.**	**Attendance and Apologies**
	2.	**Register and Conflicts of Interest** Does any member have an interest they have not previously disclosed? Does any member have an interest that may give rise to a conflict of interest with a matter on the agenda?
1.35pm	**3.**	**Confirmation of Minutes 13 February 2019**
	4.	**Action Points**
	4.1	Pandemic Preparedness Update
1.40pm	**5.**	**PERFORMANCE REPORTS**
	5.1	Provider Arm Operational Performance – Executive Summary
	5.2	Provider Arm Scorecard
	5.3	Cancer and Blood
	5.4	Cardiovascular
	5.5	Clinical Support
	5.6	Pacific Health Service
	5.7	Perioperative
	5.8	Surgical Services
	5.9	Women's Health
	5.10	Provider Arm Financial Performance Report
2.30pm	**6.**	**INFORMATION REPORTS**
	6.1	Patient Experience Report – Organisation Level
2.40pm	**7.**	**RESOLUTION TO EXCLUDE THE PUBLIC**

Next Meeting:	Wednesday, 01 May 2019 at 1.30pm A+ Trust Room, Clinical Education Centre Level 5, Auckland City Hospital, Grafton

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Attendance at Hospital Advisory Committee Meetings

Members	25 Jul.18	5 Sep.18	17 Oct.18	28 Nov.18	13 Feb 19	20 March 19	10 April 19	12 June 19	24 July 19	4 Sept 19	16 Oct 19	27 Nov 19
Judith Bassett (Chair)	1	1	1	1	1							
Joanne Agnew	1	1	1	1	x							
Michelle Atkinson (Deputy Chair)	x	1	1	1	1							
Doug Armstrong	x	1	1	1	1							
Lee Mathias	1	1	x	1	1							
Gwen Tepania-Palmer	1	1	1	1	1							
Pat Snedden	1	x	x	x	x							
Key: x = absent, # = leave of absence, c = meeting cancelled												

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

Member	Interest	Latest Disclosure
Jo AGNEW	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, minority shareholder) Shareholder - Karma Food New Zealand LTD [50% shareholding, non-director] Member – New Zealand Nurses Organization [NZNO] Member – Tertiary Education Union [TEU]	10.12.2018
Michelle ATKINSON	Director – Stripey Limited Trustee – Starship Foundation Contracting in the sector Contracting Role – Shea Pita and Associates	12.03.2019
Doug ARMSTRONG	Shareholder - Fisher and Paykel Healthcare Shareholder - Ryman Healthcare Shareholder – Orion Healthcare Trustee – Woolf Fisher Trust Trustee- Sir Woolf Fisher Charitable Trust Daughter – Partner Russell McVeagh Lawyers Member – Trans-Tasman Occupations Tribunal	18.09.2018
Judith BASSETT	Shareholder - Fisher and Paykel Healthcare Shareholder - Westpac Banking Corporation Husband – Fletcher Building Husband - shareholder of Westpac Banking Corporation Granddaughter - shareholder of Westpac Corporation	29.11.2018
Lee MATHIAS	Chair - Health Promotion Agency Chair - Health Innovation Hub (until the end of the Viclink contract in line with the director appointment) Chair – Medicines New Zealand Director/shareholder - Pictor Limited Director Pictor Diagnostics India Private Limited Director - Lee Mathias Limited Director - John Seabrook Holdings Limited Trustee - Lee Mathias Family Trust Trustee - Awamoana Family Trust Trustee - Mathias Martin Family Trust Member – New Zealand National Party Chair – Collective Hospitality Limited	30.11.2018
Pat SNEDDEN	Director and Shareholder – Snedden Publishing & Management Consultants Limited Director and Shareholder – Ayers Contracting Services Limited Director and Shareholder – Data Publishing Limited Trustee - Recovery Solutions Trust Director – Recovery Solutions Services Limited Director – Emerge Aotearoa Limited and Subsidiaries Director – Mind and Body consultants Ltd Director – Mind and Body Learning & Development Ltd Shareholder – Ayers Snedden Consultants Ltd Executive Chair – Manaiakalani Education Trust Chair – National Science Challenge Programme – A Better Start Chair – The Big Idea – Not-for-profit-trust Director – Te Urungi o Ngati Kuri Ltd	9.10.18

	Director – Wharekapua Ltd Director – Te Paki Ltd Director – Ngati Kuri Tourism Ltd Director – Waimarama Orchards Ltd Chair – Auckland District Health Board Director – Ports of Auckland Ltd Board Member – Counties Manukau DHB Chair – Counties Manukau Audit, Risk and Finance Committee	
Gwen TEPANIA-PALMER	Board Member - Health Quality and Safety Commission Committee Member - Lottery Northland Community Committee Chair - Ngati Hine Health Trust Life member – National Council of Maori Nurses Director - Hauora Whanui Limited Alumnus – Massey University	26.04.2018

Minutes
Hospital Advisory Committee Meeting
13 February 2019

Minutes of the Hospital Advisory Committee meeting held on Wednesday, 13 February 2019 in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton commencing at 1:30pm.

Committee Members Present	**Auckland DHB Executive Leadership Team Present**	
Judith Bassett (Chair)	Margaret Dotchin	Chief Nursing Officer
Pat Snedden (Board Chair) ex officio	Joanne Gibbs	Director Provider Services
Michelle Atkinson (Deputy Chair)	Fiona Michel	Chief Human Resources Officer
Doug Armstrong	Meg Poutasi	Chief of Strategy, Participation and Improvement
Dr Lee Mathias	Sue Waters	Chief Health Professions Officer
Gwen Tepania-Palmer	Dr Margaret Wilsher	Chief Medical Officer
	Auckland DHB Senior Staff Present	
	Dr John Beca	Director Surgical, Child Health
	Jo Brown	Funding and Development Manager Hospitals
	Sarah Devine	Patient Experience Manager
	Don Fulford	Recruitment Manager
	Kieron Millar	Acting General Manager Commercial Services
	Jenny Montague	General Manager - Community and Long Term Conditions
	Riki Nia Nia	General Manager Māori Health
	Alex Pimm	Director Patient Management Services
	Anna Schofield	Director Mental Health and Addictions
	Dr Michael Shepherd	Director Medical, Children's Health
	Rob Sherwin	Director of Women's Health
	Dr Barry Snow	Director Adult Medical
	Michael Stewart	Director Cardiovascular
	Marlene Skelton	Corporate Business Manager
	(Other staff members who attend for a particular item are named at the start of the minute for that item)	

The Director Provider Services, Jo Gibbs introduced the new Directors; Women's Health, Rob Sherwin and Cardiovascular Services, Michael Stewart to the Hospital Advisory Committee members who gave them a warm welcome to Auckland DHB.

1. APOLOGIES

That the apologies of committee members Jo Agnew and Pat Snedden be received.

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

That the apology of Mr Arend Merrie, Director Surgical Services be received.

2. REGISTER AND CONFLICTS OF INTEREST

Michelle Atkinson asked that the interest; "Evaluation Officer – Counties Manukau District Health Board", be removed from the register.

Lee Mathias asked that an interest be updated to include the word, "chair" – "Chair - Collective Hospitality Limited".

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

3. CONFIRMATION OF MINUTES 28 NOVEMBER 2018 (Pages 8-18)

Resolution: Moved Lee Mathias / Seconded Gwen Tepania-Palmer

That the minutes of the Hospital Advisory Committee held on 28 November 2018 be approved.

Carried

4. ACTION POINTS (Page 19)

Patient Experience Report – verbal update

It was advised that a number of key messages and improvements that had positively impacted patient experience had been communicated to our staff and patients. This was done via the Health Excellence Awards, through patient stories and on the website. There had been no campaign run using patient experience results.

What was being investigated was the low response rate of Maori and Pacific patients via the online survey.

A greater use of staff stories was now being made in communications.

5. PERFORMANCE REPORTS

5.1 Provider Arm Operational Performance – Executive Summary (Pages 20-24)

Jo Gibbs, Director provider services asked that the report be taken as read, briefly highlighting key points:

- While there had been some major issues around industrial action Jo was very pleased with the contingency planning that had occurred for the action taken by the NZ Resident Doctors Association (NZRDA) and the Midwifery Employee

Representation and Advisory Service (MERAS). There had been good contact with both in and out patients. . The impact on appointments and electives will continue to be felt for some time but patients are being rebooked based on clinical priority. During the MERAS strike the safety of women and babies was of paramount importance to the contingency planning.

- Jo acknowledged the directorate leadership and emergency planning teams who had put in hours of work planning for both sets of action.
- ESPI 2 and ESPI 5 waiting time targets have not been met for this reporting period. This pattern of non-compliance is being felt nationally. Auckland DHB currently sits in the middle of the 20 DHBs in relation to non-compliance around wait times. However, as the industrial action continues it is possible that this position could deteriorate further.
- A steady increase of children requiring general anaesthetic treatment through the Oral Health Service has been seen since July 2017. The majority of referrals are Maori and Pacific children. A large proportion are Counties Manukau DHB residents and work is being done with Counties Manukau DHB in an effort to reduce the wait time by providing local access to a service for these children.
- The cardiovascular directorate continues to see high transplant volumes with a notable increase in lung transplant volumes which is proving challenging as it displaces elective patients and impacts on wait times for cardiac surgery.
- The current Faster Cancer Treatment quarter two performance was 93.6%, however an adjusted performance for the end of January 2019 predicts a drop to 87.8%. Head and Neck, Gynaecology and Breast are forecast to fall to 50%, 80% and 82.8% respectively.

The following points were covered in discussion:

- Gwen Tepania-Palmer acknowledged the directorate leadership & emergency planning team for the contingency planning undertaken for the two recent industrial actions. The Committee placed on record its thanks and appreciation for the extra hours worked and the commitment shown by staff.
- Lee Mathias asked what the trends were associated with the drop in performance around tumour streams and was advised that Gynaecology and Breast performance will recover but Head and Neck was more complicated as the surgery was major and complex and dependant on the number of surgeons available to do this work.
- Doug Armstrong raised an issue related to cancellation of weekend surgery and was advised that for the weekend being referred to major transplant surgery was undertaken and related events had theatres booked out. It is a clinical judgement in the weekend whether to defer a case. Events such as accidents involving major trauma will always take precedence over other types of surgery.

Action

That the Committee thank the directorate leadership team and express its appreciation for

the extra hours worked and the commitment shown by staff.

Resolution: Moved Gwen Tepania-Palmer / Seconded Lee Mathias

That the Hospital Advisory Committee receives the Provider Arm Operational Performance – Executive Summary for February 2019.

Carried

5.2 Provider Arm Scorecard (Pages 25-26)

Resolution:

That the Hospital Advisory Committee receives the Provider Arm Scorecard for December 2018.

Carried

5.3 Adult Medical Directorate (Pages 27-33)

Barry Snow, Director Adult Medical asked that the report be taken as read, drawing attention to two areas; the unfavourable financial performance detailed on pages 32 and 33 of the agenda and the improvement in the Adult ED performance.

- Adult ED was beginning to meet its target with the implementation of new patient flow models. The POD Model had been trialled from 11 December 2018 in ED. It had necessitated an increase in nursing staff and therefore was expensive to operate. However, it did enable targets to be met in December and January. It had been in operation during peak surge periods and there was a need to scrutinise and analyse the data from the trial more closely to understand the true benefits received so that realistic cost could be identified.

The following point was covered in discussion:

- Michelle Atkinson commented that with the knowledge that the 6 hour target is reflective of an impact on the rest of the hospital when it's not met, what happened elsewhere in the hospital as a result of the trial? Barry acknowledged that the situation was complex, with many contributing processes including ED, the admissions process and bed availability.

5.4 Child Health Directorate (Pages 34-48)

John Beca, Director of Child Health (Surgical) and Michael Shepherd, Director of Child Health (Medical and Community) asked that the report be taken as read.

- The community services were re-designed and a locality model introduced in 2016/17. The emphasis in 2018/19 is on improving outcomes (with a focus on equity) through whānau-centred, community integrated services. Historically a child by child, service by service approach was employed and now the focus is on family by family.

The following point was covered in discussion:

- John Beca confirmed for Gwen Tepania-Palmer that the increase in critical care bed capacity and programme work will be completed when the Building for the Future programme gains momentum. Currently another 8 PICU beds are required. There is a need to look at the next 5-10 years and the likely practise changes along with population growth. The patient numbers have not changed dramatically but the bed days have. This is indicating a higher level of complexity and a need to increase bed numbers by at least 20%.

5.5 Commercial Services (Pages 49-56)

Kieron Millar, Acting General Manager Commercial Services asked that the report be taken as read advising as follows:

- healthAlliance Finance, Procurement and Supply Chain (FPSC) have reported annualised opex savings of $2.16M and capex savings of$2.33M.
- The supply chain review has identified that stock could be delivered out of hours and out of work time. This would result in a savings in lift usage during peak periods.
- Auckland DHB was recently recognised by the judges at the Sustainable Business awards with a commendation on Auckland DHB's energy management achievements. This was an excellent result when recognising that the DHB was up against large corporations like Fonterra and Air NZ.

The following points were covered in discussion:

- Advice was given that the single use surgical instruments and scissors recycling trial has successfully diverted 400kg of surgical instruments and scissors. The metal and hard plastic is autoclaved, dismantled and segregated for metal and plastic recycling.
- Gwen Tepania-Palmer acknowledged on behalf of the committee the work that the Commercial Services team had undertaken around security as outlined on pages 51 and 52 of the agenda.
- Michelle Atkinson relayed that she had been privy to comment from the EECA CEO which portrayed Auckland DHB in an extremely favourable light in regard to its sustainability programme.

5.6 Community and Long Term Conditions Directorate (Pages 57-65)

Jenny Montague, General Manager - Community and Long Term Conditions asked that the report be taken as read, advising as follows:

- The Service is pleased with the progress of the work being undertaken in the Frailty work stream which is building more comprehensive geriatric care. The focus is on specialist geriatric management of frail older people throughout the Adult

Emergency Department, the Clinical Decision Unit and the Short Stay Inpatient Unit (Level 2), along with avoiding unnecessary hospital presentation of frail older people and the development of the Acute Frailty Unit due to open in May 2020.

The following points were covered in discussion:

- Lee Mathias was advised that the diabetic patients were seen predominantly at the Greenlane Clinical Centre with about 6% of patients being seen elsewhere. The aim was to make primary healthcare the home for diabetes care wherever possible.

  It would be difficult to provide a trend report on diabetes overall as the Greenlane Clinical Centre was only a part of the total picture. It would require integrated reporting, which was not currently available, to provide the correct overview.

- Michelle Atkinson queried why the pressure injury rate appeared to be rising and was advised that it was as a result of staff getting better at recognising the signs in those over 85 and stage one on pressure injury scale and then reporting these incidences.

Action

That the percentage for stage one pressure injuries be included in the next Community and Long Term Conditions Directorate report.

5.7 Maori Health Services (Pages 66-69)

Riki Nia Nia, General Manager Māori Health asked that the report be taken as read, advising as follows:

- The support work of the team is diverse and ranges from the provision of cultural support to enable a higher quality of care for whānau to bereavement support and navigation.
- The Te Reo programme to develop staff capability in Te Reo has been received enthusiastically by staff with 300 enquiries from Auckland DHB staff. The course is being offered once a week at 3.30pm and 5.30pm over an extended period.
- The team is refreshing the current model of care. The terms of reference state that the team is tasked with seeing all Māori patients who are admitted to Auckland DHB. Limited resource has meant that this has not been possible and priority areas (as described on pages 66 and 67 of the agenda) have been concentrated on. There are now many whanau too, who are entirely capable of navigating the hospital system for themselves.

The following points were covered in discussion:

- Doug Armstrong asked if the concern was mainly to see whānau within the Provider Arm or if the team engaged more widely in other areas outside the hospital. Rikki advised that conversations were being held with whānau about; what could be done better, access to the system, did they feel valued and did they feel they were getting the service they required. The team were looking to strengthen the system to provide better support for whānau. All the initiatives and innovations were around

removing barriers to access and the quality of service provided.

- Rikki advised that the team could identify the whānau requiring support through the daily inpatient list where those most in need were identified.
- Rikki advised that the team did not provide a translation service unless the situation demanded it. The demand for the team is primarily on site at Auckland DHB. A variety of issues are dealt with and there is a need to be decisive in what the team is here to do with the resource that it has.
- Gwen Tepania-Palmer commented that the report did not include a section on Māori Health Gains and would like to see how that could be integrated and incorporated. It was agreed that the topic could be covered in the next report.

Action

That the next Māori Health Services report carry a section discussing how Māori Health Gains could be integrated and incorporated in future reporting.

5.8 Mental Health and Addictions Directorate (Pages 70-79)

Anna Schofield, Director Mental Health and Addictions asked that the report be taken as read, advising as follows:

- The Action Plan is progressing and it was pleasing to see that the themes identified through the development of the action plan are aligned with the Mental Health Inquiry Report due out in March 2019. Once released it will inform what the Auckland DHB models of care might look like.
- There have been some challenging legislation changes that have led to conversations about suitable housing which is proving a significant barrier to earlier discharge for some service users as boarding houses are no longer an option. The committee asked to be updated on the housing challenge and the effectiveness of the housing specialist approach in future reports.
- Changes in criteria for the Youth Court that will significantly impact the Regional Youth Forensic Service were detailed on page 73 of the agenda.

5.9 Patient Management Services (Pages 80-87)

Alex Pimm, Director Patient Management Services asked that the report be taken as read, advising as follows:

- The last quarter has seen much work undertaken to imbed process changes within the services.
- Hospital occupancy has seen some unusual levels for this time of year and it is expected that there will be continued growth over winter.

5.10 Provider Arm Financial Performance Report (Pages 88-100)

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

- The position year-to-date is $27M unfavourable. There had been some recovery during December and January. The MECA settlements remain a significant unknown cost that could cause further deterioration in the financial position.

Resolution: Moved Gwen Tepania-Palmer / Seconded Lee Mathias

That the Provider Arm Performance Reports for December 2018 be received.

Carried

6. INFORMATION REPORTS

6.1 Patient Experience Report (Pages 101-104)

Sarah Devine, Patient Experience Manager asked that the report be taken as read, advising that focus had been applied to checking back to understand that what is being done is still relevant. There is a need to understand differences between patient and whānau perception according to cultural background, age, sex and gender, disability. Other demographic information critical to this will also form part of the refreshment of the survey tools and new reporting dashboards and templates going forward.

There were no questions

Resolution:

That the Hospital Advisory Committee receives the Patient Experience at Auckland DHB Update report.

Carried

6.2 Human Resources – Recruitment (Pages 105-114)

Don Fulford, Recruitment Manager asked that the report be taken as read, advising that after an interim injection of resource the recruitment function at Auckland DHB has improved significantly in the last 12-15 months after a previous period of under investment and resourcing. There was still however a continuing requirement to further evolve to meet current and future recruitment challenges.

There were no questions.

Resolution

That the Hospital Advisory Committee:

1. **Receives the Recruitment Deep Dive report for February 2019.**
2. **Notes the status and progress of the recruitment function at Auckland DHB.**

Carried

7. RESOLUTION TO EXCLUDE THE PUBLIC (Pages 115-118)

Resolution: Moved Gwen Tepania-Palmer / Seconded Lee Mathias

That in accordance with the provisions of Clauses 34 and 35, Schedule 4, 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. Apologies	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]
2. Register and Conflict of Interests	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 28 November 2018	**Confirmation of Minutes** As per the resolution(s) from the open section of the minutes of the above meeting, in terms of the New Zealand Public Health and Disability Act [NZPH&D Act 2000]	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**	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

	information was made public [Official Information Act 1982 s9(2)(i)]	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 HAC Monthly Report Template	**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)] **Obligation of Confidence** Information which is subject to an express obligation of confidence or which was supplied under compulsion is enclosed in this report [Official Information Act 1982 s9(2)(ba)]	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 Perioperative Services – Shortage of Anaesthesia Technicians Oversight Report	**Commercial Activities** **Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public** [Official Information Act 1982 s9(2)(i)] **Prejudice to Health or Safety** Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time. **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]s	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 Women's Health –	**Commercial Activities** **Information contained in this**	That the public conduct of the whole or the relevant part of

Midwifery Recruitment and Retention Oversight Report	**report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public** [Official Information Act 1982 s9(2)(i)] **Prejudice to Health or Safety** Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time. **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]s	the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.3 Commercial Contract Management Food Services (FMEA) Oversight 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)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.4 Transplant Oversight Report	**Privacy of Persons** Information relating to natural person(s) either living or deceased is enclosed in this report [Official Information Act s9(2)(a)] **Obligation of Confidence** Information which is subject to an express obligation of	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]

	confidence or which was supplied under compulsion is enclosed in this report [Official Information Act 1982 s9(2)(ba)]	
7.1 Complaints	**Privacy of Persons** Information relating to natural person(s) either living or deceased is enclosed in this report [Official Information Act s9(2)(a)] **Obligation of Confidence** Information which is subject to an express obligation of confidence or which was supplied under compulsion is enclosed in this report [Official Information Act 1982 s9(2)(ba)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.2 Compliments	**Privacy of Persons** Information relating to natural person(s) either living or deceased is enclosed in this report [Official Information Act s9(2)(a)] **Obligation of Confidence** Information which is subject to an express obligation of confidence or which was supplied under compulsion is enclosed in this report [Official Information Act 1982 s9(2)(ba)] **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 [Official Information Act 1982 s9(2)(c)]	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]
7.3 Incident Management	**Commercial Activities** **Information contained in this report related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that** information **was made public** [Official Information Act 1982 s9(2)(i)]	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]

7.4 Policies and Procedures (controlled document management)	**Commercial Activities Information contained in this report related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that** information **was made public** [Official Information Act 1982 s9(2)(i)]	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]

Carried

The meeting closed at 4.00pm.

Signed as a true and correct record of the Hospital Advisory Committee meeting held on Wednesday, 13 February 2019

Chair: _____ Date: _____

Judith Bassett

Action Points from Previous Hospital Advisory Committee Meetings

As at Wednesday, 20 March 2019

Meeting and Item	Detail of Action	Designated to	Action by
25 July 2018 Item 5.14	**Commercial Services: Pandemic Planning** That an information report about Auckland DHB's preparedness for emergency and pandemic response be provided to a future Hospital Advisory Committee meeting.	Justin Rawiri	See item 4.1
13 Jun 2018 Item 5.11	**Surgical Services Directorate: Site Visits** 1. That a site visit for the Hospital Advisory Committee to view the improvements made in Ophthalmology Services at Greenlane Clinical Centre be scheduled. 2. That a site visit for the Hospital Advisory Committee to view the improvements achieved from the co-location of Mental Health and Addictions and Community and Long Term Conditions teams at the Point Chevalier site be scheduled.	A Merrie K Lalit, A Schofield	19 June 2019 TBA in 2019 when build is complete
13 February 2019 Item 5.6	**Stage One Pressure Injuries** That the percentage for stage one pressure injuries be included in the next Community and Long Term Conditions Directorate report.	K Lalit	1 May 2019
13 February 2019 Item 5.7	**Maori Health Gains** That the next Māori Health Services report carry a section discussing how Māori Health Gains could be integrated and incorporated in future reporting.	R Nia Nia	1 May 2019

Pandemic Preparedness Update

Recommendation

That the Hospital Advisory Committee:

1. **Receive the Pandemic Preparedness Update.**
2. **Note the status and progress of Pandemic Preparedness**

Prepared by: Name Justin Rawiri, Director Risk and Emergency Management
Endorsed by: Name Sue Waters, Chief Health Professions Officer

Glossary

Acronym/term	Definition
NZIPAP	New Zealand Influenza Pandemic Action Plan
NHEP	National Health Emergency Plan
NRHEMG	Northern Region Health Emergency Management Group
CDEM	Civil Defence Emergency Management
RHEP	Regional Health Emergency Plan
MIP	Major Incident Plan
IMT	Incident Management Team
HEP	Health Emergency Plan
ARPHS	Auckland Regional Public Health Service

1. Board Strategic Alignment

Community, whanau and patient-centred model of care	Planning aims to minimise deaths, serious illness and serious disruption to communities and the economy arising from an influenza pandemic
Intelligence and insight	Informs and promotes planning based on a clear understanding of all key factors.
Evidence informed decision making and practice	Demonstrates integrity associated with meeting ethical and legal obligations.
Outward focus and flexible service orientation	A well-defined emergency management approach ensures the DHB is prepared to address internal and external risks and is able to implement flexible solutions.
Operational and financial sustainability	Adoption of mitigation strategies supports operational sustainability

2. Executive Summary

This report outlines influenza pandemic preparedness at a national, regional, and local (DHB) level. It is being submitted in response to an action from a previous Hospital Advisory Committee meeting that an information report about Auckland DHBs preparedness for a pandemic be provided.

As pandemics have the potential to cause a large scale health emergency, planning is led at a national level by the Ministry of Health. Understanding the response at a local level requires the context of national and regional planning.

This report provides a brief introduction to influenza pandemics before outlining current emergency management and pandemic preparedness arrangements at a national, regional, and local level. Work scheduled for 2019/2020 is then identified, again at a national, regional, and local level.

3. Introduction/Background

Influenza pandemics are characterised by the global spread of a novel type of influenza virus, and can cause unusually high morbidity and mortality for an extended period. Most people are immunologically naive to the novel virus and therefore susceptible to infection which leads to a large-scale health emergency.

Three major influenza pandemics occurred in the 20th century, reaching New Zealand in 1918, 1957 and 1968. Recent estimates put mortality from the 1918 pandemic at between 50 million and 100 million worldwide. In New Zealand, the 1918 pandemic is estimated to have infected between a third and one half of the entire population, causing about 8,000 deaths, of which at least 2,160 were Māori. The 2009 H1N1 pandemic however reminds us that some pandemics may have only a small impact on death rates.

4. Current Arrangements

Nationally

The Ministry of Health leads the Government's response to a pandemic. Through the New Zealand Influenza Pandemic Action Plan (NZIPAP), it sets out the all-of-government measures and responsibilities to plan for and respond to an influenza pandemic.

The NZIPAP has been in existence since 2002, but has undergone substantial revision since then due to lessons learnt from the H5N1 influenza pandemic in 2009, and will continue to evolve.

The NZIPAP provides an overarching framework for possible actions during a pandemic. The actions that are implemented in any pandemic will depend on a range of factors such as severity. While the NZIPAP focuses on pandemic influenza, it is acknowledged that the approach in the plan could reasonably apply to other emerging infectious diseases such as SARS, MERS, or EVD.

Regionally

While District Health Boards are the lead agencies for planning and responding to pandemics at a local level, the Ministry of Health have set out expectations within the National Health Emergency Plan (NHEP) that DHBs cooperate with neighbouring DHBs in developing and exercising regional and national emergency management plans and capabilities.

This collaborative approach is particularly relevant within the northern region primarily due to the close proximity of the three metro DHBs serving the population of one city. Because of this the northern region has a comprehensive emergency management structure in place.

Leadership and oversight to regional emergency management arrangements is provided by the Northern Region Health Emergency Management Group (NRHEMG) which is chaired by the Dale

Bramley and includes executive and subject matter representatives from the four northern region DHBs.

NRHEMG is supported by a subgroup which is the practitioner level group responsible for the delivery of the regional work plan. Membership of the subgroup includes representatives from the four northern region DHBs, Auckland Regional Public Health Service (ARPHS), St John, MoH, Primary and community care, and the CDEM sector.

Two key documents that support regional pandemic preparedness are the northern Regional Health Emergency Plan (RHEP) and the Northern Region Pandemic Plan.

The RHEP outlines regional response arrangements including response tiers, activation of the Northern Region Health Coordination Centre (NRHCC), and responsibilities of member organisations.

The Northern Region Pandemic Plan outlines the regional response to a pandemic aligned to the NZIPAP. It includes responsibilities for the four District Health Boards, St John, ARPHS and includes integrated working relationships with primary health care and PHOs, community laboratories, community pharmacies, Aged Residential Care, Mental Health and other community support agencies; as well as Civil Defence and Emergency Management sector.

Locally

As with national and regional arrangements, Auckland DHB has a range of plans to support preparedness and response to emergencies. The Auckland Health Emergency Plan (HEP) provides a high level overview of emergency management arrangements at national, regional, and local levels both within the health and wider CDEM sector. The HEP is supported by the Auckland DHB Major Incident Plan (MIP) which is a guideline for the Incident Management Team outlining local response arrangements including objectives, structure, and information management.

The MIP is in turn supported by specific plans, one of which is the Auckland DHB Pandemic Plan which has been reviewed in line with updates from the NZIPAP and northern region pandemic plan following the 2009 H1N1 pandemic. The plan outlines initial response actions that will be taken by Auckland DHB before a regional response is activated. It also contains local level guidance to issues such as infection control, visitor guidelines, clinical pathways, and human resource management.

5. Work to be done

Nationally

The Ministry of Health are in the process of recruiting to the vacant Pandemic Planner position with the aim of starting a review of the NZIPAP in June 2019. The review will include sector consultation which is being forecast for the end of 2019. The consultation and publishing of the updated NZIPAP will guide updates to regional and local plans.

Regionally

The Northern Region Health Emergency Management Committee have recently reviewed their work plan and identified the update of the NRHEP and Regional Pandemic Plan as high priorities. A proposal for additional project management resource is being submitted at the March NRHEMG meeting to coordinate and support these work streams. While an updated NZIPAP may be a number

of months's away, work on the RHEP including regional response arrangements can be reviewed and redeveloped in the short to medium term.

Locally

Following the review and redevelopment of the NZIPAP and Regional Plans the Auckland DHB Pandemic Plan will also require review. This will be supported by the business as usual continual development and maintenance of emergency management plans and processes.

6. Conclusion

Auckland DHB and the northern region have a good level of preparedness in relation to an influenza pandemic. Key to future success is the strong regional and local emergency management arrangements in place which can be activated in response. We also have the advantage of lessons learnt from the 2009 H1N1 pandemic which have been fed into national, regional, and local plans.

We are at the beginning of another pandemic planning cycle lead by the review of the NZIPAP. This will assist to drive pandemic planning at regional and local levels over the next 12 months.

Provider Arm Operational Performance – Executive Summary

Recommendation

That the Hospital Advisory Committee receives the Provider Arm Operational Performance – Executive Summary for March 2019.

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

Glossary

Acronym/term	Definition
APEX	Association of Professional and Executive Employees
ED	Emergency Department
ESPI	Elective Services Patient Flow Indicator
NZRDA	New Zealand Resident Doctors Association

1. Executive Summary

The Executive Team highlight the following performance themes for the February 2019 Hospital Advisory Committee Meeting:

- We have received strike notices from the Association of Professional and Executive Employees (APEX) Medical Physicists. The strike notices outline that Medical Physicists will not perform work at any medical imaging or radiation therapy equipment outside of the hours of 0800-1630 for the duration of the action. Strike 1 is planned to take place 12 March 2019 at 0700 hours to 18 March 2019 at 0659 hours; Strike 2 is planned to take place 18 March 2019 at 0700 hours to 25 March 2019 at 0659 hours. We are working with APEX to agree life preserving services during these strikes. Contingency plans are being developed to protect patient safety during the strike periods.
- The DHBs have made an offer to settle the Public Service Association clerical Multi Employer Collective Agreement. A terms of settlement is being drafted for ratification by the parties.
- Appreciation from the Committee has been expressed to the directorate leadership team for the extra hours worked and the commitment shown by staff during the recent industrial action.

2. Progress/Achievements/Activity

- The Adult and Children Emergency Departments (EDs) have had another very busy month due to high patient numbers. The target was not met by Adult and Children EDs during January 2019 (93.84% and 93.47% respectively).
- Adult ED has managed to maintain performance throughout January and February 2019 at an average of 94%. This is largely due to Adult ED continuing to deliver a pod-based model of care. We are in the process of calculating the costs of this model to help determine if this is a long term viable option.

- Non-compliance of the Elective Services Patient Flow Indicator (ESPI) 5 target continues to be a central focus for the Executive Leadership Team. Historical agreements with the Ministry of Health recognised the difficulties in achieving the orthopaedic plan (adult and paediatric); however we remain committed to achieving surgical ESPI 5 compliance and meeting surgical targets in all other specialties whilst making progress in the orthopaedic numbers. In addition to Orthopaedic services, other specialties are now posing a challenge, including Oral Surgery and Paediatric Cardiac. Limited theatre capacity, theatre staffing shortages and the recent New Zealand Resident Doctors' Association industrial action have had an impact on ESPI 5 performance. With the exception of Orthopaedic services and Oral Surgery, each service has a plan in place to return to compliance or moderately non-compliant by the end of this year.
- The Integrated Cancer Services Programme, which aims to support the development of regionally agreed models of non-surgical cancer care, is beginning work to develop business cases for the implementation of a Regional Cancer Electronic Health Record and Facility redevelopment at the Auckland City Hospital site. The Programme Manager for this programme commenced 4 February 2019. Work is currently underway to collate baseline data and work to date and to establish a programme structure. Scope, programme principles, stakeholder identification and communications plan development are in progress. Model of care development is the first major tranche, and the foundational work to commence this has begun.
- Our Current Faster Cancer Treatment Quarter 3 (October to March 2019) performance is 91.4% adjusted. Performance for the end of March 2019 is forecasted to drop, however will remain compliant at 90.0% adjusted. Head and Neck, Gynaecology and Breast tumour streams remain non-compliant with slight improvement to the forecasted adjusted performance at 62.5%, 81.8%, and 82.8% respectively, with the remainder of the tumour streams staying compliant. Performance remains impacted by seasonal holiday capacity, industrial action by NZRDA (Resident Medical Officers) and Operating Room theatre capacity for Head and Neck Surgery.
- Transplant volume totals 69 heart, lung and liver and 77 renal transplants, totalling 146 year to date.
- The on-going commitment of our people to respond to the increased volumes and commitment to patient care is recognised and valued.

3. Provider Services 2018/19 Programme Updates

Building for the Future

The case for an Adult Rehabilitation and Integrated Stroke Unit was endorsed by the Capital Investment Committee, is pending joint ministerial approval and is planned to open in May 2020. A letter of intent was issued for the fit-out of the decant spaces; the contract is imminent with construction commencing in March 2019. The Strategic Assessment is being finalised for review. The case for additional theatre and clinical capacity at Greenlane Clinical Centre is in progress, subject to additional seed funding. This is to be submitted mid-2019 for approval and operational by 2022.

Clinical Quality and Safety

- **Clinical Quality and Safety Governance –** A Programme Manager is now in post. A regular meeting schedule has been developed for 2019.
- **Enhance function of Clinical Quality and Safety Service** – New staff have commenced. New process for serious adverse events has been piloted in several cases with good results. Projects to commence on improving communication with patients and whānau after adverse events and on supporting our staff after adverse events. Good progress with improvements to Datix, our safety management system.
- **Improve safety culture** – Progress has been made toward progressing with the implementation of Just Culture with a start date for the project in June 2019. Patient safety culture survey results are being analysed.
- **Improve non-technical skills and teamwork** – Simulation Service is being developed.
- **Patient Deterioration** – We are continuing to embed and refine the Recognition and Response system. Work is progressing on implementing the Maternity Early Warning System for our maternity patients. The shared goals of care work is progressing within General Medicine. The Kōrero Mai project is due to commence later in the year. Structure of the steering and working groups has been refined to ensure the system for inpatient acute physical deterioration is integrated across the organisation.

Outpatients

- The Outpatients programme is on-target within currently limited resource. Through the current state stream there are a number of activities underway, including work to improve PAS team training and scheduling. A new governance approach has been agreed for the current state stream that provides more ownership and accountability to services for implementation and adherence to policy and clinic performance.
- Through the transformation stream, the programme has delivered a number of projects successfully through phases I and II, demonstrating proof of concept for initiatives such as telehealth, patient-directed follow-ups, better use of production planning and clinicians working at top of scope. Our challenge now is to scale these at an organisational level. The programme is currently developing options to support scaling project outputs to deliver a transformational change in how we deliver Outpatient services.
- **Equity Focus –** We have completed design and development of the Outpatient Access Scorecards for both Māori and Pacific people cared for by Auckland DHB. These scorecards have been developed in partnership with Māori and Pacific Health teams and focus on describing attendance and Did Not Attend rates down to specialty and clinic level for the five highest-volume services by directorate. It is anticipated that this data will inform specific clinical areas of focus for future programme activity and resourcing, and will be reported to HAC through the relevant reporting schedules.
- **Delivering Care Differently –** Patient-directed follow-ups are now live within the colorectal team and the pilot is progressing well. Planning is now underway to scale the outputs of this project to

all General Surgery services and elsewhere. This work is one of the two resourced areas of project focus for the Outpatient programme alongside telehealth deployment. Projects to scale the deployment of telehealth to multiple clusters of services are underway and are also resourced with project management support.

- **Models of Care –** Greenlane Clinical Centre Outpatient Capacity Optimisation solutions are now delivering promising improvements in utilisation, however additional production planning capacity will be required to progress this project to other Outpatient services. Of note this month has seen the impact on clinic room utilisation related to clinic cancellations and industrial action. Thoracic Surgery Preadmission and improving orientation processes for Medical Oncology Outpatients are two other current projects underway within this domain.
- **Making the Most of Capacity** – Note that there has been an impact on capacity benefits reported this month. This is due to reduced clinic space utilisation, clinic and virtual volumes and greater pressure on CT services related to industrial action. Currently 13 projects from phase I and II are now contributing capacity benefits reported within the Provider Financial Sustainability programme. The programme remains on track to meet capacity benefit targets determined by the Provider Financial Sustainability programme for the 2018/19 financial year.
- **Current State Stream** – The digital solution to better manage Interpreters, including consolidated business rules, performance management and optimised billing processes is now live. The Email Validation project trial has worked well and appointment information is now being sent by email for outpatient events. This is also likely to have a positive impact on the cost of consumables and postage. Starship Child Health has completed the recruitment of schedulers to support the Patient-Focussed Bookings initiative.

Patient Flow

- **Admissions** – Adult ED began trialling a pod-based model of care in December 2018. This model separates the patients into streams according to acuity, and specific teams look after each of these streams, aiming to improve the flow of each patient group. The average time for patients waiting to be seen has reduced by over 30 minutes. A business case for increased operational expenditure to support this model as business as usual is to be drafted for consideration in 2019/20 budget.
- **Internal processes and transfers** – The Patient Flow Facilitator role is to be extended to 24/7 by September 2019. After hours ward clerk trial until 10pm to support adult acute floor and general medicine is underway. A combined benefit resulted in the shortest wait from bed requests to transfer time from October 2018 to February 2019 – the best since 2015.
- **Integrated Operations** – Process improvement work is a focus from February to April 2019 to improve the time sick calls and resource/bureau nursing allocation is recorded in a system (e.g. Trendcare) to enable a live view of nursing capacity. The design of the new Integrated Operations Centre area is progressing with team leaders identifying opportunities to integrate across functions. Further development work for dashboards is temporarily on hold while a business case is drafted for supporting infrastructure.

- **Key Risks** – IT systems constrain the ability to produce desired development/enhancements to Operational Intelligence and Insight status at a glance, with the go-live of dashboards delayed. This is currently being managed by the Chief Digital Officer who is working with healthAlliance to address these issues. A second key risk is resourcing allocated to Patient Flow. This is currently being managed by the Programme Lead who is seeking additional resource to support Admissions improvement work.

Cancer and Blood Directorate

Speaker: Richard Sullivan, Director

Service Overview

Cancer is a major health issue for New Zealanders. One in three New Zealanders will have some experience of cancer, either personally or through a relative or friend. Cancer is the country's leading cause of death (29.8%) and a major cause of hospitalisation.
The Auckland DHB Cancer and Blood Service provide active and supportive cancer care to the 1.5 million population of the greater Auckland region. This is currently achieved by seeing approximately 5,000 new patients a year and 46,000 patients in follow-up or on treatment assessment appointments.

The Cancer and Blood Directorate is led by:

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

Directorate Priorities for 2018/19

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

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

Glossary

Acronym/term	Definition
CAMPC	Capital Asset Management Planning Committee
NRICS	Northern Region Integrated Cancer Service
PRRT	Peptide Receptor Radionuclide Therapy
SCD	Service Clinical Director

Q3 Actions – 90 day plan

1. Research and innovation: Integrated Cancer Service

The Programme Board has welcomed a Programme Manager to coordinate and manage the production of business cases, consistent with Building for the Future Programme requirements. Work has commenced on the development of regional models of care, as a precursor in support of the rebuild and electronic health record requirements.

2. Prudent operational/financial management

Ongoing work within the directorate is underway to manage service pressures. Current issues relate to the requirement to outsource radiation therapy volumes and implement an additional radiation therapy shift as a consequence of a sustained increase (4%) in referrals to FSA, resulting in an increase in radiation therapy treatment increase (6%). Service Clinical Directors (SCDs) meet two-weekly with directorate leadership to manage these issues.

3. Demand/capacity management: **Clinic space/resource expansion utilising Medirota tool**

Our directorate has implemented the Medirota tool as a means of matching staffing capacity into clinic room capacity. This is a way to actively manage wait list demand and to assist with visibility and management of these processes.

4. Improved patient experience: **Waiting room upgrade, including Māori naming**

We have been working under the guidance of the Chief Advisor Tikanga and General Manager Māori Health to identify appropriate concepts for naming our service and significant areas within our patient-facing locations. The Chief Advisor Tikanga has gifted us the name “Te Pūriri o Te Ora” - The Puriri of Life/Health. The Chief Advisor Tikanga spoke about Rongoā Māori more specifically the trees/shrubs/plants and associated “natural world” that is, birds, caterpillars and insects with their unique properties, qualities, and benefits. The Pūriri tree has that quality and numerous healing properties. It is viewed as sacred/tapu in Te Ao Māori – the Māori World. We are working in an inclusive manner to develop this theme across service areas within our Directorate.
We have Capital Asset Management Planning Committee (CAMPC) approval to proceed with an upgrade of our main Waiting Room in Building 8. This includes the application of Dry July funding for this purpose date, and will commence in May 2019. As part of this we have implemented a Pharmacy Hub Pilot so that patients can drop off chemotherapy and other prescriptions, and pick up these items more conveniently. In addition we are working with Facilities to expand our clinic capacity into a vacant space on Level 4 – this to be generic clinic capacity for use by other services when cancer rebuild complete.

5. Cancer and Blood Information System

We have secured Capex funding for this important technology, as it will facilitate technology-enabled patient/whānau care across the region. This is an integral part of the Integrated Cancer

Service in (1) above. We will progress this through DHB and regional capital approvals consistent with the wider Programme milestones.

6. Health and wellbeing of our people

Sickness: We are meeting our sickness absence targets with levels of absence remaining around 3.1%. The directorate continues to monitor absence closely at monthly meetings with each of the services and uses Bradford Factor scores in excess of 342 to monitor areas of concern.

Turnover has remained above 10% for most of the year; however turnover has decreased from 15.6% to 14.17% recently. Work continues to achieve improvement following reporting on themes discovered from exit interviews.

Leave in excess of two years is reducing slightly at 8.3% and lower than the same period for the last year, but is not reducing as would be expected and targeted. This has been due in some part to service challenges with resources resulting in inability with some roles to take leave. The directorate continues to monitor absence closely and work on solutions to this issue.

Diversity in the workplace in relation to both Māori staff and Pacific staff is not progressing as planned. Whilst all appropriately skilled and experienced Māori and Pacific staff are shortlisted and interviewed, more work needs to be done to achieve an increase in the numbers of employees from these groups.

Use of Kiosk to record Development and Performance Information: Leadership staff have recently been supported in the use of this system within Leader to enter their performance and development conversations. As an outcome of this further education and publicity we expect that there will be greater utilisation of this feature.

Employee Engagement Survey: With the completion of the Survey the Cancer and Blood leadership team have commenced planning and use of data to develop action plans to achieve improvements based on their identified areas for development.

Cancer and Blood Ward Services: The Directorate is reviewing the models of care and means to support nursing staff within this high acuity setting, noting that we are experiencing ongoing staff stress levels.

7. Service improvements

Cancer Nursing Strategy: The Strategy has now been published and roll out across the Directorate is underway. Key priorities include patient/whānau centred care, patient safety and nursing workforce development. This exciting work has ramifications region-wide, for example, assisting with appropriate training and workforce progression for nurses engaged with the local delivery of chemotherapy in both Counties Manukau and Waitematā DHBs.

Local Delivery of Chemotherapy: With our regional colleagues (Waitematā and Counties Manukau DHBs), we are proceeding with our Implementation Plan for the next stage of Local Delivery including herceptin/pertuzumab, zometa and blood transfusions. This work forms part of wider Local Delivery of Oncology intent, as patients/whānau are better served by services delivered closer to home. An evaluation against this Plan is being prepared.

Brachytherapy bunker development: We are working with Facilities and Development following the production of a Functional Brief. This bunker will free up linear accelerator capacity as the service is currently provided in this area due to radiation safety requirements, and will provide a more patient friendly service. We have extended consultation to include the anaesthetics department, as the bunker will free up theatre space. Design work and quotations will now include a patient recovery area.

Haematology Model of Care: Our subspecialisation of Haematology has begun in the inpatient area. We have developed four teams from the twelve sub specialities, constructed on volume and intensity of patients care. They are bone marrow transplant, acute leukaemia, non-leukaemia malignant and non-malignant, and thrombosis/haemophilia. Further modelling of the sub-specialisation in the outpatient setting will be the next step to match the inpatient teams, to ensure the correct split of outpatient clinics is given to each team. Realignment of the Resident Medical Officer workforce to support the new teams will run in parallel.

Scorecard

Auckland DHB - Cancer & Blood Services

HAC Scorecard for January 2019

	Measure	Actual	Target	Prev Period
Patient Safety	Medication Errors with major harm	0	0	0
	Number of falls with major harm	0	0	0
	Nosocomial pressure injury point prevalence (% of in-patients)	0%	<=6%	0%
	Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	0.5%	<=6%	0.6%
	Number of reported adverse events causing harm (SAC 1&2)	0	0	0
	Unviewed/unsigned Histology/Cytology results >30 and < 90 days	0	0	0
	Unviewed/unsigned Histology/Cytology results >= 90 days	4	0	4
Better Quality Care	(ESPI-1) % Services acknowledging 90% of FSA referrals in 15 calendar days or less	R/U	100%	100%
	% DNA rate for outpatient appointments - All Ethnicities	4.49%	<=9%	4.92%
	% DNA rate for outpatient appointments - Maori	9.72%	<=9%	10.4%
	% DNA rate for outpatient appointments - Pacific	10.93%	<=9%	10.94%
	Number of CBU Outliers - Adult	53	<=300	38
	% Very good and excellent ratings for overall inpatient experience	R/U	>=90%	75%
	% Very good and excellent ratings for overall outpatient experience	R/U	>=90%	93.6%
	Number of complaints received	1	No Target	2
	28 Day Readmission Rate - Total	R/U	TBC	27.81%
	Average LOS for WIES funded discharges (days) - Acute	4.52	TBC	3.94
	% Cancer patients receiving radiation/chemo therapy treatment within 4 weeks of DTT	84.74%	100%	86.97%
	% Chemotherapy patients (Med Onc and Haem) attending FSA within 4 weeks of referral	95.68%	100%	96.88%
	% Chemotherapy patients (Med Onc and Haem) attending FSA within 2 weeks of referral	65.5%	100%	76.24%
	% Radiation oncology patients attending FSA within 2 weeks of referral	49.62%	100%	58.29%
	% Radiation oncology patients attending FSA within 4 weeks of referral	76.79%	100%	95.24%
	% Patients from Referral to FSA within 7 days	21.93%	TBC	26.47%
	31/62 day target - % of non-surgical patients seen within the 62 day target	97.5%	>=90%	97.06%
	31/62 day target - % of surgical patients seen within the 62 day target	88.57%	>=90%	91.74%
	62 day target - % of patients treated within the 62 day target	91.82%	>=90%	93.79%
Improved Health Status	% Hospitalised smokers offered advice and support to quit	85%	>=95%	94.29%
	BMT Autologous Waitlist - Patients currently waiting > 6 weeks	1	0	1
Engaged Workforce	Excess annual leave dollars ($M)	$0.18	0	$0.19
	% Staff with excess annual leave > 1 year	29.09%	0%	30.18%
	% Staff with excess annual leave > 2 years	8.31%	0%	9.45%
	Number of Pre-employment Screenings (PES) cleared after the start date	0	0	0
	Sick leave hours taken as a percentage of total hours worked	3.11%	<=3.4%	3.11%
	% Voluntary turnover (annually)	14.17%	<=10%	14.29%
	% Voluntary turnover <1 year tenure	11.76%	<=6%	11.76%

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. Not applicable for Engaged Workforce KRA.

R/U Result unavailable

(ESPI-1) % Services acknowledging 90% of FSA referrals in 15 calendar days or less

Result unavailable until after the 16th of the next month.

% Very good and excellent ratings for overall inpatient experience

% Very good and excellent ratings for overall outpatient experience

These measures are based on retrospective survey data, i.e. completed responses for patients discharged or treated the previous month.

28 Day Readmission Rate - Total

A 35 day period is required to accurately report all acute re-admissions for the previous month's discharges. (35 days = 28 days post discharge as per MoH measures plus 5 working days to allow for coding).

Scorecard Commentary

Patient Safety/Quality:

- There have been no Severity Assessment Code 1 or 2 events, medication incidents with harm, or falls.

Better Quality Care:

- We continue to work with staff to improve access and efficiency, utilising SCRUM processes to monitor and manage demand and capacity through our clinics. Our metrics include a suite of current and aspirational measures to provide oversight.

Engaged Workforce:

- Our staff metrics are continuously monitored by SCDs, specifically with a view to reducing excess annual leave, and engaging with staff on a substantive basis – please refer to previous section.

Key achievements in the month

- Our Integrated Cancer Service Programme Board has recruited a Programme Manager to commence work on the Cancer Precinct rebuild and Regional Electronic Health Record.
- We are working closely with regional colleagues to determine the next tranche of Local Delivery of Oncology work. This work sees increased volumes of medical oncology cytotoxic and non-cytotoxic treatments delivered at patient/whānau DHB of domicile. An evaluation is underway to record planned versus achieved volumes/costs/patient impacts.
- With funders and clinicians we are developing a proposal for a National Peptide Receptor Radionuclide Therapy Service (PRRT) for patients with neuroendocrine tumours. This service would be provided by both interventional radiology and oncology services, in concert with the University of Auckland. This is consistent with Pharmac intent, and approvals will be sought through ADHB and Ministry of Health national processes.

Areas off track and remedial plans

- Achieving Financial Savings: We have developed financial savings plans with SCDs, and although these are in place they are proving challenging to deliver. Of specific interest is the radiation oncology outsourcing impact. We meet 2 weekly with senior leadership to review and manage.
- A continued demand increase within Radiation Oncology has seen a sustained 4% increase in referrals to FSA, with a flow through effect of 6% increase in radiation therapy treatments required. We have approval to employ 4 additional radiation therapy staff to run an additional late shift, and have an outsourcing arrangement with a private provider for a fixed term.

Key issues and initiatives identified in coming months

- Equity focus within Cancer and Blood Directorate: We are engaged with the Northern Region Integrated Cancer Service (NRICS) process to understand institutional racism awareness

processes, and additionally how we can best employ regional planning processes regarding the development of models of care. Our intent is to develop substantive engagement/change management processes to result in improved decision-making and outcomes.

Financial Results

STATEMENT OF FINANCIAL PERFORMANCE
Cancer & Blood Services

Reporting Date Jan-19

($000s)	MONTH			YEAR TO DATE (7 months ending Jan-19)		
	Actual	Budget	Variance	Actual	Budget	Variance
REVENUE						
Government and Crown Agency	1,053	1,025	28 F	8,884	8,451	433 F
Funder to Provider Revenue	8,569	8,097	472 F	68,186	69,177	(991) U
Other Income	103	71	32 F	398	498	(100) U
Total Revenue	**9,725**	**9,192**	**533 F**	**77,468**	**78,126**	**(658) U**
EXPENDITURE						
Personnel						
Personnel Costs	3,791	3,777	(14) U	25,519	26,122	603 F
Outsourced Personnel	42	50	8 F	393	351	(42) U
Outsourced Clinical Services	570	267	(303) U	2,586	1,870	(716) U
Clinical Supplies	4,676	3,507	(1,169) U	32,814	30,401	(2,413) U
Infrastructure & Non-Clinical Supplies	136	146	10 F	1,097	1,023	(75) U
Total Expenditure	**9,215**	**7,747**	**(1,468) U**	**62,409**	**59,767**	**(2,642) U**
Contribution	**510**	**1,445**	**(935) U**	**15,059**	**18,359**	**(3,300) U**
Allocations	740	591	(150) U	4,876	4,798	(77) U
NET RESULT	**(230)**	**855**	**(1,085) U**	**10,183**	**13,561**	**(3,378) U**

Paid FTE

	MONTH (FTE)			YEAR TO DATE (FTE) (7 months ending Jan-19)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	77.5	73.1	(4.4) U	74.7	73.1	(1.6) U
Nursing	157.0	153.5	(3.5) U	151.8	153.5	1.7 F
Allied Health	99.9	105.8	5.8 F	97.4	105.8	8.4 F
Support	2.9	1.0	(1.9) U	2.2	1.0	(1.2) U
Management/Administration	53.8	53.9	0.1 F	52.3	53.9	1.6 F
Total excluding outsourced FTEs	**391.2**	**387.3**	**(3.9) U**	**378.4**	**387.3**	**8.9 F**
Total Outsourced Services	4.4	1.3	(3.1) U	5.3	1.3	(4.0) U
Total including outsourced FTEs	**395.6**	**388.6**	**(7.0) U**	**383.8**	**388.6**	**4.9 F**

Comments on Major Financial Variances

The result for the year to date January 2019 is an unfavourable variance of $ 3,378k.

Volumes: Overall volumes are 97.8 % of contract, $1,559k under contract ($1,140k of this variance is currently recognised in the Directorate result as the revenue wash up adjustment is done monthly in arrears).

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

Key drivers of the unfavourable Variance

Total Revenue $658k unfavourable - mainly due to

- Haemophilia blood product reimbursement $554k F - demand driven and offset by higher blood product costs,
- Oncology and Haematology $991k U - mainly due to the Funder to Provider revenue wash up in Haematology offset by Pharmaceutical Cancer Treatment (PCT) revenue wash up (monthly in arrears).

Total Expenditure- $2,719k unfavourable due to

- **Personnel including Outsourced Personnel $561k F** – mainly vacancies in Allied Health personnel.
- **Outsourced Clinical Services $716k U -** mainly due to the unplanned outsourcing of radiotherapy delivered at Auckland Radiation Oncology (ARO). This is mostly offset by vacancies in radiotherapy personnel costs.
- **Clinical Supplies $2,413k U** – mainly due to
    - Haemophilia $439k U - mainly an increase in Haemophilia blood product costs (demand driven and offset by increased revenue),
    - Pharmaceuticals $1,562k U - primarily PCT drug spend in Oncology $1370k U and Haematology

      $217k U (demand driven with a significant increase in Herceptin costs – this is offset by revenue wash up monthly in arrears).

FTE – 4.9 FTE favourable mainly Allied Health (Radiation Therapist) vacancies.

Cardiovascular Services Directorate

Speaker: Michael Stewart, Director

Service Overview

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

The Cardiovascular Services Directorate is led by:

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

Directorate Priorities for 2018/19

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

1. Strengthen leadership capability. Develop interdisciplinary leadership with accountability as close to the patients as possible
2. Reconfigure our service delivery. Review patient pathway(s) both at primary and tertiary levels
3. Regional collaboration. Options/solutions for regional collaborative Models of Care; in particular Cardiology and Vascular Services
4. Plan for future service growth. Heart/Lung Transplant, Cardiovascular Critical Care Strategy. Ensure alignment with key organisational work streams
5. Increase diversity in our workforce to match our population accessing our services and ensure our workforce capacity and capability meets the service demand
6. Financial sustainability. Undertake work to review costs and revenue in alignment with the Provider Financial Sustainability Programme Board

Glossary

Acronym/term	Definition
CTSU	Cardiothoracic Surgical Unit
CVICU	Cardiothoracic and Vascular Intensive Care Unit
ECMO	Extracorporeal Membrane Oxygenation
EP	Electrophysiology
ESPI	Elective Services Patient Flow Indicator
FTE	Full-time Equivalent
HDU	High Dependency Unit
PDSA	Plan Do Study Act
RMO	Resident Medical Officer
SAC	Severity Assessment Code
SEVAR	Short Stay Endo Vascular Aneurysm Repair
TAVI	Transcatheter Aortic Valve Implantation
WIES	Weighted Inlier Equivalent Separation

Q3 Actions – 90 day plan

1. Strengthen leadership capability. Develop interdisciplinary leadership with accountability as close to the patients as possible

The directorate continues to encourage their leaders in areas of accountability and proactive planning for their services. Over the coming months the leadership team have identified focus areas for learning; improving business case writing particularly justification and benefit realisation; procurement management; risk identification and structure and accountability to manage risk at both directorate and service level. Performance conversations remain a focus for the cardiovascular directorate; Cardiothoracic and Vascular Intensive Care Unit (CVICU) has made particularly good progress on this due to the reduction in the number of direct reports each Charge Nurse/Associate Nurse Unit Manager holds, hence their ability to now achieve three monthly conversations with team members. The Cardiology Service Clinical Director SCD has started a review of the person specification of all clinical service lead roles, ensuring greater clarity on expectations of role.

2. Reconfigure service delivery for patient pathway(s)

Cardiology

The Physiology work stream has commenced, with workshops been planned for February and March 2019 to agree scope.

All Electrophysiology (EP) outpatients Clinic trials have successfully completed, supporting a newly designed EP Clinic process which improves clinic wait times for patients, a final proposal to the governance group recommending implementation is underway.

The EP Education programme is now in place providing fortnightly education covering reviews of current topics, interesting case presentations and research, the education work stream is complete.

There have been 6 identified work streams planned for the heart failure service following the design sprint work. Good progress is being made on these work streams, in particular:

- A Prototype supervised exercise programme commenced in October 2018 and was completed in January 2019. Early analysis of the collated data is promising with benefits to all participants. This programme is linked with Te Hononga o Tāmaki Me Hoturoa (Te Hononga)
- Work has begun in collaboration with Te Hononga to improve referral process for heart failure patients. Identified in the process was an agreed focus on increasing access for Māori. The service is planning a greenbelt project involving our heart failure team and Maori Health providers

Cardiothoracic Surgery

The Thoracic surgery communications project has identified the key issues as determined by the patients and developed new process;

- The thoracic surgery e-referral form will be submitted on the day of the Multi-disciplinary meeting.
- When the patient is accepted for surgery, they advise the patient at that time that the thoracic Clinical Nurse Specialist will call the following day to discuss the timeline to surgery, time off work, etc.

The new processes aim to give patients greater notice of their thoracic surgery date, and implement standardised patient-facing communications, a pilot will commence on 18 March 2019, with the intention to transition to business as usual.

Preadmission progressing to Day of Surgery Admission opportunities for thoracic patients has progressed. The Plan Do Study Act (PDSA) cycle methodology will be used to run a pre admission clinic for these patients in March with 4 patients enrolled in the clinic.

The perfusion leadership structure decision document is complete. New leadership positons reflected in the revised structure will be recruited into over the coming months.

Vascular Surgery

The PDSA cycle methodology to trial 10 patients through the Short Stay Endo Vascular Aneurysm Repair (SEVAR) pathway is near completion with 8 patients going through the process saving 8 High Dependency Unit (HDU) bed days. Once all 10 patients are complete a formal analysis of the data will be done and the process reviewed.

Cardiothoracic and Vascular Intensive Care

Improvements to the continuity of care for routine/complex patients transitioning from the CVICU to Ward 42 is ongoing with a number of work streams now nearing completion. The building work on Ward 42 for the complex patient area is complete. This is working well with a significant increase in direct patient care time for complex patients in the ward environment.

The work stream reviewing thoracic patient allocation to the HDU has finalised initial audit work which has involved compliance regarding the admission criteria. Reviewing the admission criteria to identify thoracic patients no longer requiring an HDU stay is the next step.

3. Regional collaboration: Options and solutions for regional collaborative models of care

Cardiology

We are continually working collaboratively with our Northland DHB colleagues. This work will now focus on the support NDHB requires to build a sustainable cardiology service to enable them to provide local capability when their approved catheter lab is built.

Vascular Surgery

Progress for identifying areas of opportunity for Regional Vascular Services is underway with teams meeting to discuss potential models of care. There is broad agreement to work towards a hub and spoke model with complex work centred on ACH site, implications of this on other surgical services at CMDHB are now being explored.

4. Plan for future service growth - identify resource and structure to support areas of growth within the Cardiovascular Directorate, in particular heart/lung transplant, TAVI, lead extraction and cardiovascular critical care strategy

Cardiothoracic and Vascular Intensive Care

The implementation of the national service model for Extracorporeal Membrane Oxygenation (ECMO) is progressing well, particular areas of focus: development of protocol for ambulance providers when retrieving patients for ECMO and feedback links on the current CVICU website for referrers, patients, family and whanau.

The Cardiovascular Directorate is actively engaged in the critical care strategy working group.

5. Ensure our workforce capacity and capability meet service demand.

The results of the engagement survey have been discussed at leadership forums within the directorate, high level themes have been identified and the services will now use the engagement survey results to inform the ongoing plan around safety culture and other key opportunities.

The key area identified relates to staff wellbeing and morale. The leadership team has endorsed the idea of a directorate dedicated Wellbeing Group and the first meeting is scheduled. We have enrolled staff in the pilot wellbeing training in anticipation of the Auckland DHB wellbeing strategy rollout.

Full-time Equivalent (FTE) calculations has been completed and signed off by the National Council on Ward 41. This work is part of the Care Capacity and Demand. The remaining wards in Cardiovascular will commence FTE calculations in July 2019.

CVICU is on target to reach to their required FTE in February 2019. The nursing bureau has been a successful initiative and now has 8 Registered Nurses and 1 Healthcare Assistant available for casual CVICU bookings. The CVICU team continue to implement retention and wellness strategies and are working on team building and growing peer support in the unit.

6. Financial sustainability

Please refer to the financial results section.

Scorecard

Auckland DHB - Cardiovascular Services

HAC Scorecard for January 2019

	Measure	Actual	Target	Prev Period
Patient Safety	Central line associated bacteraemia rate per 1,000 central line days	0	<=1	0
	Medication Errors with major harm	0	0	0
	Number of falls with major harm	0	0	0
	Nosocomial pressure injury point prevalence (% of in-patients)	4.2%	<=6%	2.4%
	Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	4.8%	<=6%	4.9%
	Number of reported adverse events causing harm (SAC 1&2)	1	0	0
	Unviewed/unsigned Histology/Cytology results >30 and < 90 days	6	0	3
	Unviewed/unsigned Histology/Cytology results >= 90 days	3	0	3
Better Quality Care	HT2 Elective discharges cumulative variance from target	0.99	>=1	1.03
	(ESPI-1) % Services acknowledging 90% of FSA referrals in 15 calendar days or less	R/U	100%	100%
	(ESPI-2) Patients waiting longer than 4 months for their FSA	0%	0%	0%
	(ESPI-5) Patients given a commitment to treatment but not treated within 4 months	2.06%	0%	0.48%
	% DNA rate for outpatient appointments - All Ethnicities	9.95%	TBC	8.83%
	% DNA rate for outpatient appointments - Maori	20.51%	TBC	16.13%
	% DNA rate for outpatient appointments - Pacific	23.31%	TBC	20.53%
	Elective day of surgery admission (DOSA) rate	10.61%	TBC	12.5%
	% Day Surgery Rate	12%	TBC	6.25%
	Inhouse Elective WIES through theatre - per day	R/U	TBC	27.95
	Number of CBU Outliers - Adult	63	<=300	63
	% Very good and excellent ratings for overall inpatient experience	R/U	>=90%	93.9%
	% Very good and excellent ratings for overall outpatient experience	R/U	>=90%	91.1%
	Number of complaints received	2	No Target	4
	28 Day Readmission Rate - Total	R/U	TBC	16.31%
	% Adjusted Session Theatre Utilisation	81%	>=85%	83.3%
	% Theatre Cancellations	5.98%	TBC	13.29%
	Average LOS for WIES funded discharges (days) - Acute	5.68	No Target	5.15
	Average LOS for WIES funded discharges (days) - Elective	2.86	No Target	3.08
	Cardiac bypass surgery waiting list	91	<=113	86
	% Accepted referrals for elective coronary angiography treated within 3 months	95.34%	>=90%	98.45%
Improved Health Status	% Hospitalised smokers offered advice and support to quit	96.74%	>=95%	95.79%
	Vascular surgical waitlist - longest waiting patient (days)	139	<=150	145
	Outpatient wait time for chest pain clinic patients (% compliant against 42 day target)	86.67%	>=70%	97.78%
Engaged Workforce	Excess annual leave dollars ($M)	$0.83	0	$0.83
	% Staff with excess annual leave > 1 year	33.22%	0%	34.83%
	% Staff with excess annual leave > 2 years	16.78%	0%	17.25%
	Number of Pre-employment Screenings (PES) cleared after the start date	0	0	0
	Sick leave hours taken as a percentage of total hours worked	4.28%	<=3.4%	4.35%
	% Voluntary turnover (annually)	17.98%	<=10%	18.06%
	% Voluntary turnover <1 year tenure	15.38%	<=6%	17.14%

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. Not applicable for Engaged Workforce KRA.

R/U Result unavailable

(ESPI-1) % Services acknowledging 90% of FSA referrals in 15 calendar days or less

Result unavailable until after the 16th of the next month.

% Very good and excellent ratings for overall inpatient experience

% Very good and excellent ratings for overall outpatient experience

These measures are based on retrospective survey data, i.e. completed responses for patients discharged or treated the previous month.

28 Day Readmission Rate - Total

A 35 day period is required to accurately report all acute re-admissions for the previous month's discharges. (35 days = 28 days post discharge as per MoH measures plus 5 working days to allow for coding).

Inhouse Elective WIES through theatre - per day

Result unavailable

Scorecard Commentary

- There were no Severity Assessment Code (SAC) 1 events reported for January 2019 for the Cardiovascular Directorate. There was one SAC 2 event- a Stage 3 pressure injury; this incident is currently being reviewed. There was one complaint received in January 2019 for the directorate relating to patient experience whilst undergoing ECMO; this complaint has been addressed.
- There were no medication errors resulting in harm.
- There were no falls resulting in harm at the end of January 2019.
- Elective Services Patient Flow Indicator (ESPI) 2 in Cardiology continues to meet 4 month targets.
- The Cardiology wait lists are tracking as follows:
    - Interventional: 118 patients on the waiting list.
    - Device: 73 patients on the waiting list.
    - EP: 175 patients are on the waiting list.
- The cardiac surgery eligible bypass waitlist decreased from 104 patients to 99. The service had 5 breaches for ESPI 5 predominately due to the volume of acute/transplant work and reduced capacity as a result of the Resident Medical Officer (RMO) industrial action. The service performed 4 lung and 2 heart transplants and cared for 1 patient.
- Vascular surgery continues to meet Elective Services Patient Flow Indicator (ESPI) 2 targets but did have 5 breaches for ESPI 5 due to the volume of acute work leading to elective cancellations and reduced OR capacity due to the RMO Industrial action.
- For both Vascular and Cardiothoracic Surgical Unit (CTSU) services we are working closely with clinical teams to mitigate any further ESPI 5 pressure, the service remains confident that patients are scheduled according to clinical prioritisation.

Key achievements in the month

- The Cardiology Ward, 31, successfully decanted over the Christmas period to enable full ward refurbishment which was completed on schedule, creating a much improved environment for patient care.
- The perfusion leadership structure decision document was endorsed, recruitment will commence for the leadership positons.
- CVICU have seen their ongoing recruitment efforts over the previous months rewarded, they are on target to reach their required FTE in February 2019.
- CVICU has successfully implemented all modules of the Releasing Time to Care programme.
- Managing elective demand through the CVICU remains a challenge. In response the team has produced flow diagrams outlining standard processes for managing identified bed or staffing shortfalls, this allows proactive management of capacity challenges as opposed to reactive.

Areas off track and remedial plans

- The device waiting list within the EP has grown during December 2018. This service has not had a full complement of SMO operators since December 2018; the service will be reviewing locum availability and expects to be able to increase capacity from April 2019 onwards.
- The service has been unable to maintain 100% compliance in their ESPI 5 targets for vascular and cardiac surgery. The service is confident that clinical prioritisation is being managed daily and Auckland DHB maintains good relationships with refers to the service; there are no real or perceived barriers to referral. Recovery plans will be used to improve this position in the coming months.
- Although there is commitment to progress the regional vascular conversation there are some challenges regarding changing this current vascular services model within each DHB. This is delaying models of care conversations and moving forward to a preferred hub and spoke model.
- Overall revenue variance year to date is $3,141k U due in the main to the under-delivery primarily in CTSU and Cardiology. High transplant volumes displacing elective delivery and impact of the industrial action over the past 6 months are the predominate contributing factors. The service did achieve contract volumes in December 2018 and January 2019 and working with each service to agree recovery and improvement projects to improve the overall revenue positon by year end is ongoing.

Key issues and initiatives identified in coming months

- Commencement of the build for the EP Catheter Lab upgrade, working to mitigate any catheter lab down time during the upcoming winter months.
- Finalising the 6 work streams in the cardiology EP service.
- Completing a service review within cardiac sonography (echocardiography) service to deliver improved waiting times and patient experience.
- Progress service recovery plans as well as agree improvement projects that will deliver improved catheter lab utilisation, reduced length of stay and early discharge in the Coronary Care Unit, CVICU and the post-operative wards.
- Provide cardiovascular input into the Critical care strategy.
- Close monthly financial analysis with a particular focus on revenue.
- Working with teams to identify and develop actions plans in response to engagement survey results.

Financial Results

STATEMENT OF FINANCIAL PERFORMANCE

Cardiovascular Services

Reporting Date Jan-19

($000s)	MONTH			YEAR TO DATE (7 months ending Jan-19)		
	Actual	Budget	Variance	Actual	Budget	Variance
REVENUE						
Government and Crown Agency	170	184	(14) U	1,429	1,288	142 F
Funder to Provider Revenue	10,727	10,070	657 F	83,820	86,325	(2,505) U
Other Income	601	715	(114) U	4,225	5,004	(778) U
Total Revenue	**11,498**	**10,969**	**529 F**	**89,475**	**92,616**	**(3,141) U**
EXPENDITURE						
Personnel						
Personnel Costs	6,661	6,463	(197) U	44,146	44,288	143 F
Outsourced Personnel	46	50	4 F	353	350	(3) U
Outsourced Clinical Services	1	72	71 F	428	503	75 F
Clinical Supplies	2,557	2,544	(13) U	22,214	21,479	(736) U
Infrastructure & Non-Clinical Supplies	251	171	(80) U	1,320	1,197	(123) U
Total Expenditure	**9,516**	**9,300**	**(216) U**	**68,461**	**67,817**	**(644) U**
Contribution	**1,982**	**1,669**	**313 F**	**21,014**	**24,799**	**(3,786) U**
Allocations	1,042	990	(52) U	8,883	8,040	(843) U
NET RESULT	**941**	**679**	**262 F**	**12,130**	**16,759**	**(4,628) U**

Paid FTE

	MONTH (FTE)			YEAR TO DATE (FTE) (7 months ending Jan-19)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	101.1	100.4	(0.8) U	100.0	100.4	0.3 F
Nursing	364.3	355.2	(9.1) U	359.1	354.3	(4.8) U
Allied Health	68.9	69.0	0.1 F	70.8	68.1	(2.6) U
Support	2.7	2.7	0.0 F	2.7	2.7	(0.0) U
Management/Administration	31.4	36.3	4.9 F	32.0	35.5	3.4 F
Total excluding outsourced FTEs	**568.4**	**563.5**	**(4.9) U**	**564.6**	**560.9**	**(3.6) U**
Total Outsourced Services	2.2	1.7	(0.4) U	3.0	1.7	(1.3) U
Total including outsourced FTEs	**570.6**	**565.2**	**(5.3) U**	**567.6**	**562.7**	**(4.9) U**

Comments on Major Financial Variances

The January year to date result is $4.6M U – driven by unfavourable Revenue and Clinical Supply costs and partially offset by favourable Personnel costs.

Inpatient Weighted Inlier Equivalent Separation (WIES) year to date is 96% of budget with Cardiology at 90%, cardio-thoracic at 95% and vascular at 116% of budget.

Year to date FTE Employed/Contracted is 4.9 unfavourable.

Revenue

Overall revenue variance year to date is $3,141k U due in the main to the under-delivery primarily in CTSU and Cardiology. High transplant volumes is one key driver of the CTSU lower elective through-put as we are not funded for additional transplant activity but we lose capacity for core elective surgery when this occurs.

The impact of the July strike is approximately 200 WIES and although results have improved over the past months, they are heavily (negatively) influenced by high transplant and ECMO volumes.

The December and January month volumes did achieve contract volumes and we are forecasting to improve overall performance throughout the balance of the year.

Expenditure

Total Expenditure (including Allocations) for the month is $1.487M U, this is mainly due to:

- Personnel and Outsourced personnel costs being net $140k F; with the cost/FTE being 1.2% lower than year to date budget, particularly in allied health and nursing.
- Outsourced Clinical is $75k F for the year. We will continue refraining from outsourcing wherever possible however a number of CTSU cases have been outsourced due to capacity issues at Auckland City Hospital. Additionally some Saturday EP cardiology work commenced in September, which has been budgeted as outsourced costs.
- Clinical Supplies is $736k U. The main drivers are:
    - 12 heart and 23 lung transplants (blood costs $211k U). This is double the contracted transplant numbers and 20% up on prior year. This also drives other transplant related travel/accommodation/ambulance costs ($150k U).
    - Depreciation $175k U – primarily for clinical equipment in cardiology and intensive care.
    - A review of stock levels in Cardiac Investigation Unit with Health Alliance is on-going due to high costs in July.
    - Catheter and Stent costs are under review due to high expenditure in December.
    - We continue to work on opportunities in the Procurement space reviewing graft and stent usage and engaging Health Alliance to negotiate rebates with suppliers.
- Infrastructure and Non-Clinical Supplies is $123k U, of which $136k relates to a Bad Debt provision. Internal Allocations are $843k U of which $666k U relates to Vascular Interventional Radiology. Work continues in this area and coding reviews of high-cost interventional cases have been requested.

In summary, there are a number of improvement projects running across the directorate that, whilst focused on quality outcomes, patient experience, and improved utilisation and patient flow - will have the indirect benefit of improving productivity and effectiveness of spend. We expect our expenditure to generally remain under control. We are currently reviewing our recovery plan to determine whether we will be able to fully catch up the first quarter deficit.

Clinical Support Directorate

Speaker: Ian Costello, Director

Service Overview

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

The Clinical Support Directorate is led by:

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

Directorate Priorities for 2018/19

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

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

5. **Service quality and improvement:** Further develop the Quality and Safety Excellence Programme across the Directorate, building on work already in place to ensure quality and safety excellence is embedded across all our services. To develop indicators and measure and improve patient-centred outcomes and clinical safety.
6. **Operational/financial management:** Achieve a sustainable financial position which supports best clinical practice. An agreed Strategy for managing significant key equipment replacement and facilities constraints is developed and implemented.
7. **Research and collaboration networks:** Clinical networks established for all our services. Our services have agreed research strategies aligned to strategic priorities. Further develop collaborations with the University of Auckland, in Pharmacy, Pathology and Laboratory Medicine Services and Radiology. To develop further collaborations with Auckland University of Technology and other potential partners to deliver improvement in quality, outcomes, training, research and joint ventures.

Glossary

Acronym/term	Definition
AH	Allied Health
CCDM	Care Capacity Demand Management
CT	Computed Tomography
MoH	Ministry of Health
MRI	Magnetic Resonance Imaging
MRT	Medical Radiation Therapist
PAS	Patient Administration Services
PSC	Patient Services Centre

Q3 Actions – 90 day plan

Priority	Action Plan
1	• Finalise strategies for Patient Services Centre (PSC), C and Radiology, all aligned to Strategic Programmes of work
2	• Develop our workforce, capacity plans, recruitment and retention strategy and business model for Phlebotomy, Physiotherapy, Occupational Health and Clinical Engineering
3	• Develop and agree a regional interpreter service strategy
4	• Embed the employment survey results within each service • Develop and implement succession plans within each service
5	• Automate quality measures where possible • Develop capacity and demand reports for Radiology, Laboratories, Pharmacy, Patient Service Centre and the Contact Centre
6	• Identify revenue, savings targets and capital expenditure strategies for all our services. Sustained and effective financial management across financial years with balanced cost/revenue emphasis • Develop and agree the capital strategy
7.	• Develop clinical networks in Pathology and Laboratory and Radiology. Further embed

	and develop academic partnerships

Scorecard

Auckland DHB - Clinical Support Services

HAC Scorecard for January 2019

	Measure	Actual	Target	Prev Period
Patient Safety	Medication Errors with major harm	0	0	0
	Number of reported adverse events causing harm (SAC 1&2)	0	0	0
Better Quality Care	Number of complaints received	3	No Target	2
	% Outpatients and community referred MRI completed < 6 weeks	52.47%	>=95%	65.57%
	% Outpatients and community referred CT completed < 6 weeks	82.38%	>=95%	94.79%
	% Outpatients and community referred US completed < 6 weeks	73.8%	>=95%	88.5%
Engaged Workforce	Excess annual leave dollars ($M)	$0.66	0	$0.67
	% Staff with excess annual leave > 1 year	28.27%	0%	32.07%
	% Staff with excess annual leave > 2 years	7.76%	0%	8.28%
	Number of Pre-employment Screenings (PES) cleared after the start date	0	0	0
	Sick leave hours taken as a percentage of total hours worked	3.63%	<=3.4%	3.61%
	% Voluntary turnover (annually)	9.45%	<=10%	9.92%
	% Voluntary turnover <1 year tenure	8.66%	<=6%	9.09%

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. Not applicable for Engaged Workforce KRA.

Scorecard Commentary

Radiology

Overall, performance against the Ministry of Health (MoH) indicators across Magnetic Resonance Imaging (MRI) and Computerised Tomography (CT) has deteriorated in January 2019.

MRI

Performance against the MRI target of 95% of referrals completed within six weeks has deteriorated in January 2019 to 52.5% (55.4% for General MRI and 27.2% for Cardiac MRI) compared to performance in December 2018 (66%). High inpatient volumes, reduced outsourced provider availability and unplanned leave over the holiday period have resulted in deterioration against the target. The department is close to full establishment but it has proven difficult to recruit experienced Medical Radiation Therapists (MRTs) into these roles. The majority of new recruits are recent graduates who require a further six months post-graduate training to be able to perform MRIs.

A number of challenges still remain with specialist investigations, especially congenital cardiac services due to acute staffing issues in Cardiology. We are working with the Cardiovascular Directorate to rectify this issue and manage the waiting list based on clinical priority. We are looking at options for providing additional sessions to enable maximal utilisation of available sessions.

The number of adult non-cardiac patients waiting longer than 42 days was 126 at the end of January 2019 compared to 133 at the end of December 2018. The total waiting list has decreased from 592 in December 2018 to 448 in January 2019.

The number of paediatric patients waiting longer than 42 days was 15 at the end of January 2019 compared to 3 in December 2018.

The number of adult cardiac patients waiting longer than 42 days as at the end of January 2019 was 42 compared to 77 in December 2018 with the total waiting list reducing from 115 in December 2018 to 76 in January 2019.

The number of paediatric cardiac patients waiting longer than 42 days at the end of January 2019 was 6 compared to 8 at the end of December 2018. The total number of patients waiting has decreased from 14 in December 2018 to 11 in January 2019.

CT

Performance against the MoH indicator of 95% of out-patients completed within six weeks has deteriorated to 82.4% in January 2019 compared to 94.8% in December 2018.

The number of adult patients waiting longer than 42 days is 9 at the end of January 2019 compared to 12 at the end of December 2018.

The number of paediatric patients waiting longer than 42 days is 1 patient at the end of January 2019.

Ultrasound

Whilst there is an internal target (95%) we are mindful of the importance of patient access to service and safe waitlist management. Performance against this target has shown deterioration of 73.8% of out-patients scanned within 6 weeks at the end of January 2019 compared to 88.5% in December 2018.

There has been deterioration in performance against target in January 2019 compared with December 2018 due to an average vacancy of 3.0 FTE over the last 4 months. Radiology were able to maintain the waitlist up until Christmas through running additional Saturday sessions but were unable to schedule this in January 2019 due to leave.

The number of adult patients waiting longer than 6 weeks is 244 patients at the end of January 2019 compared to 25 at the end of December 2018. The total number of patients on the waiting list has increased from 699 in December 2018 to 914 in January 2019.

The number of paediatric patients waiting longer than 6 weeks is 19 at the end of January 2019 compared to 14 at the end of December 2018. The total number of patients on the waiting list has increased from 57 in December 2018 to 80 in January 2019.

Pathology and Laboratory Medicine

Performance for small biopsies reported within 5 working days improved significantly in January 2019 to 86%. This is in part due to low volumes during this period but also a focus on turnaround times from the service. The service is currently reviewing constraints through the laboratory and reporting processes to ensure these levels of performance can be achieved consistently going forward. One of the factors leading to longer turnaround times is the increase in the proportion of tests that require immunohistochemistry testing. This will be evaluated as part of this work to build resilience within the service.

Complaints

There were 2 complaints received in January 2019 compared to 3 in December 2018. All the complaints in January 2018 relate to poor/lack of communication.

Quality and Safety

The directorate Quality and Safe Care Governance Group meets monthly with nominated leads from each service. Quality scorecards have been developed and being reported on for most services within the directorate. The two departments working towards their development are the PSC and AH cluster of services. We now also have a Quality Dashboard for the directorate which is reviewed once a month by the Senior Leadership Team and also by the directorate Quality and Safe Care Forum. Service level quality and risk is overseen by the directorate AH Director, with newly reported incidents reviewed within 24 hours.

From a patient safety perspective indicators are being developed from the data available through Datix. Dashboards will be developed and in place by the end of the financial year.

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

Incidents

Medication Incidents

There were 10 medication incidents reported in January 2019 relating to Pharmacy omissions/delays, damaged/unusable medicine, incorrect dose prescribed and documentation. There was no harm to patients for any of these incidents.

Falls

There were 2 falls reported in January 2019, the first involved equipment within Radiology and the second in Occupational Therapy whilst a patient was utilising a commode.

Severity Assessment Codes incidents

There were no Severity Assessment Codes reported in January 2019.

Our People

- Talent Management has become a key focus for this quarter and managers within our services are currently being trained in the talent framework. The initial stage will identify talent across the top levels of management for each service and is due for completion by 1 April 2019. This will give us good insight into where we have capability gaps and will create more defined development plans for individuals as well as succession planning.
- Managers are working through their employee survey results within each service which will also become a key focus for this quarter. This will involve collaborating with our employees to prepare action plans within each service to identify ways of continuing to make this a great place to work and identifying opportunities that the service can work on.

Key achievements in the month

- Bereavement care paper presented at SLT
- E-mailing appointment letters Phase 1 complete with 36% of all letters now e-mailed to patients. Phase 2 roll out has begun.
- Interpreter system has been implemented and gone live across the organisation.
- Secured seed funding to scope the facilities work required to install the second CT scanner on Level 2.

Areas off track and remedial plans

- Adult and paediatric cardiac MRI waiting lists. Cardiac are working on providing additional sessions. Production planning and recovery trajectory to be reported from March 2019.
- WDHB acute and elective Interventional Radiology volumes planning.
- Regional strategy for the Interpreters.

Key issues and initiatives identified in coming months

- Continue to implement solutions for PSC data quality reports in conjunction with Business Intelligence and Ernst and Young.
- Continue to improve the process for patients receiving their appointment letters.
- Continue with implementation of the Interpreter Improvement Project.
- Radiology waiting list recovery plan and reporting.
- MRT workforce planning.
- Finalise the Radiology clinical leadership proposal.
- Review additional outsourcing capacity for Radiology should inpatient volumes remains high.
- Further develop our Māori and Pacific employee recruitment and retention strategy.
- Continue discussions with the Ministry of Justice on the National Forensic Pathology and Coronial Support Services.
- Continue with engagement and values workshops in all services.
- Review Radiology nursing workforce in view of the changing clinical and capacity demands on the profession.

Financial Results

STATEMENT OF FINANCIAL PERFORMANCE
Clinical Support Services

Reporting Date Jan-19

($000s)	MONTH			YEAR TO DATE (7 months ending Jan-19)		
	Actual	Budget	Variance	Actual	Budget	Variance
REVENUE						
Government and Crown Agency	1,511	1,498	13 F	10,906	10,370	536 F
Funder to Provider Revenue	3,389	2,869	519 F	25,094	24,271	824 F
Other Income	2,690	2,882	(193) U	20,043	20,177	(134) U
Total Revenue	**7,590**	**7,250**	**340 F**	**56,043**	**54,818**	**1,225 F**
EXPENDITURE						
Personnel						
Personnel Costs	10,856	11,606	751 F	77,530	80,938	3,408 F
Outsourced Personnel	118	88	(30) U	1,045	613	(432) U
Outsourced Clinical Services	768	581	(187) U	5,322	4,017	(1,305) U
Clinical Supplies	3,922	3,248	(673) U	30,008	26,889	(3,119) U
Infrastructure & Non-Clinical Supplies	1,788	1,959	171 F	14,467	13,697	(770) U
Total Expenditure	**17,451**	**17,482**	**32 F**	**128,373**	**126,154**	**(2,218) U**
Contribution	**(9,861)**	**(10,232)**	**372 F**	**(72,330)**	**(71,337)**	**(993) U**
Allocations	(8,192)	(7,222)	970 F	(61,677)	(58,947)	2,730 F
NET RESULT	**(1,669)**	**(3,011)**	**1,342 F**	**(10,653)**	**(12,390)**	**1,737 F**

Paid FTE

	MONTH (FTE)			YEAR TO DATE (FTE) (7 months ending Jan-19)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	148.7	151.0	2.3 F	147.5	151.0	3.5 F
Nursing	28.3	28.4	0.1 F	29.4	28.4	(1.0) U
Allied Health	888.6	880.7	(8.0) U	871.2	878.9	7.6 F
Support	0.0	0.0	0.0 F	0.0	0.0	(0.0) U
Management/Administration	270.2	287.2	17.0 F	267.1	287.1	20.0 F
Total excluding outsourced FTEs	**1,335.8**	**1,347.2**	**11.4 F**	**1,315.3**	**1,345.4**	**30.1 F**
Total :Outsourced Services	17.3	2.1	(15.2) U	18.7	2.1	(16.6) U
Total including outsourced FTEs	**1,353.1**	**1,349.3**	**(3.8) U**	**1,334.0**	**1,347.5**	**13.5 F**

Comments on Major Financial Variances

YTD result is $1,737K F. The key drivers of this result are;

- Personnel costs including outsourced were $2,976K F to budget. This is driven by vacancies across the directorate and cost per FTE being below budget.
- The main contributors to Outsourced Clinical Services were MRI scans in Radiology. This is necessary to try and meet MOH targets of 95% of referrals completed within six weeks.
- Clinical Supplies are $3,119K U. This is mainly due to our bottom line savings targets allocated to Clinical Supplies but achieved in our bottom line result. High consumable costs associated with high volumes of interventional radiology procedures continue to drive over expenditure in this area.

- Revenue is $1,225K F. $625K relates to the Retail Pharmacy and is offset by additional cost of goods sold. Funder to provider revenue is $824K F due to volumes above contract.

Pacific Health Service

Service Overview

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

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

Directorate Priorities for 2018/19

In 2018/19 we will focus on the following Directorate priorities:

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

Pacific Staff Starting and exiting

There were 872 total Pacific staff employed by Auckland DHB as of 31 December 2018.

Filled Position Count (31 December 2018) Excludes contractors

Professional Group	Asian	Euro	Māori	MELAA	Other	Pacific	Unknown	Total
Allied	584	1257	105	61	51	107	83	2248
Management/Admin	470	749	106	39	37	148	42	1591
Nursing	1646	2105	184	96	85	414	150	4680
Support	194	63	35	20	7	172	34	525
RMO	233	342	41	24	14	19	59	732
SMO	216	768	17	26	33	12	84	1156
Grand Total	**3343**	**5284**	**488**	**266**	**227**	**872**	**452**	**10932**

The biggest group for Pacific staff is in nursing at 414 followed by support roles at 172, followed by Management\Administration and then Allied Health Scientific and Technical.

The Pacific Alliance Leadership Team have set targets to see the lift of those in Resident Medical Officer and Senior Medical Officer roles. Our Health Science Academy team are currently working with both Otago and Auckland medical intake programmes to ensure high successful uptake from the student cohort.

Directorates Filled Position Count (31 December 2018) Excludes contractors

Directorate	Asian	Euro	Māori	MELAA	Other	Pacific	Unknown	Total
Adult Community & LTC	201	329	41	19	14	51	15	670
Adult Health Research	7	23	1	4		1	2	38
Adult Medical Services	430	463	43	20	22	82	47	1107
Cancer & Blood Research	11	18	1	2	1			33
Cancer & Blood Services	124	254	12	6	8	12	17	433
Cardiac Research	3	12		1			1	17
Cardiovascular Services	249	296	17	10	11	27	25	635
Child Health	299	977	71	22	34	79	59	1541
Children's Research	3	6				1	1	11
Clinical Support	511	729	48	37	41	88	66	1520
Governance and Funding Administration		9	1			1	1	12
Mental Health & Addictions	134	467	72	24	12	69	25	803
Patient Management Services	273	341	51	40	17	224	48	994
Perioperative Services	331	293	21	16	26	69	35	791
Public Health	45	86	10	8	1	15	6	171
Support Services	189	320	40	18	13	35	17	632
Surgical Services	443	398	41	33	20	92	67	1094
Women's Health	90	259	18	6	6	26	20	425
Women's Health Research		4			1			5
Total	**3343**	**5284**	**488**	**266**	**227**	**872**	**452**	**10932**

The highest recruiter of Pacific staff is the Patient Management Services Directorate who employs over 25% (224) of our total Pacific staff. This also equates to 22.5% of their total staffing for the directorate. This is followed by 10.5% (92) employed in Surgical Services which make up 8% of their total directorate staff. Clinical Support employs 10% (88) of the total Pacific staff which equates to 5.7% of their total staff for their directorate. The Adult Medical Directorate employs 9.4% (82) of the total Pacific staff which equates to 7.4% of their total staff. 9% (79) of the total Pacific staff are in Child Health which makes up 5% of their Directorate total staff. Mental Health and Addictions and Perioperative Directorates trail at a twin rate of 8% (69) equating to 9% respectively of their total staffing. 6% of the total Women's Health Directorate staff are of Pacific ethnicity.

New starters (October 2018-Decemeber 2018)

Professional Group	Asian	Euro	Māori	MELAA	Other	Pacific	Unknown	Total
Allied	28	60	2	3	3	3	1	100
Management/Admin	29	54	6	4	4	4	3	104
Nursing	79	76	8	6	12	4	3	188
Support	11	7	2	0	6	1	2	29
RMO	119	178	22	11	7	3	16	356
SMO	15	40	0	2	0	1	1	59
Grand Total	**281**	**415**	**40**	**26**	**32**	**16**	**26**	**836**

Staff exits (October 2018-Decemeber 2018)

Professional Group	Asian	Euro	Māori	MELAA	Other	Pacific	Unknown	Total
Allied	16	32	8	2	4	1	3	66
Management/Admin	10	30	5	0	1	0	2	48
Nursing	45	83	15	3	18	6	0	170
Support	4	2	3	0	5	0	1	15
RMO	104	144	13	13	9	8	19	310
SMO	6	30	0	1	0	3	2	42
Grand Total	185	321	44	19	37	18	27	651

Auckland DHB continue to courageously progress the policy of shortlisting all Māori and Pacific candidates who fulfil criteria and enlisting the appropriate peoples on the recruiting panel who reflect the worldviews of the interviewees.

Did Not Attend (DNA) Scorecard

Overall the Pacific DNA rate has fallen across the organisation over the last month according to the provider dashboard – note that in this scorecard this is best illustrated by the 'trend versus last month' column.

Key:	Trend	Risk Trigger	
↓	Pacific DNA % of in-person appointments has fallen relative to last month	N	Pacific DNA % is below 9% this month and has not exceeded 9% three times over preceeding six months
↑	Pacific DNA % of in-person appointments has risen relative to last month	Y	Pacific DNA % is greater than 9% this month for two consecutive months or has exceeded 9% at least three times over previous six months
↔	Pacific DNA % of in-person appointments has remained static relative to last month	Monitor	Pacific DNA % exceeds 9% this month but not for two months consecutively or three times over the last six months

KRA/ Quality Domain	Domain Description	Directorate	KPI	Trigger/ Tolerance	Top 5 Services by Volume - ATTENDED EVENTS EXCLUDING VIRTUAL/ TELEHEALTH	Total attended event volume this month - excluding virtual/ telehealth	Pacific attended event volume this month	Pacific cancelled event volume this month excluding virtuals/ telehealth	Pacific DNA event volume this month excluding virtuals/ telehealth	Data Source	All Ethnicities Actual DNA % This Month excluding cancellations	Actual Pacific DNA % This Month - FEBRUARY 18 excluding virtuals/ telehealth/ cancellations	Target	Pacific DNA % Last Month	Trend vs last month	Risk Trigger
Equity of Access	Understanding Pacific Appointment Attendances by Service and Directorate	Surgical	<9% Pacific DNA All Attended OP Appointment Types excluding Virtual/ Telehealth/ Videoconference	DNA exceeds 9% target for 2 consecutive months or 3x within six months	Eye Clinic - GCC incl. acute and procedure clinics, excluding Waitakere	5922	683	31	136	TITAN DW	6.5%	16.6%	<9%	18.1%	↓	Y
					Oral Health Clinic	2315	565	52	101	TITAN DW	12.9%	15.2%	<9%	14.4%	↑	Y
					Orthopaedic Outpatients Clinic	1594	167	6	32	TITAN DW	9.2%	16.1%	<9%	14.1%	↑	Y
					General Surgery & GSU	1131	147	27	22	TITAN DW	7.7%	13.0%	<9%	10.2%	↑	Y
					ORL (ENT)	995	149	8	26	TITAN DW	7.6%	14.9%	<9%	22.1%	↓	Y
		Child Health	<9% Pacific DNA All Attended OP Appointment Types excluding Virtual/ Telehealth/ Videoconference	DNA exceeds 9% target for 2 consecutive months or 3x within six months	Paediatric Orthopaedics	937	109	4	23	TITAN DW	9.5%	17.4%	<9%	24.2%	↓	Y
					Hearing & Ear Health	802	146	15	13	TITAN DW	8.2%	8.2%	<9%	18.1%	↓	N
					Paediatric Haematology/ Oncology	472	67	2	7	TITAN DW	1.4%	9.5%	<9%	3.0%	↑	N
					Paediatric ORL	505	94	4	18	TITAN DW	11.9%	16.1%	<9%	24.3%	↓	Y
					Paediatric Cardiology - excluding ward 38	127	30	5	3	TITAN DW	7.3%	9.1%	<9%	7.5%	↑	N
Equity of Access	Understanding Pacific Appointment Attendances by Service and Directorate	Adult Medical	<9% Pacific DNA All Attended OP Appointment Types excluding Virtual/ Telehealth/ Videoconference	DNA exceeds 9% target for 2 consecutive months or 3x within six months	Renal Medicine incl. renal transplant clinic, excl. dialysis	314	96	1	7	TITAN DW	3.4%	6.8%	<9%	15.7%	↓	Y
					Respiratory incl. labs, chest clinic & transplant	1119	168	16	47	TITAN DW	10.0%	21.9%	<9%	22.9%	↓	Y
					Neurology incl. specialty, daystay and research	587	29	0	15	TITAN DW	8.7%	34.0%	<9%	16.0%	↑	Y
					Gastroenterology	379	18	1	4	TITAN DW	9.8%	18.2%	<9%	26.0%	↓	N
					Infectious Diseases incl. HIV Clinic	140	11	0	7	TITAN DW	20.0%	39.0%	<9%	25.8%	↑	Y
		CSS	<9% Pacific DNA All Attended OP Appointment Types excluding Virtual/ Telehealth/ Videoconference	DNA exceeds 9% target for 2 consecutive months or 3x within six months	Adult Allied Health	884	80	4	15	TITAN DW	9.9%	16.1%	<9%	17.5%	↓	Y
					Women's Allied Health	462	42	2	5	TITAN DW	9.8%	11.9%	<9%	19.2%	↓	Y
					Clinical Dietetics	516	119	3	13	TITAN DW	6.0%	8.1%	<9%	7.8%	↑	N

KRA/ Quality Domain	Domain Description	Directorate	KPI	Trigger/ Tolerance	Top 5 Services by Volume - ATTENDED EVENTS EXCLUDING VIRTUAL/ TELEHEALTH	Total attended event volume this month - excluding virtual/ telehealth	Pacific attended event volume this month	Pacific cancelled event volume this month excluding virtuals/ telehealth	Pacific DNA event volume this month excluding virtuals/ telehealth	Data Source	All Ethnicities Actual DNA % This Month excluding cancellations	Actual Pacific DNA % This Month - FEBRUARY 18 excluding virtuals/ telehealth/ cancellations	Target	Pacific DNA % Last Month	Trend vs last month	Risk Trigger
Equity of Access	Understanding Pacific Appointment Attendances by Service and Directorate	Cardiovascular	<9% Pacific DNA All Attended OP Appointment Types excluding Virtual/ Telehealth/ Videoconference	DNA exceeds 9% target for 2 consecutive months or 3x within six months	Cardiology Outpatients	843	126	7	20	TITAN DW	7.8%	13.7%	<9%	25.4%	↓	Y
					Cardiac Physiology	648	77	1	5	TITAN DW	2.6%	6.1%	<9%	7.4%	↓	N
					Vascular Surgery Clinic	417	33	1	4	TITAN DW	5.4%	10.8%	<9%	22.2%	↓	Y
					Echocardiography	377	63	2	0	TITAN DW	0.2%	0.0%	<9%	0.0%	↔	N
					Cardiac Ultrasound (Echocardiography)	343	59	0	11	TITAN DW	6.5%	15.7%	<9%	16.4%	↓	Y
		Cancer & Blood	<9% Pacific DNA All Attended OP Appointment Types excluding Virtual/ Telehealth/ Videoconference	DNA exceeds 9% target for 2 consecutive months or 3x within six months	Medical Oncology incl. GCC and off-site clinics	3567	479	38	22	TITAN DW	2.7%	4.4%	<9%	6.1%	↓	N
					Radiotherapy Clinic	3740	330	0	0	TITAN DW	0.0%	0.0%	<9%	0.0%	↔	N
					Haematology Daystay incl. Outpatient Clinic	1714	212	14	3	TITAN DW	1.8%	1.4%	<9%	4.1%	↓	N
					Radiation Oncology incl. GCC and off-site	875	70	12	9	TITAN DW	4.2%	11.4%	<9%	16.3%	↓	Y
					Genetics - Regional Hub	213	15	1	3	TITAN DW	7.0%	16.7%	<9%	20.0%	↓	Y
Equity of Access	Understanding Pacific Appointment Attendances by Service and Directorate	Community & LTC	<9% Pacific DNA All Attended OP Appointment Types excluding Virtual/ Telehealth/ Videoconference	DNA exceeds 9% target for 2 consecutive months or 3x within six months	Community service	9740	1440	0	139	TITAN DW	4.2%	8.8%	<9%	8.5%	↑	N
					Diabetes	2072	504	200	216	TITAN DW	19.1%	30.0%	<9%	33.1%	↓	Y
					Dermatology	920	75	1	8	TITAN DW	4.4%	9.6%	<9%	14.9%	↓	Y
					The Auckland Regional Pain Service	763	22	4	4	TITAN DW	4.6%	15.4%	<9%	21.7%	↓	N
					Endocrinology	613	50	7	5	TITAN DW	5.0%	9.1%	<9%	5.3%	↑	N
		Womens Health	<9% Pacific DNA All Attended OP Appointment Types excluding Virtual/ Telehealth/ Videoconference	DNA exceeds 9% target for 2 consecutive months or 3x within six months	Obstetrics	2894	564	33	95	TITAN DW	5.2%	14.4%	<9%	12.3%	↑	Y
					Gynaecology	2067	296	8	32	TITAN DW	5.1%	9.5%	<9%	10.3%	↓	Y
					Fertility Plus	183	29	0	0	TITAN DW	3.8%	0.0%	<9%	0.0%	↔	N
					Gynae Oncology	179	15	1	0	TITAN DW	0.0%	0.0%	<9%	0.0%	↔	N

Key achievements in the month

Pacific Health Science Academies

The year has commenced for the Pacific Health Science Academies schools with their respective Parent and Family fono held over this school term.

This year we have Waitākere College, James Cook High, De La Salle, Tangaroa College, Onehunga High School, new schools Tāmaki College and Auckland Girls Grammar, and expressions of interest from a partnership between Kelston Boys and Girls Colleges to commence prep-phase this year.

Key issues and initiatives identified in coming months

Pacific Week –" Moana People Today"

1-5 April 2019 for Auckland DHB. 6 April 2019 Pacific Week Ball

This year's Pacific week celebrations have a focus on the past, present and future with a particular attention on *sustainability/environmental and expertise*.

The official opening is 1 April 2019 on Level 3 where we will feature our Tongan staff leading a traditional Tongan Kava ceremony, followed by an address by Auckland University Pro Vice chancellor (Pacific) Dr Toeolesululu Damon Salesa, and then our sustainability forum in the afternoon. The week will also feature a youth focussed symposium, a dramatic performance from "Fresh Movement", ward decorations competition and performances from the Pacific community, across Grafton and Greenlane sites with various speakers and much more. The week ends with a Pacific ball 6 April 2019.

The Pacific Week programme for Auckland DHB is as below:

OUR PROGRAMME
Pasifika Week
AUCKLAND DISTRICT HEALTH BOARD
1-5 April 2019
MOANA
People Today
Healthy Ocean, Healthy People • Ole Vasa saogalemu Tagata Soifuamaloloina • Oseni mo'ui lelei, kakai mo'ui lelei • Moana meitaki, Oraanga meitaki
Na Wasawasa bulabula, Na Leve ni vanua Bulabula • Ka mea moe moui alaola tau koloa he Moana to mouie alaola moe malolo tau tagata
TIME
MON
10 – 12noon
Official Opening
Auckland City Hospital
Level 3 Atrium
1 – 3pm
Environmental Session
Auckland City Hospital
Marion Davis Library
TIME
TUE
WED
THU
FRI
9.45am
Opening Prayer
Opening Prayer
Opening Prayer
Opening Prayer
10 – 12noon
Strengthening Pacific Connections Within the Community
Greenlane Clinical Centre
Lotofale Meeting Room
Kapasa and Yavu "Talanoa"
Auckland City Hospital
Marion Davis Library
Davui Youth Group / ADHB Matua Advisory Council "Tala Moana"
Auckland City Hospital
Marion Davis Library
Pacific Parish Nurses & Coordinators In-Services
(start time 9am – 12noon)
Auckland City Hospital
Marion Davis Library
12 – 1pm
Performance Group
Pacific Shared Lunch
Greenlane Clinical Centre
Grassed Area in front of Oasis Café
Soakai Dance Group
Auckland City Hospital
Level 5, Main Reception
Ivana
Sing and Dance
Starship Hospital
Main Foyer (Level 2)
Auckland City Hospital Stalls
Ward Competition Marking
Auckland City Hospital
Greenlane Clinical Centre
Tausisi Dance Group
Auckland City Hospital
Level 5, Main Reception
Closing and Thanks Giving Service
Auckland City Hospital
Level 6, Chapel
1 – 3pm
Health and Wellness Session
Greenlane Clinical Centre
Grassed Area in front of Oasis Café
"The Super Nurse of Today"
Auckland City Hospital
Marion Davis Library
Fresh Movement
Auckland City Hospital
Clinical Education Centre Auditorium
AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai
Welcome Haere Mai | Respect Manaaki | Together Tūhono | Aim High Angamua

Perioperative Directorate

Speaker: Vanessa Beavis, Director

Service Overview

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

The Perioperative Directorate is led by:

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

Directorate Priorities for 2018/19

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

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

Glossary

Acronym/term	Definition
ACH	Auckland City Hospital
CSSD	Central Sterile Supply Department
FTE	Full-time equivalent
GSU	Greenlane Surgical Unit
MoH	Ministry of Health
OR	Operating Room
SAC	Severity Assessment Code
TDOC	Traceability Documentation
YTD	Year to Date

Q3 Actions – 90 day plan

1. Health and wellbeing of our people

Activity	Progress
Staff engagement	• The Perioperative leadership team is focussing on "welcome", as the first experience that our new employees have of our directorate. • The 2018 staff engagement survey results recorded a good participation rate across the Directorate being 68% overall. SMO participation saw an increase, being the 3rd highest for the organisation, and also increased RMO participation was noted as well across the directorate. Staff Engagement had a marginal increase of 3%. RMO's were noted to be highly engaged as 16% higher than average for the organisation.

2. Safe and quality services

Activity	Progress
Implementation of Operating Room (OR) Instrument Tracking Module	**TDOC Upgrade version 8 to Version 14 – Completed** • BAU issues are managed by healthAlliance **Single Instrument Tracking System:** The business case was approved by the Ministry of Health (MoH) on 26 November 2018. First Steering Group Meeting was held on 15 January 2019 with the below update. • hA activities such as procurement of hardware and refreshing of non-production environment will be addressed via service requests at no direct cost (for hA resource time) to the project. • The business case states that the T-DOC –to-Oracle interface (2-way [page 13, 4.1 Project Deliverables) is in scope. It was discussed that the project was primarily to deliver patient safety and the interface was not directly related to the primary outcome. Should there be funds left over work on the interface may be possible, but not necessary. • We are currently awaiting recruitment of new project manager following which, the next steering group meeting will be held.

3. Service size to meet growth in demand

Activity	Progress
Staff in post% against Full-time Equivalent (FTE) across Directorate	• Recruiting for anaesthetic technicians has been a major focus and we have done an amazing job as follows: o 21 Job offers pending (all interviewed) o Of those 21, 8 are students who will be sitting the registration exams early March. o 2 are local offers, i.e. people coming back to ADHB from private or other DHBs. o 11 overseas recruits of which 1 arrived in New Zealand in March 2019. As of 7 March 2019, we have 17 FTE vacancies in total for the Anaesthetic Technicians. • Nursing Staffing supply and demand was noted as a significant ongoing challenge. A number of orientees were noted to be coming through including filling up slots to the New to OR programme. • Currently working with the University of Auckland to attract more interest from nursing students including overseas advertisement campaigns targeting different countries. • A taskforce is being put together to look at interim, medium and long term plans.

4. Efficient and effective clinical care

Activity	Progress
Acute index time to OR from booking reporting available	• A heavy acute load and maintaining the elective throughput is finely balanced. We are pleased to have achieved 90% against a target of 90%. These are January figures and reflect reduced elective loads, (industrial action and the summer slowdown period) hence freeing up capacity for acutes.

5. Embed leadership structure

Activity	Progress
Establish governance arrangements for measuring quality within Starship ORs	• The Directors of Perioperative Services and Child Health are working through the best way to ensure comprehensive collaboration. • Issues and matters of common interest are resolved through regular meetings which are presently set up for the Senior Leadership teams and Directors of both Directorates.
Succession planning and leadership directorate plans in place	• Underway, with the new key appointments settling into their roles and assuming strategic leadership responsibilities, including being part of different

	projects i.e. Building for the future, Greenlane Optimisation project, cultural changes etc.

6. Financial sustainability

Activity	Progress
Financial performance	• See financial report.

Scorecard

Auckland DHB - Perioperative Services

HAC Scorecard for January 2019

	Measure	Actual	Target	Prev Period
Patient Safety	% Acute index operation within acuity guidelines	90.09%	>=90%	79.41%
	Wrong site surgery	0	0	0
Better Quality Care	% Unplanned overnight admission	6.03%	<=3%	6.31%
	% Cases with unintended ICU / other area stay	0.79%	<=3%	0.29%
	% 30 day mortality rate for surgical events	0.21%	<=2%	0.16%
	% CSSD incidents	3.03%	<=2%	3.81%
Improved Health Status	% Elective sessions planned vs actual	R/U	>=97%	76.5%
	% Adjusted theatre utilisation - All suites (except CIU)	84.6%	>=85%	86.43%
Engaged Workforce	Excess annual leave dollars ($M)	$0.55	0	$0.56
	% of Staff with excess annual leave > 1 year < 2 years	26.75%	<=30%	27.47%
	% Staff with excess annual leave > 2 years	11.96%	0%	12.86%
	Number of Pre-employment Screenings (PES) cleared after the start date	0	0	0
	Sick leave hours taken as a percentage of total hours worked	4.66%	<=3.9%	4.58%
	% Voluntary turnover (annually)	11.95%	<=10%	12.87%
	% Voluntary turnover <1 year tenure	9.41%	<=6%	9.89%

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. Not applicable for Engaged Workforce KRA.

R/U Result unavailable

% Elective sessions planned vs actual

Result unavailable

Scorecard Commentary

- There was one complaint received for Perioperative services for January 2019.
- No Perioperative Severity Assessment Code (SAC) 1 and no SAC 2 incident was reported in the three months from 1 November to 31 January 2019, although we are supporting other directorates as required.
- Recommendations from previous Root Cause Analysis have been implemented. Formal auditing of the surgical safety check list has recommenced this quarter, with good rates of engagement and compliance. The ministry reporting tool has been offline for a while, so the results have been underreported in that forum.
- There were four minor medication incidents reported for January 2019. Each department holds a monthly quality meeting where all incidents are reviewed and investigated. This is monitored by a directorate quality meeting where any recurring trends are reviewed and action plans agreed as necessary.
- Unplanned overnight admissions for January 2019 were at 6.03% against a target of 3%. Investigation of the cause of the increase seems to be in some part due to clerical errors.

Key achievements in the month

- Employee survey results are out. Good participation rate was noted across the Directorate being 68% overall. SMO participation increased being the 3rd highest for the organisation, and also increased RMO participation as well across the directorate. Staff Engagement had a marginal increase of 3%. RMO were noted to be highly engaged as 16% higher than average for the organisation.
- Ryan Warmington has been appointed to the role of clinical coach for Anaesthetic Technicians, which is a newly established role. We expect this role to grow as we are better able to accommodate the requirements of trainees and the Hospital
- CSSD are encouraging their Sterile Supply Technicians to get Registration with NZSSA (self-regulatory). There have also been some internal staff promotions as listed below:
    - Zoheb Hussain – promoted to Shift Coordinator (RMD Cleaning & Disinfection).
    - Charles Calderon – promoted to Shift Coordinator (Sterile Room & Case Cart Management System).
    - Benjamin Ikinofo – promoted to OR-CSSD Liaison Technician (pilot position for Level 8).

Areas off track and remedial plans

- Recruitment of staff for the additional acute work (the flex team, the extended Auckland Surgical Unit hours and the flex sessions at GSU) is slow. The recruitment process has been reviewed and refined. There is more extensive advertising, targeted to specific groups using the networks of local contacts.
- On-going recruitment continues for all operating suites on the ACH site with further difficulty in attracting applicants for Anaesthetic Technician vacancies. However, an increase in the training program will start to mitigate that in 6-12 months, along with other initiatives.

Key issues and initiatives identified in coming months

- Anaesthetic Technician training and staffing shortfall has significantly improved. As of 7 March 2019, the directorate has 17 vacancies, 14 of these are new positions. To ensure a sustainable workforce is maintained following measures are being worked upon:
    - Still training
    - Recruitment strategies – looking at other countries to target, currently in the process of checking qualifications.
    - Drawing ex-employees back and agency staff to take on permanent contracts.
    - Discussions with other DHB's regarding another recruitment drive to the United Kingdom.
- Presenting results of the staff engagement survey to the teams and developing the action plan.
- CAPEX requirements for 2019/2020 are likely to considerably outstrip available funding. This is an area which we are monitoring closely and has resulted in a very vulnerable position.
- The Greenlane improvement project has produced some pleasing productivity gains.

Financial Results

Summary Net Result

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

STATEMENT OF FINANCIAL PERFORMANCE
Perioperative Services

Reporting Date Jan-19

($000s)	MONTH			YEAR TO DATE (7 months ending Jan-19)		
	Actual	Budget	Variance	Actual	Budget	Variance
REVENUE						
Government and Crown Agency	166	171	(4) U	1,154	1,195	(41) U
Funder to Provider Revenue	71	9	62 F	488	81	408 F
Other Income	11	17	(6) U	109	117	(8) U
Total Revenue	**248**	**196**	**52 F**	**1,751**	**1,393**	**358 F**
EXPENDITURE						
Personnel						
Personnel Costs	7,835	7,580	(255) U	51,972	51,737	(235) U
Outsourced Personnel	69	68	(2) U	542	473	(69) U
Outsourced Clinical Services	0	0	0 F	2	0	(2) U
Clinical Supplies	3,327	2,540	(787) U	23,728	22,253	(1,475) U
Infrastructure & Non-Clinical Supplies	125	146	21 F	1,127	1,019	(108) U
Total Expenditure	**11,356**	**10,334**	**(1,022) U**	**77,371**	**75,482**	**(1,889) U**
Contribution	**(11,107)**	**(10,137)**	**(970) U**	**(75,620)**	**(74,089)**	**(1,531) U**
Allocations	11	11	1 F	70	110	41 F
NET RESULT	**(11,118)**	**(10,149)**	**(969) U**	**(75,690)**	**(74,199)**	**(1,490) U**

Paid FTE

	MONTH (FTE)			YEAR TO DATE (FTE) (7 months ending Jan-19)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	135.2	141.2	5.9 F	134.1	141.2	7.0 F
Nursing	377.5	417.9	40.4 F	387.7	412.5	24.8 F
Allied Health	76.7	106.4	29.7 F	77.6	102.0	24.4 F
Support	110.6	115.3	4.7 F	109.0	115.3	6.3 F
Management/Administration	22.9	13.7	(9.2) U	21.8	13.7	(8.1) U
Total excluding outsourced FTEs	**722.9**	**794.5**	**71.6 F**	**730.2**	**784.7**	**54.5 F**
Total :Outsourced Services	1.4	0.0	(1.4) U	1.8	0.0	(1.8) U
Total including outsourced FTEs	**724.3**	**794.5**	**70.1 F**	**732.0**	**784.7**	**52.7 F**

Comments on major financial variances

Volumes

All Theatres (excl SSOR)	Year to date				
	Actual	Budget	Variance to budget	Prior year Actual	Variance year on year
Minutes	2,063,112	2,095,369	98.5%	2,077,943	99.3%
Cases	21,995	22,428	98.1%	22,125	99.4%
Cost per minute	$ 36.69	$ 35.41	103.6%	$ 33.35	110.0%
Average minutes per case	93.8	93.4		93.9	

Year to Date
The result is $1,491k unfavourable for the year to date.

Production is slightly behind plan YTD in minutes at 98.5% with a slight increase in average minutes per case against budget resulting in 98.1% of cases completed against budget. YTD Volumes have been impacted by Industrial action and vacancy.

Revenue
- Funder to provider revenue is $408k favourable due to the funding support from the Ministry of Health for the Nursing MECA settlement

Expenditure
- Personnel costs are $235k U with the main drivers being:
    - overtime and SMO additional duties
    - Increased cost of call allowances due to MECA and call back.

The additional revenue for MECA support is currently offsetting our unfavourable variance and vacancy is reducing the impact of higher costs.
- Outsourced Personnel $69k U high use of Anaesthetic Technicians to cover vacancy.
- Clinical supplies spend $1,475k U YTD with the main drivers of cost being Instruments and equipment$1,404k U
    - Use of disposable instruments $479k U
    - Write off of equipment due to CJD contamination risk $108k U
    - Instruments and equipment repairs $435k U
    - Depreciation and loss on disposal of assets $280k U

The actual cost per minute YTD is $36.69 against a budget of $35.41. The high proportion of fixed costs to operate the directorate results in higher cost per minute when production volumes are lower than budget. Perioperative carries the budget for a number of Theatre support services e.g. CSSD, Anaesthetic Technician Trainees, Pain Team which also support the Starship OR Suite and patients. As a result the cost per minute is higher than in previous years, due to the reduction in theatre minutes which are now reported through Child Health.

Below is a comparative table demonstrating the cost per minute for all theatres across ADHB provider.

All Theatres (Incl SSOR)	Year to date				
	Actual	Budget	Variance to budget	Prior year Actual	Variance year on year
Minutes	2,514,720	2,556,518	98.4%	2,539,092	99.0%
Cases	28,087	28,697	97.9%	28,394	98.9%
Cost per minute	$ 35.16	$ 33.93	103.6%	$ 31.96	110.0%
Average minutes per case	89.5	89.1		89.4	

Surgical Services Directorate

Speaker: Arend Merrie, Director

Service Overview

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

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

The Surgical Services Directorate is led by:

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

Directorate Priorities for 2018/19

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

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

Glossary

Acronym/term	Definition
ACC	Accident Compensation Corporation
CCDM	Care Capacity Demand Management
ESPI	Elective Services Patient Flow Indicator
FSA	First Specialist Assessment
FTE	Full-time Equivalent
GSU	Greenlane Surgical Unit
KPI	Key Performance Indicators
NZNO	New Zealand Nurses Organisation
NZRDA	New Zealand Resident Doctors' Association
OR	Operating Room
ORL	Otorhinolaryngology
SAC	Severity Assessment Code
SMO	Senior Medical Officer
YTD	Year to Date

Q3 Actions – 90 day plan

1. Culture of safety

Activity	Progress
Embed the risk module within Datix across our services	• The services have started adding risks to Datix with agreed Directorate review to ensure consistent scoring.
Ensure that incidents and risks are continually reviewed and managed within agreed timescales	• Weekly Directorate governance review is now embedded which review outstanding incidents, Severity Assessment Code (SAC) 1 & 2 events and newly added risks. • Positive progress is being seen with the completion of outstanding serious events reviews and our overdue serious adverse event incidents are reducing. Regular reporting of overdue reviews is shared with teams. A recent charge nurse workshop explored management of incidents to meet the agreed timescales. • Datix champions for the directorate and named quality leads for each service are being established.
Ensure TrendCare is fully implemented within inpatient services to ensure appropriate response to patient acuity and nursing staffing requirements	• Each surgical portfolio has established regular Trendcare focus groups and there is a monthly Directorate oversight group. It is envisaged this group will morph into the local data council as we progress through the Care Capacity Demand Management (CCDM) process. • Three wards are progressing through the Full-time Equivalent (FTE) calculations process. Additional staff are currently being recruited and we are estimating commencing new rosters for two of the

	wards in May 2019. • Additional funding from the Accord was awarded to two services within the Surgical Directorate and we are working in partnership with New Zealand Nurses Organisation (NZNO) to implement appropriate roles to provide immediate relief for these areas. • A regular directorate NZNO meeting has been established to work with all stakeholders on relevant issues with a focus on safe staffing and short staffing reported incidents.

2. Timely and effective

Activity	Progress
Complete seed funding business case for the expansion of operating rooms (ORs) as part of the Building for the Future Programme Board	• Building for the Future OR capacity group was established in August 2018. • We have started to build decant plans for Auckland City Hospital ORs to Greenlane Surgical Unit (GSU) with the capacity created through Oral Health and Ophthalmology Services being established at Waitematā DHB. • A GSU project group was established in October 2018 and meeting fortnightly to increase volumes and complexity of surgery at the GSU site. • From February 2019 all 80 GSU sessions have been staffed and allocated to services with a net gain of 11 sessions over the 4 week period. • The Building for the Future group held their first steering group in February 2019 for GSU expansion and the first concept design session was held 25 February 2019 with plans to have a strategic business case completed for submission by April 2019.
Develop medium term plans to utilise all appropriate and available capacity to deliver sustainable high quality healthcare	• Agreed outsourcing model in place for Ophthalmology with 2 providers agreed for 2018/19 for 1400 procedures. • Orthopaedic outsourcing continuing through 2018/19 levels. As of 23 October 2018 a revised plan has forecast delivery of between 380-400 cases (Plan for 350). • Waitematā DHB facility agreements to start through Q1 in Oral Health and Ophthalmology. Ophthalmology commenced 24 August 2018, Oral and Dental Health commenced 1 October 2018. • Due to the discharge position and large waiting lists in Oral Health – further capacity has been sourced with an external provider.

3. Equitable and inclusive access

Activity	Progress
Develop robust waiting list processes for managing equitable access to elective surgery	• Develop service A3s to include Key Performance Indicators (KPIs) for delivery against Access, Booking and Choice policy.
Develop reporting tools which identify our patient population groups	• Business Intelligence reporting was updated through October 2018 to allow dashboard reports to be split by ethnicity. • KPI established and monitored around the reduction of Did Not Attend rates for Māori and Pacific patients in Ophthalmology at Waitākere Hospital.
Develop inclusivity plans involving intentional and deliberate targeted recruitment	• Good progress within nursing recruitment targeting Māori and Pacific applicants.

4. Efficient and financially sustainable pathways

Activity	Progress
Develop the future local and regional strategies for Orthopaedics, Urology and Ophthalmology	• The regional Ophthalmology group was established in November 2018 with 3 meetings held with an initial focus on having consistent data sets across all DHBs.
Implement the findings of the Transplant and regional Head and Neck Cancer reviews	• The Head and Neck Cancer Framework document was approved by the Regional Executive Forum and the Northern Region Integrated Cancer Service Programme Board in December 2018 and has been shared with the relevant teams and multidisciplinary staff involved in all areas with the implementation of this framework.
Undertake a service improvement programme across Neurosurgery	• Service improvement group meeting in July 2018 with particular focus on day of surgery admission opportunities and breakdown of virtual follow-up activity which is a key contributor to loss making within the service. The directorate team is reviewing these opportunities and aligning these with organisational and directorate work streams and priorities.

Identify and address loss making services	• Loss making reports have been completed for:
	  ○ General Surgery
	  ○ Neurosurgery
	  ○ Otorhinolaryngology (ORL)
	  ○ Orthopaedics
	• Action logs are being established for each service in time for the next Financial Sustainability Steering Group.

5. Our people are happy, healthy and high performing

Activity	Progress
Continued recruitment towards a sustainable workforce and understand and address retention issues	• Recruitment improvement workshop was presented in August 2018, training recruiting managers how to reduce 'on boarding time' with agreement for continual recruitment to high turnover roles instead of waiting for vacancies. • There has been a significant drop in the average time taken from the initiation of the request to recruit to the date of acceptance to 43 days. This is 7 days under the target for the organisation of 50 days. • There has also been a reduction in the number of offers made over the past 2 months.
Finalise staff engagement plans across the Directorate incorporating a leadership structure	• The 2018/19 staff survey results have been made available to management who are being assisted with their interpretation to enable them to prepare action plans. • There was a significant increase in participation from 55% to 68% compared to the last survey 2 years ago. Employee engagement is high at 80%. • Results for most of the units within each service have been compiled and distributed for discussion at a surgical 'hui' on 27 February 2019. In addition to sharing the results for the Directorate, the wider leadership team will commence the process of creating action plans.
Prepare a communications strategy in preparation of the 2018/19 staff Employee Survey	• A proposed central communications plan has been circulated and from this a draft communications strategy has been prepared. This will be used as the bases for establishing directorate wide communications. The emphasis will be on staff groups where low engagement survey completion rates have been received.
Embed values, Speak Up and a culture of kindness	• The delivery of values and Speak Up sessions continue across the Directorate with 27% being held across all services in the last 12 months. Two more are scheduled for March 2019. • The number of incidents of bullying and harassment being reported remains low which is reflected in the engagement surgery results.

Scorecard

Auckland DHB - Surgical Services

HAC Scorecard for January 2019

	Measure	Actual	Target	Prev Period
Patient Safety	Medication Errors with major harm	0	0	0
	Number of falls with major harm	1	0	0
	Nosocomial pressure injury point prevalence (% of in-patients)	2.3%	<=6%	1.6%
	Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	3.1%	<=6%	3.2%
	Number of reported adverse events causing harm (SAC 1&2)	2	0	0
	Unviewed/unsigned Histology/Cytology results >30 and < 90 days	49	0	30
	Unviewed/unsigned Histology/Cytology results >= 90 days	27	0	20
Better Quality Care	HT2 Elective discharges cumulative variance from target	0.84	>=1	0.85
	(ESPI-1) % Services acknowledging 90% of FSA referrals in 15 calendar days or less	R/U	100%	86.46%
	(ESPI-2) Patients waiting longer than 4 months for their FSA	1.21%	0%	1.4%
	(ESPI-5) Patients given a commitment to treatment but not treated within 4 months	9.9%	0%	8.13%
	(ESPI-8) Proportion of patients prioritised using nationally recognised processes or tools	99.83%	100%	99.77%
	% DNA rate for outpatient appointments - All Ethnicities	8.32%	<=9%	8.46%
	% DNA rate for outpatient appointments - Maori	20.92%	<=9%	17.74%
	% DNA rate for outpatient appointments - Pacific	15.56%	<=9%	17.7%
	Elective day of surgery admission (DOSA) rate	83.4%	>=68%	74.93%
	% Day Surgery Rate	65.92%	>=70%	56.82%
	Inhouse Elective WIES through theatre - per day	R/U	TBC	58.09
	Number of CBU Outliers - Adult	198	<=300	219
	% Patients cared for in a mixed gender room at midday - Adult	20.76%	TBC	15.86%
	% Very good and excellent ratings for overall inpatient experience	R/U	>=90%	87.7%
	% Very good and excellent ratings for overall outpatient experience	R/U	>=90%	87.1%
	Number of complaints received	14	No Target	14
	28 Day Readmission Rate - Total	R/U	<=10%	10.68%
	Average LOS for WIES funded discharges (days) - Acute	3.45	TBC	3.11
	Average LOS for WIES funded discharges (days) - Elective	0.79	TBC	1.43
	31/62 day target - % of non-surgical patients seen within the 62 day target	97.5%	>=90%	97.06%
	31/62 day target - % of surgical patients seen within the 62 day target	88.57%	>=90%	91.74%
	62 day target - % of patients treated within the 62 day target	91.82%	>=90%	93.79%
Improved Health Status	% Hospitalised smokers offered advice and support to quit	94.62%	>=95%	96.02%
Engaged Workforce	Excess annual leave dollars ($M)	$1.1	0	$1.21
	% Staff with excess annual leave > 1 year	31.89%	0%	33.25%
	% Staff with excess annual leave > 2 years	14.14%	0%	15.16%
	Number of Pre-employment Screenings (PES) cleared after the start date	0	0	0
	Sick leave hours taken as a percentage of total hours worked	3.55%	<=3.4%	3.55%
	% Voluntary turnover (annually)	13.04%	<=10%	13.45%
	% Voluntary turnover <1 year tenure	16.98%	<=6%	15.74%

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. Not applicable for Engaged Workforce KRA.

R/U Result unavailable

(ESPI-1) % Services acknowledging 90% of FSA referrals in 15 calendar days or less

Result unavailable until after the 16th of the next month.

% Very good and excellent ratings for overall inpatient experience

% Very good and excellent ratings for overall outpatient experience

These measures are based on retrospective survey data, i.e. completed responses for patients discharged or treated the previous month.

28 Day Readmission Rate - Total

A 35 day period is required to accurately report all acute re-admissions for the previous month's discharges. (35 days = 28 days post discharge as per MoH measures plus 5 working days to allow for coding).

Inhouse Elective WIES through theatre - per day

Result unavailable.

Scorecard Commentary

- There were two SAC 1 and 2 reported events in January 2019:
  - A fall resulting in a fracture
  - A patient who developed respiratory stridor, airway compromise and desaturation after neck biopsy
- The New Zealand Resident Doctors' Association (NZRDA) industrial action resulted in 4 full days of elective surgery being deferred through January 2019. This resulted in 164 elective operations not taking place across all services in Adult Surgery. This is the primary reason for the further deterioration of the elective health target.
- There is a forecast recovery of Elective Services Patient Flow Indicator (ESPI) 2 in February 2019 with a number of additional weekend clinics taking place in General Surgery, ORL and Ophthalmology. ESPI 5 recovery plans have been drafted which will see recovery in Ophthalmology by February 2019. ORL, Urology, Oromaxillofacial recovery by July 2019. Oral Surgery and Orthopaedics capacity constraints result in recovery not occurring for approximately 18 months.
- All services carry the risk of further deterioration if further industrial action takes place.

Key achievements in the month

- Further improvement of day of surgery admission rate due to successful implementation across services bringing patients in on day of surgery.
- Improved level of engagement for the Directorate in the staff engagement survey:
  - 13% increase across the Directorate in participation
  - 80% Employee engagement
  - 94% The values and behaviours expected of me are clear
  - 96% staff feel clear about objectives and responsibilities
- The following improvement actions have been implemented to optimise usage and utilisation of the Greenlane Operating Rooms:
  - Overnight anaesthetic coverage has been in place at Greenlane since December 2018
  - All 11 Flex sessions have been allocated to specific services, and are fully staffed and resourced
  - All available operating room sessions (80 per week) will be fully utilised from March 2019
  - Agreement to move 4 Urology operating room sessions per month from Level 8, Auckland City Hospital to Greenlane from February 2019 to increase Orthopaedic elective capacity at Auckland City Hospital

- Agreement to move the majority of General Surgery local anaesthetic skin lists out of operating rooms into treatment rooms to enable backfill with surgical discharges from April 2019
- Weekly tracker now distributed to all stakeholders to monitor operating room usage at Greenlane

Areas off track and remedial plans

- ESPI 2 breach performance across the majority of services within surgery due to the combination of summer annual leave and industrial action. Action plans are in place with recovery of ESPI 2 performance in February 2019.
- Discharge position deterioration largely due to NZRDA industrial action in January 2019 that has resulted in reducing adult surgical elective lists for 4 full days in January 2019.
- ESPI 5 positioning worsening across Urology, Ophthalmology, ORL, Orthopaedics, Oral Health and Neurosurgery mainly driven by impact of Resident Medical Officer industrial action.

Key issues and initiatives identified in coming months

Impact of industrial action in 2019

There has been significant impact of industrial action resulting in large reductions in elective operating times. There remains a significant risk with the position deteriorating further with increased strike action planned from the NZRDA and further risk of action from the Public Service Association.

Month	Group	Hours	Discharge Impact
Jul 2018	NZNO	500	300
Jan 2019	NZRDA	300	170
Feb 2019	NZRDA	150	85
TOTAL		**950**	**555**

Service updates

General Surgery

- Implementation of FTE calculations in three wards, additional nursing roles and VRM.
- Involvement in trial communication tool for clinical teams.

Ophthalmology

- ARC/ECC Acute over performance in volumes.
    - Volumes are being driven by a combination of increased volumes and time waiting in the emergency eye clinic
    - The project started in April 2018 to address this with senior triage being trialled which has seen waiting times reduce significantly
- Overdue follow-up position.
    - With the increased levels of patients in the service this has taken up significant resource has resulted into the overdue follow-ups increasing to just under 300 with the highest risk score of 3 (sustained delivery of 1.5 risk). There has also been a reduction in paediatric Senior Medical Officers (SMOs) due to a resignation which is being recruited to help address this backlog

Orthopaedics

- Ongoing capacity constraints are limiting plans to reduce waiting times. Additional internal capacity for Orthopaedics, combined with continuing of outsourced capacity is expected to deliver an improved position by year end.
- A KPI has been established monitoring the % of non-compliant patients booked for elective surgery is higher than 60%.

Orthopaedic triage Greenbelt update

- Senior physiotherapist Desiree McCracken has completed her Greenbelt project looking at a musculoskeletal (MSK) pathway for Priority D (non-urgent) shoulder and knee patients referred to the orthopaedic service. In total 69 patients have received their assessment through the MSK pathway: 49 (71%) of these were managed by Physiotherapy and/or discharged back to the GP, 8 (12%) trialled Physiotherapy prior to seeing an SMO and 12 (17%) wanted or needed to see an SMO. The mean wait time for FSA assessments for category D patients were 101 days for an SMO, and 33 days for the MSK pathway. The pathway is being continued as business as usual with the purpose of reducing the conversion rate to elective surgery. The next phase is reducing SMO input and once that's established the service will look at potential pathways to implement across other orthopaedic sub specialties.

Urology

- The mobile lithotripsy unit has been arranged to visit Greenlane monthly until July 2019 which delivers services 3 days per month. An investment case will be submitted to backfill these OR sessions from the new financial year.
- There have been successful pathway changes in taking both perineal biopsies and urology botox injections out of the operating room and into treatment rooms to allow increased OR sessional time for complex work.

Oral Health

- On-going capacity constraint with short notice SMO vacancies leading to problems with triaging patients and seeing FSAs in a timely manner.
- With the increase of FSAs over the last 6 months and no material increase in OR allocation has made the total number of children waiting for an oral health procedure more apparent with high conversions to surgery. This has resulted in increased waiting times and ESPI 5 non-compliance.
    - The Service is currently near completion of service sizing so the workforce gap is understood
    - As a large proportion of these patients are CMDHB domicile, an approach has been made around operating capacity being made available at CMDHB to deliver increased volumes

ORL

- There is continued ESPI pressure within the ORL service driven by high complexity cases and shortfall in OR allocations. Saturday insourcing will continue to mitigate this.

Oromaxillofacial Surgery

- The new microvascular maxillofacial surgeon has been appointed and commenced work at the beginning of February 2019.
- The directorate is reworking the OR timetable in order to increase OR capacity for the service in 2018/19 recommendation from the Head and Neck review.

Financial Results

STATEMENT OF FINANCIAL PERFORMANCE
Surgical Services

Reporting Date Jan-19

($000s)	MONTH			YEAR TO DATE (7 months ending Jan-19)		
	Actual	Budget	Variance	Actual	Budget	Variance
REVENUE						
Government and Crown Agency	698	671	27 F	6,424	4,697	1,727 F
Funder to Provider Revenue	19,569	19,524	45 F	161,783	169,013	(7,230) U
Other Income	419	427	(8) U	3,385	2,988	397 F
Total Revenue	**20,686**	**20,622**	**64 F**	**171,592**	**176,698**	**(5,106) U**
EXPENDITURE						
Personnel						
Personnel Costs	9,100	9,000	(101) U	63,450	61,017	(2,433) U
Outsourced Personnel	554	385	(170) U	2,899	2,693	(206) U
Outsourced Clinical Services	306	307	1 F	2,034	2,052	18 F
Clinical Supplies	2,988	2,041	(947) U	21,133	17,589	(3,544) U
Infrastructure & Non-Clinical Supplies	306	264	(41) U	2,098	1,850	(248) U
Total Expenditure	**13,254**	**11,997**	**(1,257) U**	**91,613**	**85,201**	**(6,413) U**
Contribution	**7,432**	**8,626**	**(1,193) U**	**79,978**	**91,497**	**(11,519) U**
Allocations	2,303	2,197	(106) U	17,729	17,514	(215) U
NET RESULT	**5,129**	**6,428**	**(1,299) U**	**62,249**	**73,983**	**(11,734) U**

Paid FTE

	MONTH (FTE)			YEAR TO DATE (FTE) (7 months ending Jan-19)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	227.8	235.6	7.8 F	238.8	230.4	(8.3) U
Nursing	532.0	495.4	(36.6) U	529.2	490.8	(38.4) U
Allied Health	44.6	49.0	4.4 F	42.3	49.0	6.6 F
Support	0.0	0.0	0.0 F	0.0	0.0	0.0 F
Management/Administration	101.8	81.3	(20.5) U	96.9	81.3	(15.6) U
Total excluding outsourced FTEs	**906.1**	**861.2**	**(44.9) U**	**907.2**	**851.5**	**(55.7) U**
Total :Outsourced Services	19.2	19.4	0.2 F	17.9	19.4	1.5 F
Total including outsourced FTEs	**925.3**	**880.7**	**(44.7) U**	**925.2**	**870.9**	**(54.2) U**

Comments on Major Financial Variances

Surgical Services $11,734k U for Year to Date (YTD) January.

Revenue

Total volumes delivered are 96% of contract for the YTD. Demand for acute services is 97.6% and elective volumes at 85.4% against contract YTD. This is predominantly a result of the nursing industrial action in July and high levels of staff sickness and high inpatient volumes across the hospital. The revenue adjustment of $7,745k U is reflected in the financial result for Funder to Provider revenue relates to the year to December with January reported at budget level. This is offset by additional revenue to support the NZNO Multi Employer Collective Agreement settlement of $514k F.

Accident Compensation Corporation (ACC) Revenue is $1,714k F which includes a one off upside relating to prior year. Volumes of ACC patients are relatively static.

Expenditure

The key drivers to the result are:-

- Expenditure including Internal Allocations $6,628k U.
- Personnel costs are $2,433k U mainly driven by overspends in nursing due to the need for patient attenders to monitor high acuity patients, high occupancy across the hospital as well as high sick leave. The CCDM process has concluded for the first three surgical wards (61, 71 and 73) and implementation is in progress, There has also been some additional FTE allocated under the Nursing Accord for a further four wards and this is also being implemented Budget for these changes will be released once the implementation is complete.
- Clinical supplies $3,544 U:
    - Treatment Disposables – Blood costs $359k U noting a single Trauma event in August 2018 costing $105k
    - Pharmaceutical costs remain very high at $1,544k U with $367k U for transplant patients and Ophthalmology $1,218K U. The high cost is a result of a new Ophthalmic pharmaceutical (Eylea) compounded by very high referrals. These are currently being reviewed to understand the drivers of the increase and develop plans to manage forward
    - Implants – Ophthalmology $331k U mainly resulting from higher number of cataract procedures requiring lenses compared to the same period last year. General surgery, Neurosurgery and Urology $411k U due to high cost stimulators YTD noting a number of the stimulator procedures are ACC and implant costs are fully reimbursed when the patient care is invoiced. These overspends are being offset by Orthopaedics implants are currently $280k F however this is in line with lower elective volumes and will be spent as production volumes increase over the remainder of the year
    - Instruments and equipment $350k U driven by rental of mattresses and bariatric bundles $105k U disposable instruments $52k U and minor purchases $172k U
    - Orthotics costs are $293k U these are being investigated and the contract is currently being negotiated by health Alliance
- Infrastructure costs $128k U - Bad debt write offs and provisions against non-resident billing $168k U, and clinical audit software costs $63k U.
- Internal Allocations $215k U, driven mainly by radiology with high charges for Neurosurgery $449k U partially offset by lower usage across other services.

Women's Health Directorate

Speaker: Rob Sherwin, Director

Service Overview

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

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

The Women's Health Directorate is led by:

Director:	Rob Sherwin
Interim General Manager:	Joy Farley
Director of Midwifery:	Vacant
Director of Allied Health:	Vacant
Director of Primary Care:	Orna McGinn
Interim Associate Nurse Director	Lisa Middelberg

Directorate Priorities for 2018/19

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

1. Safe and high quality services
2. Enhanced outcomes for vulnerable populations
3. Strengthened leadership for operational matters and clinical quality and safety
4. Our workforce capacity and capability to ensure we meet the service demand
5. Develop models of care that are patient focused, sustainable and maximise value
6. Develop sustainable delivery models for Fetal Medicine, Fertility Plus, the Epsom Day Unit and Gynae-Oncology

Glossary

Acronym/term	Definition
DNA	Did Not Attend
FTE	Full-time Equivalent
LARC	Long Acting Reversible Contraceptive
MFM	Maternal Fetal Medicine
MoH	Ministry of Health
MQSP	Maternity Quality and Safety Programme
PVS	Price Volume Schedule
WIES	Weighted Inlier Equivalent Separation
YTD	Year to Date

Q3 Actions – 180 day plan

Priority	Action Plan	Commentary
1	Safe and Quality Services	• The Maternity Quality and Safety Programme (MQSP) has been submitted to the Ministry of Health (MoH). Thia is an ambitious 2 year work plan with specific deliverables; good traction is being made.
2	Enhance outcomes for vulnerable populations	The following programmes support this priority: • Pregnancy and Parenting Programme supporting access and engagement in care for Māori, Pacific, refugee and recent migrant women. The Funder has signalled the opportunity to develop new options to support engagement in the 2019/20 year. The Provider and Funder will work together to ensure that all opportunities are integrated into the wider programme and promoted effectively to women. • Aranga Tetekura - Maternal Wellbeing and Child protection for babies under the Vulnerable Women's Group is on track. • Antenatal community vaccination programme for pregnant women and their babies is on track. • The infrastructure needed to support a project plan for implementing the Te Manawa o Hine Service is in development. • The Long Acting Reversible Contraception (LARC) clinic was launched on 14 February 2019 at the Glen Innes Health Centre with a mihi whakatau followed by karakia. This is a pilot set up to provide Long Acting Reversible Contraception and Sexual Health services via a youth appropriate, nurse-led clinic. This will run for one session per week for 24 weeks in Ngāti Whātua o Orākei Health Centre. Data will be reported monthly, with quarterly patient feedback. Information regarding the pilot will be compiled in a brief report which will include recommendations for future services.
3	Strengthened leadership for operational matters	• Applications for our Midwifery Director post have closed- we are pleased with the response and are moving to the next phase of the selection process on 4 March 2019.

Priority	Action Plan	Commentary
	and clinical quality and safety	• Our Primary Care Director, Dr Orna McGinn, commenced in post 19 February 2019. • We are recruiting for a permanent appointment to the MQSP Coordinator role and also for the Charge Nurse position for the Epsom Day Unit. • We are reviewing the current leadership structure of the Womens Assessment Unit (WAU) which has turned over three Charge Midwives in two years. We aim to understand the leadership needs of this combined obstetrics and gynaecology unit.
4	Our workforce capacity and capability meets the service demand	• The ongoing midwifery shortage contiunues to place significant pressure on staff. • In response, the DHB leadership decided to temporarily reduce overall maternity, bed capacity by 11 beds (October 2018) in order to improve midwifery staffing levels. However an actual reduction in bed utilistation has proven challenging to achieve. • Daily monitoring of the capacity and demand to flex the bed base is in place. To support longer term planning, a group has been formed to develop some metrics for formally assessing the performance of Tamaki Ward including a breakdown of demand for beds across the 24 hour period, impact on resources and staffing, and the quality of care.
5	Develop models of care that are patient focused, sustainable and maximise value	• Maternity workforce challenges remain, coupled with high demand on the service challenging the assumptions around bed numbers. • Further engagement regarding models of care is planned with the service over Q3.
6	Develop sustainable delivery models for Fetal Medicine, Fertility Plus, Epsom Day Unit and Gynae-Oncology	• The National Improvement Advisory Group for Maternal Fetal Medicine (MFM) has started and is tasked to deliver a comprehensive national plan for the future of MFM services. This will include defining models of care, support and referral pathways. The group is due to report before the end of this year, with the next meeting scheduled for 1 April 2019. • Fertility Plus: The patient information system "Artemis" Phase 1 was implemented in December 2018 with successful go live. We are now working on phase 2; improving functionality and unit processes. • We have started developing a new model of care for integrating all ambulatory gynaecology services including those that require access to a day procedure operating room. This will define the future needs of the Womens Health Service and inform the Greenlane Clinical Centre redesign process. Regular updates will be provided to the GCC Steering Committee for Tranche One - Building for the Future programme.

Scorecard

Auckland DHB - Women's Health

HAC Scorecard for January 2019

	Measure	Actual	Target	Prev Period
Patient Safety	Medication Errors with major harm	0	0	0
	Number of falls with major harm	0	0	0
	Nosocomial pressure injury point prevalence (% of in-patients)	0%	<=6%	0%
	Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	0%	<=6%	0%
	Number of reported adverse events causing harm (SAC 1&2)	0	0	0
	Unviewed/unsigned Histology/Cytology results >30 and < 90 days	4	0	4
	Unviewed/unsigned Histology/Cytology results >= 90 days	8	0	7
Better Quality Care	HT2 Elective discharges cumulative variance from target	0.94	>=1	0.94
	(ESPI-1) % Services acknowledging 90% of FSA referrals in 15 calendar days or less	R/U	100%	100%
	(ESPI-2) Patients waiting longer than 4 months for their FSA	0%	0%	0.1%
	(ESPI-5) Patients given a commitment to treatment but not treated within 4 months	1.14%	0%	0%
	% DNA rate for outpatient appointments - All Ethnicities	7.78%	<=9%	10.3%
	% DNA rate for outpatient appointments - Maori	16.44%	<=9%	28.47%
	% DNA rate for outpatient appointments - Pacific	17.5%	<=9%	22.71%
	Elective day of surgery admission (DOSA) rate	88.46%	>=68%	93.55%
	% Day Surgery Rate	38.94%	>=50%	42.96%
	Inhouse Elective WIES through theatre - per day	R/U	>=4.5	6.59
	Number of CBU Outliers - Adult	18	<=300	8
	% Very good and excellent ratings for overall inpatient experience	R/U	>=90%	81.5%
	% Very good and excellent ratings for overall outpatient experience	R/U	>=90%	82.2%
	Number of complaints received	14	No Target	5
	Number of patient discharges to Birthcare	299	TBC	299
	Average LOS for WIES funded discharges (days) - Acute	1.77	<=2.1	1.57
	Average LOS for WIES funded discharges (days) - Elective	1.51	<=1.5	1.31
	Post Gynaecological Surgery 28 Day Acute Readmission Rate	R/U	No Target	5.93%
Improved Health Status	% Hospitalised smokers offered advice and support to quit	86.36%	>=95%	93.06%
	Breastfeeding rate on discharge excluding NICU admissions	R/U	>=75%	74.5%
Engaged Workforce	Excess annual leave dollars ($M)	$0.39	0	$0.41
	% Staff with excess annual leave > 1 year	32.39%	0%	36.62%
	% Staff with excess annual leave > 2 years	13.88%	0%	13.38%
	Number of Employees who have taken greater than 80 hours sick leave in the past 12 months	122	60	122
	Number of Pre-employment Screenings (PES) cleared after the start date	0	0	0
	Sick leave hours taken as a percentage of total hours worked	4.06%	<=3.4%	4.17%
	% Voluntary turnover (annually)	13.45%	<=10%	13.05%
	% Voluntary turnover <1 year tenure	1.92%	<=6%	4%

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. Not applicable for Engaged Workforce KRA.

R/U Result unavailable

(ESPI-1) % Services acknowledging 90% of FSA referrals in 15 calendar days or less

Result unavailable until after the 16th of the next month.

% Very good and excellent ratings for overall inpatient experience

% Very good and excellent ratings for overall outpatient experience

These measures are based on retrospective survey data, i.e. completed responses for patients discharged or treated the previous month.

Post Gynaecological Surgery 28 Day Acute Readmission Rate

This measure has been developed specifically for Women's Health and should not be compared to the 28 Day Readmission Rate reported by other Directorates. This measure is reported a month in arrears in order to accurately report the readmissions arising from the previous months

Breastfeeding rate on discharge excluding NICU admissions

Result unavailable until after the 20th of the next month.

Inhouse Elective WIES through theatre - per day

Result unavailable.

Scorecard Commentary

- There have been no Severity Assessment Code (SAC) 1 and 1 SAC 2 events reported in January 2019. There were no falls, medication errors with major harm, or pressure injuries (stage 2) reported.
- Histology and cytology reporting is close to achievement – a revised Standard Operating Procedure for signoff and escalation of laboratory or radiology results in Women's Health will be approved next month.
- Elective discharge targets and Elective Services Patient Flow Indicator compliance remain behind plan, but within the predicted levels given the impact of industrial action; a recovery plan is in place.
- The number of complaints received in January 2019 has markedly increased; all are being investigated by the directorate teams and will be addressed within timeframes. We are also looking at collating the themes and issues to help us respond to any systemic issues.
- While overall Did Not Attend (DNA) rates are close to target. Māori and Pacific rate of DNA are well outside – we need to undertake a stocktake of the initiatives that are underway, aimed at improving attendance rates. We will also build further improvement strategies for the future.

Key achievements in the month

- Stabilisation of the leadership team with the arrival of a new Director of Women's Health and recruitment planning well underway for all key leadership positions.
- Service delivery maintained through significant industrial action.
- Engagement process with staff to assess the results of the staff survey and implementing change.
- Completed a progress plan reset to support annual plan deliverables.
- Support from our Midwifery leadership team in supporting new graduate intakes at Auckland DHB. Our recruitment meeting with Auckland University of Technology students was held 9 January 2019. This was led by our Midwifery Unit Managers/Educators/ Midwife Consultant and staff. The meeting was well received and feedback included;

  "Your presentation was positive and inspiring. The students commented that they felt like they would be warmly welcomed and well supported at your organisation and were very impressed about what you have to offer". Auckland University of Technology Lecturer

Areas off track and remedial plans

- Sick leave and annual leave accruals remain high in this quarter. Underpinning progress in improving this situation is resolution of the on-going vacancies.
- Developing a sustainable pipeline of midwives remains a primary focus. The launch of the Recruitment, Retention and Responsiveness project in conjunction with Midwifery Employee

Representation and Advisory Service and New Zealand Nurses Organisation is critical to improving these workforce metrics. This is championed by our Chief Nursing Officer and this project has a high priority within our directorate leadership team.

- The Elective discharge targets remain a focus for the service and there are waiting list initiatives planned for next month, to mitigate the position. However, with further industrial action signalled and the on-going pressures from elective/acute Caesarean Sections, discharge targets remain at risk.

Key issues and initiatives identified in coming months

- Mitigating the impact of our on-going midwifery vacancies whilst developing a sustainable pipeline of midwives remains an on-going challenge.
- The temporary relocation of Ward 97, as part of the replacement floor project, and the use of the vacated space by the Fraser McDonald Unit, will be completed mid-April 2019. We will be focusing our attention on what we have learned from the interim arrangements to inform what options exist to do something differently with the aim of improving the quality of care and experience for our patients and staff.
- Employment engagement survey road shows are to be held across the Women's Health to promote feedback and learning across the directorate. We want to utilise the results of this feedback to strengthen our leadership for quality, safety and operational excellence.
- The MoH is now engaging with DHBs to roll out the national maternity information system (MCIS-Maternity Clinical information system). Health Alliance is working with Auckland DHB to engage with the MoH and the vendor to understand the processes involved.

Financial Results

STATEMENT OF FINANCIAL PERFORMANCE

Womens Health Services

Reporting Date Jan-19

($000s)	MONTH			YEAR TO DATE (7 months ending Jan-19)		
	Actual	Budget	Variance	Actual	Budget	Variance
REVENUE						
Government and Crown Agency	174	189	(15) U	1,259	1,323	(64) U
Funder to Provider Revenue	6,126	6,228	(102) U	50,670	51,047	(378) U
Other Income	192	172	21 F	1,152	1,203	(51) U
Total Revenue	**6,492**	**6,589**	**(97) U**	**53,080**	**53,574**	**(493) U**
EXPENDITURE						
Personnel						
Personnel Costs	3,595	3,770	175 F	25,464	26,037	573 F
Outsourced Personnel	64	83	19 F	457	580	123 F
Outsourced Clinical Services	25	46	21 F	299	325	26 F
Clinical Supplies	436	421	(15) U	3,369	3,422	54 F
Infrastructure & Non-Clinical Supplies	98	112	14 F	705	784	79 F
Total Expenditure	**4,219**	**4,432**	**214 F**	**30,294**	**31,148**	**854 F**
Contribution	**2,273**	**2,157**	**116 F**	**22,786**	**22,425**	**360 F**
Allocations	632	577	(55) U	4,923	4,624	(299) U
NET RESULT	**1,642**	**1,580**	**62 F**	**17,863**	**17,802**	**62 F**

Paid FTE

	MONTH (FTE)			YEAR TO DATE (FTE) (7 months ending Jan-19)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	69.5	71.0	1.6 F	70.6	71.0	0.5 F
Midwives, Nursing	241.3	256.4	15.1 F	245.3	256.4	11.1 F
Allied Health	9.7	9.7	0.0 F	10.3	9.7	(0.6) U
Support	0.0	0.0	0.0 F	0.0	0.0	0.0 F
Management/Administration	37.1	39.1	2.0 F	36.4	39.1	2.7 F
Other	0.0	0.0	0.0 F	0.0	0.0	0.0 F
Total excluding outsourced FTEs	**357.5**	**376.2**	**18.7 F**	**362.5**	**376.2**	**13.7 F**
Total :Outsourced Services	4.5	3.1	(1.5) U	4.0	3.1	(1.0) U
Total including outsourced FTEs	**362.1**	**379.3**	**17.2 F**	**366.5**	**379.3**	**12.7 F**

Comments on major financial variances

The Directorate's result year-to-date (YTD) has a favourable budget variance of $62k. This is due largely to the contribution from a favorable personnel variance of $573k arising from vacancies, particularly of Registered Midwives. This is offset against Price Volume Schedule (PVS) revenue shortfalls in gynecology and the laboratory costs allocated to the service.

Overall YTD Case Weighted Discharges volumes are at 97.7% of contract, with Specialist Neonates at 86% (FY17/18: 65%).

The Gynaecology and Gynae-Oncology acute Weighted Inlier Equivalent Separation (WIES) were 99.6% of contract. Performance of their electives contract was 94.8% (of WIES contract value, not discharge target) which has recovered well from the impact of the recent industrial action.

YTD Obstetric inpatient WIES is (1.3%) below PVS contract due to birth numbers being 3.9% lower, year on year, but this is offset by an increase, year-on-year, in the average WIES of 3.9%

YTD Financial Analysis

Revenue $493k U YTD

- We have received unbudgeted revenues of Tertiary Adjuster $144k F, and a new service contract of $122k F. Offsetting these have been the PVS shortfall to contract from Gynaecology of $856k (U) partially offset by Gynae-oncology $575 (F). Obstetrics is $284k U (correlating with Year on Year birth numbers being down 3.9%).

Expenses $555k F YTD

- This positive expenditure variance is largely due to Full-time Equivalent (FTE) vacancies.

Personnel $573k F YTD

<u>Medical $156k U</u>

- There is expected to be some timing issue for membership and training costs, earlier in the year. Also some new appointments will be coming on board in the following months.

<u>Midwives and Nursing $650k F</u>

- Budget cost variance here is due to net 11.1YTD FTE vacancies – this is after contributions from both bureau and nursing.

<u>Allied Health $42k U</u>

- Due to some laboratory demand, there has been some re-direction of resource, over budget, into Allied Health by offsetting some favourable Admin FTE budget variance.

<u>Management / Admin $120k F</u>

- Arising from 2.7 FTE YTD vacancies.

Outsourced personnel $123k F

- Arising from University vacancies.

Outsourced Clinical Services $26k F

- There are fewer send-away tests being performed; $20k F.

Clinical supplies $54k F

- This 1.5% variance correlates with the PVS volume shortfalls to contract/budget.

Infrastructure & Non-Clinical $79K F

- There is currently a favourable doubtful debts budget variance, as well as some unspent costs due to timing difference to the budget phasing.

Internal Allocations total $299k U

- The largest of which are Labs charges of $288k U, split across Maternity $38k U and Gynaecology $250k U.

Financial Performance

Glossary

Acronym/term	Definition
ALOS	Average Length of Stay
DRG	Diagnostic Related Group
FTE	Full-time Equivalent
IDF	Inter District Flow
MECA	Multi Employer Collective Agreement
MoH	Ministry of Health
PCT	Pharmaceutical Cancer Treatment
RMO	Resident Medical Officer
WIES	Weighted Inlier Equivalent Separation
YTD	Year to Date

Consolidated Statement of Financial Performance - January 2019

Provider	Month (Jan-19)			YTD (7 months ending Jan-19)		
$000s	Actual	Budget	Variance	Actual	Budget	Variance
Income						
Government and Crown Agency sourced	8,110	8,809	(699) U	61,475	62,611	(1,136) U
Non-Government & Crown Agency Sourced	6,707	7,854	(1,146) U	52,429	54,832	(2,402) U
Inter-DHB & Internal Revenue	3,479	1,579	1,900 F	(5,195)	11,051	(16,246) U
Internal Allocation DHB Provider	115,309	114,491	818 F	808,522	801,438	7,084 F
	133,605	**132,733**	**873 F**	**917,232**	**929,932**	**(12,700) U**
Expenditure						
Personnel	84,619	86,599	1,980 F	585,436	598,483	13,047 F
Outsourced Personnel	2,444	1,113	(1,331) U	16,603	7,883	(8,720) U
Outsourced Clinical Services	2,848	2,929	81 F	20,585	20,304	(281) U
Outsourced Other	5,197	5,141	(56) U	36,584	35,989	(595) U
Clinical Supplies	23,478	19,044	(4,434) U	176,233	161,057	(15,175) U
Infrastructure & Non-Clinical Supplies	16,279	16,816	538 F	121,790	117,249	(4,541) U
Internal Allocations	368	453	85 F	3,594	3,171	(423) U
Total Expenditure	**135,233**	**132,096**	**(3,137) U**	**960,824**	**944,136**	**(16,688) U**
Net Surplus / (Deficit)	**(1,628)**	**636**	**(2,264) U**	**(43,593)**	**(14,204)**	**(29,388) U**

Consolidated Statement of Financial Performance – January 2019

Performance Summary by Directorate

By Directorate $000s	Month (Jan-19)			YTD (7 months ending Jan-19)		
	Actual	Budget	Variance	Actual	Budget	Variance
Adult Medical Services	(755)	193	(948) U	7,684	11,658	(3,975) U
Adult Community and LTC	1,303	540	763 F	13,257	11,532	1,725 F
Surgical Services	5,129	6,428	(1,299) U	62,249	73,983	(11,734) U
Women's Health	1,642	1,580	62 F	17,863	17,802	62 F
Child Health	20	1,251	(1,231) U	28,352	33,113	(4,761) U
Cardiac Services	941	679	262 F	12,130	16,759	(4,628) U
Clinical Support Services	(1,669)	(3,011)	1,342 F	(10,653)	(12,390)	1,737 F
Patient Management Services	(2,255)	(2,155)	(100) U	(15,576)	(14,898)	(677) U
Perioperative Services	(11,118)	(10,149)	(969) U	(75,690)	(74,199)	(1,490) U
Cancer & Blood Services	(230)	855	(1,085) U	10,183	13,561	(3,378) U
Operational - Other	22,419	22,355	64 F	32,383	37,110	(4,727) U
Mental Health & Addictions	460	(203)	663 F	2,526	233	2,293 F
Ancillary Services	(17,516)	(17,727)	211 F	(128,302)	(128,468)	166 F
Net Surplus / (Deficit)	**(1,628)**	**636**	**(2,264) U**	**(43,593)**	**(14,204)**	**(29,388) U**

Consolidated Statement of Personnel by Professional Group – January 2019

Employee Group $000s	Month (Jan-19)			YTD (7 months ending Jan-19)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical Personnel	30,719	32,117	1,397 F	216,731	221,817	5,086 F
Nursing Personnel	29,659	29,775	116 F	197,244	199,422	2,178 F
Allied Health Personnel	12,718	14,501	1,783 F	91,487	96,681	5,194 F
Support Personnel	2,152	2,066	(86) U	13,968	13,899	(69) U
Management/ Admin Personnel	9,370	8,140	(1,230) U	66,007	66,665	658 F
Total (before Outsourced Personnel)	**84,619**	**86,599**	**1,980 F**	**585,436**	**598,483**	**13,047 F**
Outsourced Medical	1,023	899	(124) U	6,295	6,295	0 F
Outsourced Nursing	599	12	(587) U	3,179	83	(3,095) U
Outsourced Allied Health	68	34	(34) U	528	290	(238) U
Outsourced Support	67	27	(40) U	816	187	(630) U
Outsourced Management/Admin	687	142	(545) U	5,785	1,028	(4,757) U
Total Outsourced Personnel	**2,444**	**1,113**	**(1,331) U**	**16,603**	**7,883**	**(8,720) U**
Total Personnel	**87,063**	**87,713**	**650 F**	**602,039**	**606,366**	**4,328 F**

Consolidated Statement of FTE by Professional Group – January 2019

FTE by Employee Group	Month (Jan-19)			YTD (7 months ending Jan-19)		
	Actual FTE	Budget FTE	Variance	Actual FTE	Budget FTE	Variance
Medical Personnel	1,466	1,480	13 F	1,457	1,468	12 F
Nursing Personnel	3,900	3,891	(9) U	3,868	3,852	(16) U
Allied Health Personnel	1,922	2,003	81 F	1,910	1,993	83 F
Support Personnel	446	461	15 F	441	461	21 F
Management/ Admin Personnel	1,420	1,448	29 F	1,387	1,448	60 F
Total (before Outsourced Personnel)	**9,155**	**9,284**	**129 F**	**9,062**	**9,222**	**159 F**
Outsourced Medical	21	26	5 F	27	26	() U
Outsourced Nursing	1	1	0 F	0	1	0 F
Outsourced Allied Health	2	0	(2) U	3	0	(3) U
Outsourced Support	18	0	(18) U	33	0	(33) U
Outsourced Management/Admin	120	18	(102) U	139	18	(121) U
Total Outsourced Personnel	**162**	**45**	**(117) U**	**201**	**45**	**(156) U**
Total Personnel	**9,317**	**9,328**	**11 F**	**9,263**	**9,267**	**3 F**

Consolidated Statement of FTE by Directorate – January 2019

Employee FTE by Directorate Group (including Outsourced FTE)	Month (Jan-19)			YTD (7 months ending Jan-19)		
	Actual FTE	Budget FTE	Variance	Actual FTE	Budget FTE	Variance
Adult Medical Services	1,017	959	(58) U	993	959	(34) U
Adult Community and LTC	579	559	(21) U	572	559	(13) U
Surgical Services	925	881	(45) U	925	871	(54) U
Women's Health	362	379	17 F	367	379	13 F
Child Health	1,329	1,309	(20) U	1,320	1,304	(16) U
Cardiac Services	571	565	(5) U	568	563	(5) U
Clinical Support Services	1,353	1,349	(4) U	1,334	1,348	14 F
Patient Management Services	424	418	(5) U	437	418	(18) U
Perioperative Services	724	794	70 F	732	785	53 F
Cancer & Blood Services	396	389	(7) U	384	389	5 F
Operational - Others	0	54	54 F	0	32	32 F
Mental Health & Addictions	761	797	36 F	761	789	28 F
Ancillary Services	876	875	(1) U	871	872	1 F
Total Personnel	**9,317**	**9,328**	**11 F**	**9,263**	**9,267**	**3 F**

Month Result

The Provider Arm result for the month is $2.3M unfavourable. This result is expenditure driven with the key drivers being high clinical supplies costs for the month.

Overall volumes (for total Auckland DHB and Inter District Flow [IDF] Funders) are reported at 105.6% of the seasonally phased contract, equating to $4.9M above contract.

Total revenue for the month is $0.9M (0.7%) favourable, however within this there are offsetting variances.

- Provision for elective and IDF washup $2.3M favourable i.e. a reduction in the provision. This follows two months of volumes close to or above contract, thereby reducing the liability for IDF and elective washup.
- Funder to Provider revenue is net $0.3M favourable for Ministry of Health (MoH) Nursing Multi Employer Collective Agreement (MECA) funding, additional funding sub-contracts and Pharmac rebates. The reported variance is $0.8M favourable, however most of these revenue streams were budgeted as external revenue ($0.5M) which now shows unfavourable variances, meaning the net underlying favourable variance is $0.3M.
- Additional revenue assumed for budget initiatives not yet received $0.6M unfavourable.
- MoH Public Health funding $0.2M unfavourable, in line with services delivered.
- Non Resident Income $0.3M unfavourable – this income varies from month to month, year to date is favourable.
- Donations $0.2M unfavourable – this income varies from month to month, year to date is favourable.

Total expenditure for the month is $3.1M (2.4%) unfavourable with the key variances as follows:

- Personnel/Outsourced Personnel costs $0.7M (0.7%) favourable. Total Full-time Equivalent (FTE) is slightly below budget by 11 (0.1%). The unfavourable financial variance reflects high annual leave taken during the month.
- Clinical Supplies $4.4M (23.3%) unfavourable. This variance is widespread across many services, with the key items as follows:
    - Adult and Paediatric Oncology Services $0.8M unfavourable due to the cost of Pharmaceutical Cancer Treatment (PCT) drugs greater than contract (most of this variance is subject to washup and will be funded).
    - Haemophilia $0.3M unfavourable due to higher than budgeted usage, which varies from period to period, but is offset by higher revenue.
    - Blood products (non Haemophilia) $0.8M unfavourable driven by higher price increase than budget assumption and increased usage across a number of services – this is under investigation.

- Ophthalmology $0.4M unfavourable reflecting the Pharmac approval for a new drug that has extended the indications for use to include diabetes retinopathy conditions not previously funded, resulting in an increase in the number of patients receiving treatment. This is partially offset by a reduction in costs for some existing treatments.
- Perioperative instruments and equipment $0.5M unfavourable reflecting increased equipment repair costs and increased use of disposable instruments.
- Radiology $0.1M unfavourable due to volume and cost of high cost interventional radiology procedures above budget.
- Clinical Support $0.3M unfavourable due to the directorate's bottom line savings targets allocated to Clinical Supplies but achieved across all expenditure categories – year to date total expenditure for the directorate is favourable to budget.
- The Clinical Supplies budget was phased to reflect lower volumes in December 2018 and January 2019, whereas the actual volume decrease in January 2019 was not as great as the phasing decrease. This has created a phasing variance for the month of $0.3M which will smooth over future months.
- Assumed savings for Pharmac management of hospital medicines not yet achieved $0.1M unfavourable.

- Infrastructure and Non Clinical Supplies $0.5M (3.2%) favourable reflecting lower utilities, laundry and patient meal costs for lower volumes over January.

Year to Date (YTD) Result

The Provider Arm result for the year to date is $29.4M unfavourable. The two key drivers of this result are volumes under contract (key variance being provision for elective and IDF funding washup) and high clinical supplies costs due to cost drivers not necessarily reflected in the consolidated volume position.

Overall volumes (for total Auckland DHB and IDF Funders) are reported at 98.5% of the seasonally phased contract, equating to $10.8M below contract. The mix of services under and over contract within the consolidated position indicates a net elective and IDF washup liability, and $13.0M has been provided for in the result.

Total revenue for the year to date is $12.7 M (1.4%) unfavourable, with the key variances as follows:

- Provision for elective and IDF washup $13.0M unfavourable.
- Additional Funder to Provider revenue for MoH Nursing MECA funding ($3.5M), additional funding sub-contracts ($0.4M), MoH wash-up for 17/18 national services ($1.1M), and Pharmac rebates ($2.1M). Most of these revenue streams were budgeted as external revenue ($5.0M) which now show unfavourable variances, so the net underlying favourable variance is $2.1M.

- Accident Compensation Corporation Income $2.1M favourable reflecting one off invoicing – likely to trend back closer to budget over the remainder of the year.
- Haemophilia $0.5M favourable due to higher than budgeted usage, which varies from period to period, but is offset by higher expenditure.
- Non Resident Income $0.5M favourable – this income varies from month to month, and is offset by an increase in Bad/Doubtful Debts expenditure.
- MoH Public Health funding $0.7M unfavourable, in line with services delivered.
- Additional revenue assumed for budget initiatives not yet received $4.1M unfavourable.

Total expenditure for the year to date is $16.7M (1.8%) unfavourable with the key variances as follows:

- Personnel/Outsourced Personnel costs $4.3M (0.7%) favourable, reflecting year to date FTE very close to budget (3 below budget).
- Clinical Supplies $15.2M (9.4%) unfavourable, reflecting the following key variances:
    - Ophthalmology $1.8M unfavourable reflecting i) the Pharmac approval for a new drug that has extended the indications for use to include diabetes retinopathy conditions not previously funded, resulting in an increase in the number of patients receiving treatment - this is partially offset by a reduction in costs for some existing treatments, and ii) lenses - volumes are similar to prior year, however a the mix of product purchased indicates use of some more expensive lenses compared to prior year and budgeted spend.
    - Higher volumes of national transplants over the first half of the year compared to prior years - $0.7M unfavourable
    - Adult and Paediatric Oncology Services $2.2M unfavourable due to unusually high volumes for this service driving higher than normal expenditure on high cost pharmaceuticals – most of which is funded PCTs.
    - Haemophilia blood product costs $0.5M unfavourable due to higher than budgeted usage, which varies from period to period, but is offset by higher revenue.
    - Blood products (non Haemophilia) $2.2M unfavourable – driven by higher price increase than budget assumption ($0.5M) and increased usage across a number of services – this is under investigation.
    - Clinical Support $2.2M unfavourable due to the directorate's bottom line savings targets allocated to Clinical Supplies but achieved across all expenditure categories – year to date total expenditure for the directorate is close to budget.
    - Radiology $1.2M unfavourable reflecting both volume and cost of high cost interventional radiology procedures above budget.
    - Perioperative instruments and equipment $1.4M unfavourable reflecting increased equipment repair costs and increased use of disposable instruments.

- Equipment Costs $2.0M unfavourable, primarily due to low budgets for depreciation and lease costs.
- Assumed savings for Pharmac management of hospital medicines not yet achieved $0.6M.

- Infrastructure & Non Clinical Supplies $4.5M (3.9%) unfavourable, with the key variances being:
  - Repairs and Maintenance $2.9M unfavourable reflecting high infrastructure maintenance costs.
  - Bad and Doubtful Debts $1.0M unfavourable – partly reflecting Non Resident Income being $0.5M favourable for the year to date, but Bad and Doubtful Debts vary from period to period, not necessarily aligning with the revenue position.
  - Cost of Goods Sold in Retail Pharmacy $0.5M above budget, but this is offset by additional retail income.

FTE

Total FTE (including contract/outsourced) for January 2019 were 9,317 which was 11 below budget. This was a reduction of 107 FTE from the prior month which was over budget due to a temporary spike in Resident Medical Officer (RMO) FTE following the roster rotations in December 2018 (the first rotation for the new academic year) and Administration FTE mostly due to temporary staff for project work and backfill to cover leave.

Provider Financial Sustainability

The plan for 2018/19 is to deliver total benefits of $11.5M. Benefits have been phased according to expected delivery. For year to date, benefits of $3,327k have been achieved against the phased target of $3,395k - $68k favourable to plan.

Summary Position

2018/19 Provider Financial Sustainability	YTD Actual	YTD Target	YTD Variance	Full Year Forecast	Full Year Target	Full Year Variance
Revenue Growth	754	438	316	3,700	3,250	450
Procurement & Supply Chain	1,354	1,371	-17	3,232	3,513	-281
Loss Making Services	55	509	-454	1,476	2,118	-642
Cost Containment	0	0	0	60	60	0
Sustainability Initiatives	0	0	0	0	200	-200
Models of Care	121	121	0	500	500	0
Patient Flow	18	23	-5	40	40	0
Outpatients	1,025	933	92	1,982	1,832	150
Total	3,327	3,395	-68	10,990	11,513	-523

Detail by Work stream

- **Revenue Growth [YTD $316k F]**

  This workstream covers a range of initiatives including data quality work focusing on ensuring all activity is captured and appropriately funded, and reviewing funding for national services. Forecast is $450k favourable to full year target.

- **Procurement & Supply Chain [YTD $17k U]**

  This initiative relates to healthAlliance, Pharmac, Ministry of Business, Innovation and Employment and DHB led procurement and supply chain savings. The initiatives include efficiencies in stock management, product rationalisation and procurement savings. HealthAlliance savings of $1,354k are reported against a budget of $1,371k, with a full year forecast of $3.2M.

- **Loss Making Services [YTD $454k U]**

  Eleven services have been identified and prioritised for review. To date reviews have been completed for Bone Marrow Transplant Unit, Cardiology, Vascular, Neurosurgery, ORL, Orthopaedics, General Surgery and Cardiothoracic. The reviews have highlighted opportunities for improved volume and revenue capture as well as possible cost containment. Work on realising the identified opportunities will continue throughout the year. The Cardiovascular services (Cardiology, Vascular and Cardiothoracic) have developed workstreams to address the opportunities and have benefit targets phased from November 2018 and reported benefits of $50k for the month. The year to date unfavourable variance is for Haematology cost savings not yet realised. The forecast for Haematology and Cardiovascular workstreams has been reduced by $642k.

- **Cost Containment**

  Benefits from the FCM Online Travel Approvals system – phased to commence quarter 1 2019.

- **Sustainability Initiatives**

  Benefits for this specific project will not be recognised in this financial year.

- **Models of Care**

  YTD benefits for COPD and Cellulitis have been reported in January. Other opportunities in this area are being investigated.

- **Patient Flow [YTD $5k U]**

  This reflects the benefits achieved year to date for the Discharge Planning project.

- **Outpatients [YTD $92k F]**

  The Outpatient Production planning programme went live during May and has delivered benefits in this financial year of $1M through increasing clinic session utilisation. The programme is on target as at quarter 3 and forecasting additional benefit of $150k.

Volume Performance

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

		Jan-2019				YTD (7 months ending Jan-19)			
		$000s				$000s			
Directorate	**Service**	**Cont**	**Act**	**Var**	**Prog %**	**Cont**	**Act**	**Var**	**Prog %**
Adult Community & LTC	Ambulatory Services	1,021	1,114	93	109.1%	8,402	9,263	861	110.3%
	Community Services	1,353	1,704	351	125.9%	12,394	13,651	1,257	110.1%
	Diabetes	543	453	(89)	83.5%	3,854	3,777	(77)	98.0%
	Palliative Care	39	39	0	100.0%	273	273	0	100.0%
	Reablement Services	1,978	2,123	145	107.3%	17,375	14,255	(3,120)	82.0%
	Sexual Health	401	600	199	149.7%	3,475	4,224	749	121.6%
Adult Community & LTC Total		**5,335**	**6,033**	**699**	**113.1%**	**45,773**	**45,444**	**(329)**	**99.3%**
Adult Medical Services	AED, APU, DCCM, Air Ambulance	2,278	2,644	366	116.1%	16,767	17,025	258	101.5%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	11,191	11,590	399	103.6%	90,506	90,811	305	100.3%
Adult Medical Services Total		**13,470**	**14,234**	**764**	**105.7%**	**107,274**	**107,836**	**562**	**100.5%**
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	7,451	8,152	701	109.4%	63,739	63,586	(154)	99.8%
	N Surg, Oral, ORL, Transpl, Uro	8,585	8,722	137	101.6%	72,566	70,503	(2,062)	97.2%
	Orthopaedics Adult	3,488	3,731	244	107.0%	32,708	28,228	(4,480)	86.3%
Surgical Services Total		**19,524**	**20,605**	**1,081**	**105.5%**	**169,013**	**162,317**	**(6,696)**	**96.0%**
Cancer & Blood Services	Cancer & Blood Services	7,885	8,677	792	110.0%	67,092	65,719	(1,372)	98.0%
	Genetics	212	236	25	111.7%	2,085	1,898	(187)	91.0%
Cancer & Blood Services Total		**8,097**	**8,914**	**817**	**110.1%**	**69,177**	**67,618**	**(1,559)**	**97.7%**
Cardiovascular Services		**10,070**	**10,402**	**331**	**103.3%**	**86,325**	**83,686**	**(2,639)**	**96.9%**
Children's Health	Child Health & Disability	923	949	26	102.8%	6,741	6,694	(47)	99.3%
	Medical & Community	5,129	5,267	138	102.7%	51,464	50,943	(521)	99.0%
	Paediatric Cardiac & ICU	4,167	4,663	496	111.9%	34,349	35,986	1,636	104.8%
	Surgical & Community	3,995	4,349	354	108.9%	33,643	31,196	(2,448)	92.7%
Children's Health Total		**14,214**	**15,229**	**1,014**	**107.1%**	**126,197**	**124,818**	**(1,379)**	**98.9%**
Clinical Support Services		**2,869**	**3,300**	**431**	**115.0%**	**24,271**	**25,494**	**1,223**	**105.0%**
DHB Funds		**7,290**	**6,755**	**(536)**	**92.7%**	**51,600**	**50,559**	**(1,041)**	**98.0%**
Perioperative Services		**9**	**6**	**(3)**	**69.6%**	**81**	**81**	**1**	**101.1%**
Public Health Services		**130**	**130**	**0**	**100.0%**	**907**	**907**	**0**	**100.0%**
Support Services		**101**	**101**	**0**	**100.0%**	**709**	**709**	**0**	**100.0%**
Women's Health Total		**6,228**	**6,528**	**299**	**104.8%**	**51,047**	**52,138**	**1,091**	**102.1%**
Grand Total		**87,338**	**92,236**	**4,899**	**105.6%**	**732,373**	**721,607**	**(10,767)**	**98.5%**

2) Total Discharges for the YTD (7 Months to January 2019)

		Cases Subject to WIES Payment		All Discharges			Same Day discharges		Same Day as % of all discharges	
		Inpatient								
Directorate	**Service**	**2018**	**2019**	**Last YTD**	**This YTD**	**% Change**	**Last YTD**	**This YTD**	**Last YTD**	**This YTD**
Adult Community & LTC	Ambulatory Services	1,342	1,347	1,709	1,748	2.3%	1,649	1,665	96.5%	95.3%
	Reablement Services	0	0	1,358	1,197	(11.9%)	38	34	2.8%	2.8%
Adult Community & LTC Total		1,342	1,347	3,067	2,945	(4.0%)	1,687	1,699	55.0%	57.7%
Adult Medical Services	AED, APU, DCCM, Air Ambulance	7,519	7,962	7,739	8,018	3.6%	5,649	5,635	73.0%	70.3%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	11,971	12,609	12,256	12,812	4.5%	2,090	2,012	17.1%	15.7%
Adult Medical Services Total		19,490	20,571	19,995	20,830	4.2%	7,739	7,647	38.7%	36.7%
Cancer & Blood Total		2,936	2,971	3,408	3,451	1.3%	1,772	1,863	52.0%	54.0%
Cardiovascular Services Total		4,996	5,113	5,192	5,317	2.4%	1,389	1,392	26.8%	26.2%
Children's Health	Medical & Community	8,350	8,729	9,157	9,566	4.5%	5,485	5,747	59.9%	60.1%
	Paediatric Cardiac &	1,245	1,367	1,344	1,420	5.7%	232	219	17.3%	15.4%
	Surgical & Community	5,317	4,872	5,631	5,155	(8.5%)	2,544	2,532	45.2%	49.1%
Children's Health Total		14,912	14,968	16,132	16,141	0.1%	8,261	8,498	51.2%	52.6%
DHB Funds Total		631	879	633	881	39.2%	479	689	75.7%	78.2%
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	10,895	10,385	12,412	11,876	(4.3%)	7,302	6,792	58.8%	57.2%
	N Surg, Oral, ORL, Transpl, Uro	6,910	7,080	7,458	7,597	1.9%	2,990	3,146	40.1%	41.4%
	Orthopaedics Adult	2,808	2,634	2,917	2,740	(6.1%)	558	474	19.1%	17.3%
Surgical Services Total		20,613	20,100	22,787	22,213	(2.5%)	10,850	10,412	47.6%	46.9%
Women's Health Total		12,021	11,581	12,526	11,991	(4.3%)	4,644	4,427	37.1%	36.9%
Grand Total		**76,941**	**77,530**	**83,740**	**83,769**	**0.0%**	**36,821**	**36,627**	**44.0%**	**43.7%**

3) Caseweight Activity for the YTD (7 Months to January 2019 (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		**555**	**695**	**139**	**2,814**	**3,520**	**706**	**125.1%**	**68**	**48**	**(20)**	**343**	**243**	**(100)**	**70.9%**	**623**	**743**	**120**	**3,157**	**3,763**	**606**	**119.2%**
Adult Medical Services	AED, APU, DCCM, Air Ambulance	2,263	2,230	(33)	11,471	11,304	(167)	98.5%	0	0	0	0	0	0	0.0%	2,263	2,230	(33)	11,471	11,304	(167)	98.5%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	12,055	11,730	(325)	61,097	59,447	(1,649)	97.3%	4	0	(4)	18	0	(18)	0.0%	12,059	11,730	(329)	61,115	59,447	(1,668)	97.3%
Adult Medical Services Total		**14,318**	**13,960**	**(358)**	**72,567**	**70,751**	**(1,816)**	**97.5%**	**4**	**0**	**(4)**	**18**	**0**	**(18)**	**0.0%**	**14,322**	**13,960**	**(362)**	**72,586**	**70,751**	**(1,834)**	**97.5%**
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	5,513	5,354	(159)	27,940	27,134	(806)	97.1%	4,284	3,983	(301)	21,711	20,184	(1,527)	93.0%	9,797	9,336	(460)	49,651	47,318	(2,333)	95.3%
	N Surg, Oral, ORL, Transpl, Uro	5,985	6,011	26	30,332	30,466	134	100.4%	4,361	3,773	(588)	22,102	19,123	(2,979)	86.5%	10,346	9,785	(561)	52,434	49,589	(2,845)	94.6%
	Orthopaedics Adult	3,580	3,357	(223)	18,142	17,013	(1,128)	93.8%	2,275	1,570	(705)	11,532	7,959	(3,573)	69.0%	5,855	4,927	(928)	29,674	24,972	(4,701)	84.2%
Surgical Services Total		**15,077**	**14,722**	**(355)**	**76,413**	**74,613**	**(1,800)**	**97.6%**	**10,920**	**9,326**	**(1,594)**	**55,346**	**47,266**	**(8,079)**	**85.4%**	**25,998**	**24,048**	**(1,949)**	**131,759**	**121,879**	**(9,880)**	**92.5%**
Cancer & Blood Services		**3,847**	**3,651**	**(196)**	**19,499**	**18,505**	**(994)**	**94.9%**	**0**	**0**	**0**	**0**	**0**	**0**	**0.0%**	**3,847**	**3,651**	**(196)**	**19,499**	**18,505**	**(994)**	**94.9%**
Cardiovascular Services		**8,905**	**9,228**	**323**	**45,130**	**46,769**	**1,638**	**103.6%**	**6,210**	**5,343**	**(867)**	**31,474**	**27,079**	**(4,394)**	**86.0%**	**15,115**	**14,571**	**(544)**	**76,604**	**73,848**	**(2,756)**	**96.4%**
Children's Health	Medical & Community	7,042	6,919	(123)	35,691	35,067	(624)	98.3%	33	28	(5)	166	140	(25)	84.8%	7,075	6,947	(128)	35,856	35,207	(649)	98.2%
	Paediatric Cardiac & ICU	3,552	4,077	525	18,002	20,664	2,662	114.8%	1,446	1,289	(157)	7,327	6,532	(795)	89.2%	4,998	5,366	368	25,329	27,196	1,867	107.4%
	Surgical & Community	3,178	2,687	(491)	16,106	13,617	(2,488)	84.5%	2,562	2,495	(67)	12,982	12,645	(337)	97.4%	5,739	5,182	(558)	29,088	26,262	(2,826)	90.3%
Children's Health Total		**13,772**	**13,683**	**(89)**	**69,799**	**69,348**	**(450)**	**99.4%**	**4,040**	**3,812**	**(228)**	**20,475**	**19,318**	**(1,157)**	**94.3%**	**17,812**	**17,495**	**(317)**	**90,273**	**88,666**	**(1,608)**	**98.2%**
Women's Health Services		**6,009**	**5,904**	**(104)**	**30,452**	**29,924**	**(529)**	**98.3%**	**1,264**	**1,198**	**(66)**	**6,404**	**6,071**	**(333)**	**94.8%**	**7,272**	**7,102**	**(170)**	**36,856**	**35,995**	**(861)**	**97.7%**
DHB Funds		**84**	**84**	**0**	**428**	**428**	**0**	**100.0%**	**1,025**	**906**	**(118)**	**5,192**	**4,593**	**(599)**	**88.5%**	**1,109**	**991**	**(118)**	**5,621**	**5,022**	**(599)**	**89.3%**
Grand Total		**62,568**	**61,928**	**(640)**	**317,103**	**313,858**	**(3,245)**	**99.0%**	**23,530**	**20,633**	**(2,897)**	**119,251**	**104,571**	**(14,681)**	**87.7%**	**86,098**	**82,561**	**(3,537)**	**436,355**	**418,429**	**(17,926)**	**95.9%**
Excludes caseweight Provision																						

Acute Services

Acute performance does not appear to have been impacted by the two 48 hour RMO strikes with acute discharges being similar to the same period last year. Performance to contract has consequently improved for acute services. Total acute discharges for YTD January are now 1.2% higher than the same period last year (in contrast to YTD December where there had been no growth in acute discharges over the previous 6 months).

Activity by service type:

- Acute medical discharges continue to increase - discharges are now 4.8% higher than the same period last year. Average Weighted Inlier Equivalent Separation (WIES) is still lower than the same period last year, but there was a slight increase over January 2019. However Average Length of Stay (ALOS) continues to sit 2% higher than the same period last year.
- Discharge rates for acute surgical continue to be lower than last year but have increased slightly over the last three months. Average WIES is sitting at 3% higher than the same period last year. There has been a very small increase in ALOS.
- There was a small increase in Obstetric discharges over January which was expected as there had been an increase in antenatal appointments. Average WIES is 2.6% higher than the same period last year and LOS is unchanged. New-born services are also higher than the same period last year (15% - a slight drop from YTD December), with average WIES sitting 12% lower and ALOS down by 6%.
- The proposed revised clot retrieval WIES funding model would result in a further 355 acute WIES.

Elective Services

The RMO strikes resulted in a reduction of 170 discharges for the month. Average WIES was also lower than last year, reflecting a lower complexity.

4) Non-DRG Activity (ALL DHBs)

		Jan-2019				YTD (7 months ending Jan-19)			
		$000s				$000s			
Directorate	**Service**	**Cont**	**Act**	**Var**	**Prog %**	**Cont**	**Act**	**Var**	**Prog %**
Adult Community & LTC	Ambulatory Services	603	652	49	108.1%	5,245	5,500	255	104.9%
	Community Services	1,353	1,704	351	125.9%	12,394	13,651	1,257	110.1%
	Diabetes	543	453	(89)	83.5%	3,854	3,777	(77)	98.0%
	Palliative Care	39	39	0	100.0%	273	273	0	100.0%
	Reablement Services	1,978	2,123	145	107.3%	17,375	14,255	(3,120)	82.0%
	Sexual Health	401	600	199	149.7%	3,475	4,224	749	121.6%
Adult Community & LTC Total		**4,917**	**5,571**	**654**	**113.3%**	**42,616**	**41,681**	**(935)**	**97.8%**
Adult Medical Services	AED, APU, DCCM, Air Ambulance	754	893	139	118.5%	5,297	5,721	425	108.0%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	3,192	4,084	892	127.9%	29,392	31,364	1,972	106.7%
Adult Medical Services Total		**3,946**	**4,977**	**1,031**	**126.1%**	**34,688**	**37,085**	**2,397**	**106.9%**
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	1,469	1,883	415	128.2%	14,088	16,268	2,179	115.5%
	N Surg, Oral, ORL, Transpl, Uro	2,471	2,655	183	107.4%	20,131	20,914	783	103.9%
	Orthopaedics Adult	343	477	134	139.0%	3,034	3,256	221	107.3%
Surgical Services Total		**4,283**	**5,015**	**732**	**117.1%**	**37,254**	**40,438**	**3,184**	**108.5%**
Cancer & Blood Services	Cancer & Blood Services	5,076	5,940	863	117.0%	47,592	47,214	(378)	99.2%
	Genetics	212	236	25	111.7%	2,085	1,898	(187)	91.0%
Cancer & Blood Services Total		**5,288**	**6,176**	**888**	**116.8%**	**49,678**	**49,112**	**(565)**	**98.9%**
Cardiovascular Services		**1,205**	**1,276**	**71**	**105.9%**	**9,721**	**9,838**	**117**	**101.2%**
Children's Health	Child Health & Disability	923	949	26	102.8%	6,741	6,694	(47)	99.3%
	Medical & Community	1,882	1,888	6	100.3%	15,608	15,735	128	100.8%
	Paediatric Cardiac & ICU	1,200	1,158	(42)	96.5%	9,020	8,789	(231)	97.4%
	Surgical & Community	491	675	184	137.4%	4,556	4,934	378	108.3%
Children's Health Total		**4,497**	**4,670**	**173**	**103.9%**	**35,924**	**36,152**	**228**	**100.6%**
Clinical Support Services		**2,869**	**3,300**	**431**	**115.0%**	**24,271**	**25,494**	**1,223**	**105.0%**
DHB Funds		**6,568**	**6,505**	**(63)**	**99.0%**	**45,979**	**45,537**	**(442)**	**99.0%**
Perioperative Services		**9**	**6**	**(3)**	**69.6%**	**81**	**81**	**1**	**101.1%**
Public Health Services		**130**	**130**	**0**	**100.0%**	**907**	**907**	**0**	**100.0%**
Support Services		**101**	**101**	**0**	**100.0%**	**709**	**709**	**0**	**100.0%**
Women's Health Total		**1,562**	**1,950**	**388**	**124.8%**	**14,191**	**16,144**	**1,952**	**113.8%**
Grand Total		**35,376**	**39,679**	**4,303**	**112.2%**	**296,018**	**303,177**	**7,159**	**102.4%**

Non Diagnostic Related Group (DRG) activity improved against the seasonally phased contract in January 2019, notwithstanding the strikes, and is now 2% over contract. Cancer Services activity has increased over the past three months and the wash up risk is now minimal assuming the demand pressure continues.

Patient Experience at Auckland DHB

Recommendation

That the Hospital Advisory Committee receives the Patient Experience at Auckland DHB report for March 2019.

Prepared by: Suzanne Corcoran (Director of Participation and Experience) and Sarah Devine (Manager Patient Experience)
Endorsed by: Margaret Dotchin (Chief Nursing Officer) and Meg Poutasi (Chief of Strategy, Participation and Improvement)

1. Executive Summary

Communication and Information is one of the key dimensions driving an overall health care experience. These reports focus on our overall performance for this domain of care for both inpatient and outpatients for the period ending December 2018. We know that this dimension matters most to patients and is a key enabler to patients making effective decisions about their own health and wellbeing including care and treatment. This care domain is a critical element of health literacy in that it aims to ensure patients and whānau access information that they can understand to assist them make informed decisions and direct their own health care.

While we migrate data from our current online feedback survey platform to our new provider, we are unable to develop directorate level reports. The transition of existing data is underway but for a brief period data will be collected in two systems as the surveys are open concurrently in both. This should be finalised in early March 2019 with the new dashboards scheduled for launch in late March to early April 2019 with the embedding of the new online platform. The Participation and Experience Team (PET) continues to ensure clinical service directorates have access to their patient experience data from the online surveys through the existing online portal. Specific results for clinical directorates can also be requested from PET during this transition phase. In addition, the overall patient experience directorate ratings are included in the HAC dashboards.

Alongside the transition to our new provider, we have two closely linked pieces of work underway. These are to redesign our survey questions and to ensure we are hearing from all populations, in particular Māori and Pacific patients and whānau. Reports have also been prepared to inform key staff and the Patient and Whānau Centred Care Council of a range of other feedback options such as story-telling and narrative that may enable more Māori and Pacific patients to provide feedback.

Our patients provide a clear picture of the impact of effective communication combined with good information through these reports. Given its consistent rating as key domain of a patient experience, the challenge for us is to ensure we use this data to inform planning, design, implementation and evaluation to support and demonstrate sustained improvements in how we communicate and inform patients and whānau over time. Work continues on the development of an integrated feedback framework underpinning performance improvement and planning with the aim of observing real improvements in this important domain in the short and long term.

Auckland District Health Board

INPATIENT EXPERIENCE SURVEY

2019: Report No. 1

AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

IN FOCUS

This month's report looks at Communication and Information.

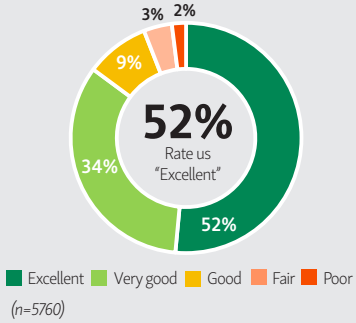
This report focuses on our performance on Communication and Information in 2018. While we continue to rate generally well in these areas we have not made improvements over the previous year. We know that these dimensions matter to patients, are important drivers of overall experience and are key components of enabling patients to make effective decisions for their own health and wellbeing.

Our patients give us a clear picture of the impact of effective communication combined with relevant and appropriate information; these are areas that all directorates can address.

OVERALL RESULTS

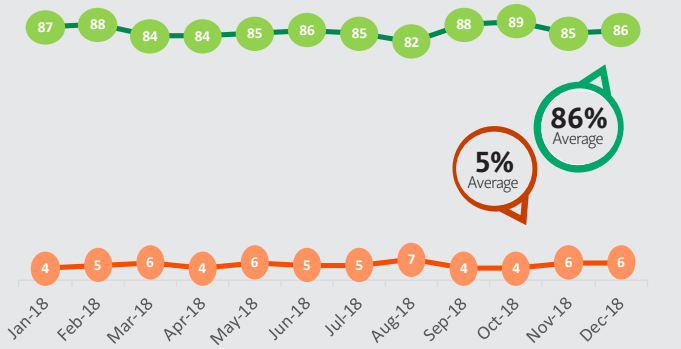
We aim to have 90% of patients rating their overall care as either "very good" or "excellent."

HOW DO WE RATE? (JAN 2018- DEC 2018)



(n=5760)

OVERALL CARE RATINGS JAN 2018- DEC 2018



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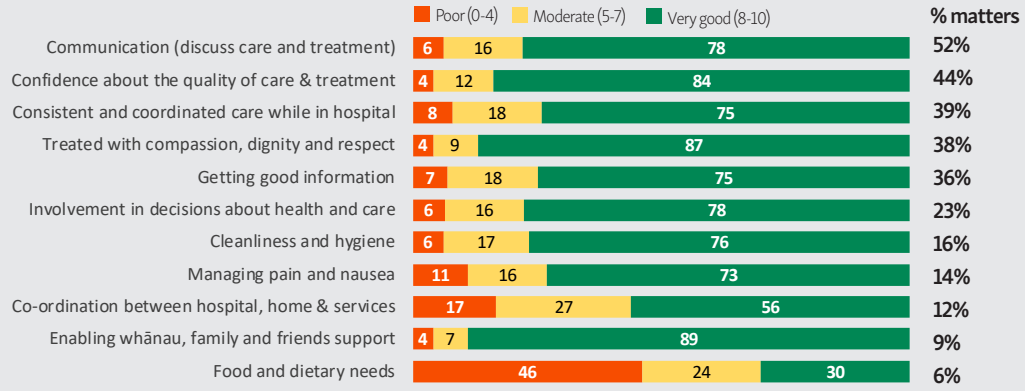
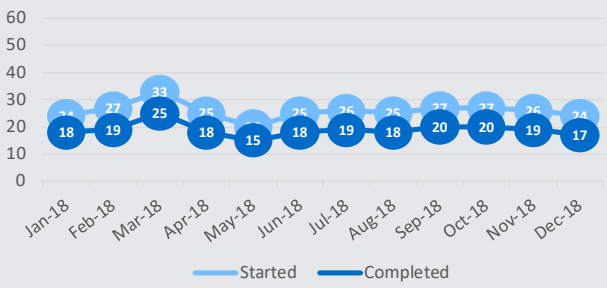
DIMENSIONS

The dimensions of care are ordered according to what matters most to our inpatients.



RESPONSE RATE

The response rate for the Inpatient Experience Survey averaged 25% in 2018.



CHANGES TO THE ONLINE PORTAL

We are making changes to our online portal for reviewing survey results and will be launching our new look portal in late March.

If you already have access we will be in touch with a new link; to get access to our new portal contact:

Sarah Devine
SarahD@adhb.govt.nz

REPORT KEYS

Each graph in the report is colour coded. **Green** indicates where we are doing well, and **gold** and **orange** indicate where there is room for improvement.

YEAR ON YEAR DIFFERENCES

All information in this report is from the 2018 calendar year (01 January 2018- 31 December 2018). The data has been compared with data from the same period in 2017 (01 January 2017- 31 December 2017). Any statistically significant differences (<p.05) are noted.

FEEDBACK

If you have any questions about or feedback on patient experience, please contact:

Sarah Devine
SarahD@adhb.govt.nz
or
Jing Yin
jingy@adhb.govt.nz

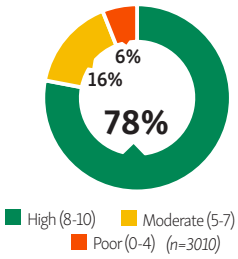
COMMUNICATION

01 January 2018- 31 December 2018

COMMUNICATION MATTERS

52% of inpatients tell us that communication is one of the three things that matter most to their care and treatment.

COMMUNICATION RATINGS



"The [staff] explained everything and were fast with treatment. They were all very very approachable and always willing to help and ask if we needed things. They explained everything in simple terms and our questions were answered without us feeling stupid."

RATED OVERALL CARE EXCELLENT

"The Dr spoke clearly and drew diagrams and answered all my questions."

RATED OVERALL CARE EXCELLENT

"The results of my treatment were explained to me straight after surgery, therefore, I was left unsure about what happened ... an effort should have been made to ensure I understood what had happened or that one of my family members were informed..."

RATED OVERALL CARE FAIR

AVERAGE RATING OVER LAST FOUR QUARTERS

Inpatients who say communcation matters most rate our communication highly. In 2018 the average rating was 8.3 out of 10.

(n=3010)

ASKING IMPORTANT QUESTIONS

We asked our inpatients if they got answers they could understand from Doctors, Nurses and Administration staff when they had important questions to ask.

Almost eight out of 10 respondents said that doctors and nurses **always** gave them answers they could understand.

One in 5, or 20 percent of patients said that doctors, nurses and admin staff **sometimes** gave them answers they could understand.

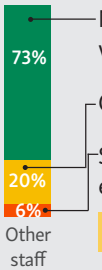
Nearly one in 10 inpatients said administration staff **never** gave clear answers.

There has been no significant change on any of these measures when compared with the same period in 2017.

Doctors n=5629; Nurses n=4684; Admin staff n=3427.

EXPLAINING CONDITION AND TREATMENT

We asked inpatients if other members of their healthcare team, such as physiotherapists, radiographers, dietitians, or occupational therapists, talked to them about their condition and treatment in ways that made it easy for them to understand.



Nearly three-quarters of inpatients (73%) said allied health workers **always** talked to them in ways they could understand.

One in five inpatients (20%) said this happened **sometimes**.

Six percent of inpatients said that allied health workers **did not** explain things in ways they could understand.

There has been no change on this measure when compared with the same period in 2017.

n=3698

PATIENTS ASK THAT STAFF...

Listen actively without interruption. Patients understand that staff are busy, and ask that we ensure any time spent with them is therefore focussed and free from distraction.

Explain things clearly, using everyday language. Patients appreciate it when staff are able to tailor their communication towards the level of understanding the patient has about their condition.

Do their best to ensure that communication occurs between staff and teams, so that patients are given consistent information and do not have to continually repeat themselves.

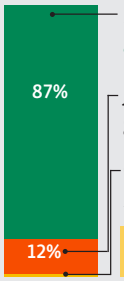
Communicate respectfully with them, and each other. Patients tell us that staff who complain about or blame each other make them uncomfortable and undermine their confidence.

INFORMATION

01 January 2018- 31 December 2018

AMOUNT OF INFORMATION

We asked our inpatients how much information was given to them about their condition and treatment.



Most inpatients (87%) said they got **the right amount.**

Just over one in ten (12%) said they weren't given **enough** information.

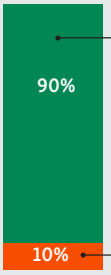
Only 1% of patients (40 out of 5763 inpatients) said they were given **too much** information.

There has been no change on this measure when compared with the same period in 2017.

n=5763

AMOUNT OF INFORMATION (ED)

We asked our inpatients who were admitted through the emergency department how much information they were given about their condition and treatment.



Nine out of 10 (90%) patients said they got the right amount of information whilst in ED.

Ten percent (10%) said they weren't given enough information whilst in ED.

There has been no change on this measure when compared with the same period in 2017.

n=608

PATIENTS ASK THAT STAFF...

Use diagrams or pictures as a discussion aid, particularly if patients appear to have trouble hearing or experience language difficulties.

Check for understanding, particularly if information is given at a time when the patient may not comprehend what they are told (i.e. soon after surgery).

Keep them informed as to what is happening next with their care and treatment, including time frames. Patients particularly appreciate being told about delays in a timely manner.

Give clear information about their diagnosis and treatment, including expected recovery time and any do's and dont's during the recovery period.

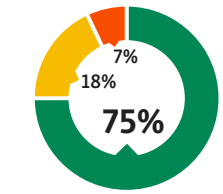
Ensure they leave with good discharge information which includes danger signals to watch out for and a person to contact if they have any concerns.

Provide all the information they need for their prescribed medications, including timing, side effects and where to get their prescription filled.

INFORMATION MATTERS

36% of inpatients tell us that getting good information is one of the three things that matter most to their care and treatment.

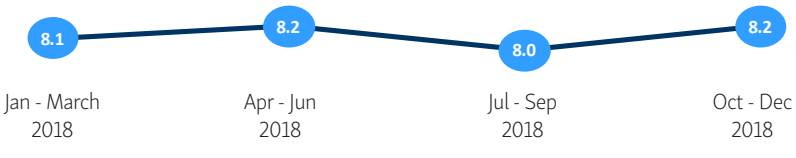
INFORMATION RATINGS



High (8-10) Moderate (5-7) Poor (0-4) *(n=3010)*

AVERAGE RATING OVER LAST FOUR QUARTERS

Inpatients who say getting good information matters most rated our performance an average of 8.2 out of 10 in 2018.



(n=2064)

"Excellent informative pamphlets with information, diagrams of affected body parts and follow up discussions with head nurses and surgeons as to operation procedures that would be necessary in my particular case."

RATED OVERALL CARE EXCELLENT

"Although nursing staff were under pressure, they were all caring and respectful. Often checking on how I was coping, although there were delays waiting for doctors to come, they kept me informed so that I didn't think they had forgotten me." (E.D. patient)

RATED OVERALL CARE EXCELLENT

"Would of liked more info on the condition itself and aftercare process, especially any side effects with surgery, medicine etc...."

RATED OVERALL CARE POOR

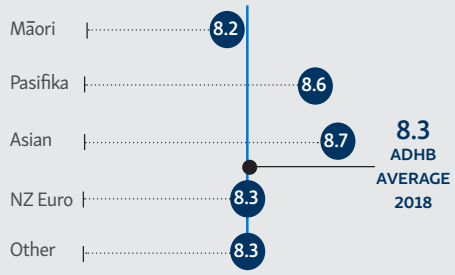
THE EXPERIENCE OF DIFFERENT POPULATIONS

01 January 2018- 31 December 2018

Communication

ETHNICITY

AVERAGE SCORE



"Follow ups & morning consultations provided opportunities for Q&A where ALL medical staff were patient and forthcoming with information, explanations & daily updates. Found everyone very approachable & sincere in their communication which made us feel valued & cared for."

(MĀORI) RATED OVERALL CARE EXCELLENT

"Sometimes felt there was no coordination between departments. Doctor would say one thing and nurse would say something else. Always felt I was repeating myself."

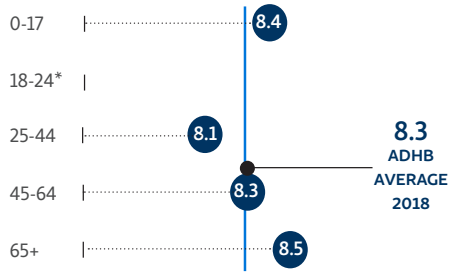
(PASIFIKA) RATED OVERALL CARE GOOD

"They talked clearly and slowly that made me understand."

(ASIAN) RATED OVERALL CARE EXCELLENT

AGE

AVERAGE SCORE



"Absolutely outstanding communication, I was listened to, very clearly communicated the plan for what would happen from the onset."

(45-64) RATED OVERALL CARE EXCELLENT

"Nurses were a-ma-zing... so caring and present to my son and his needs."

(0-17) RATED OVERALL CARE EXCELLENT

"Doctors explained well to patient and family. They also listened!"

(65+) RATED OVERALL CARE VERY GOOD

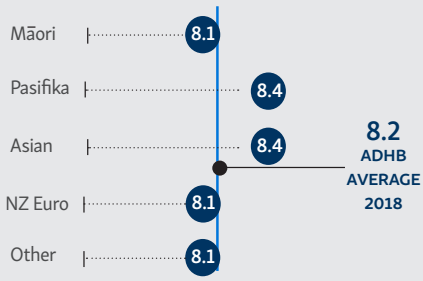
"I felt like I never knew who was my midwife on duty, didn't ever see anyone unless I asked for help, didn't know how the place works or what I should be doing or how long I would be staying."

(18-24) RATED OVERALL CARE GOOD

Information

ETHNICITY

AVERAGE SCORE



"All the medications prescribed were explained to me as to what they were, why they were needed and what they were doing for me."

(PASIFIKA) RATED OVERALL CARE EXCELLENT

"Medical staff explained everything clearly and in a very understandable way.."

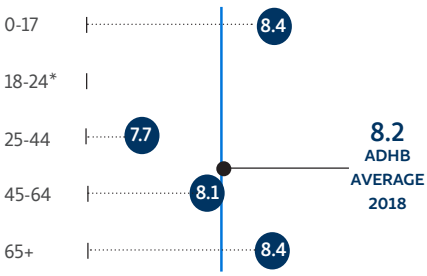
(ASIAN) RATED OVERALL CARE EXCELLENT

"I didn't get told what was wrong with me, or what was going to happen with regards to discharge. When I was waiting for treatment, I had no idea how long I would be waiting, and while there was a perfunctory "tell us if you get worse" I didn't know what worse was, or how much worse I had to get before it would be worth trying to communicate."

(MĀORI) RATED OVERALL CARE GOOD

AGE

AVERAGE SCORE



"Each person I saw told me what they were doing. Answered any questions I had. The printed info helped too so I could read about the operation at home."

(65+) RATED OVERALL CARE EXCELLENT

"Information about my condition helped me make the right decision at the time with the help of staff."

(25-44) RATED OVERALL CARE VERY GOOD

"It was explained in detail with a management plan to go with it."

(25-44) RATED OVERALL CARE EXCELLENT

"We were discharged without being given the appropriate advice on how to manage my son's issues ... and so consequently ended up back in A&E the following night."

(0-17) RATED OVERALL CARE VERY GOOD

IN FOCUS

This month's report looks at Communication and Information.

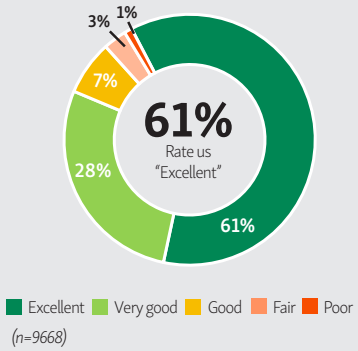
We have chosen to look at Communication and Information because they are important dimensions to patients, drive overall experience and importantly link together to support health literacy; that is *"being able to obtain, understand and use basic health information to navigate health services and make appropriate health decisions. It is the responsibility of the health care professional to present health information in a way that a person can understand."* (HQSC)

Our performance on these dimensions in 2018, while generally good has not shown change over our 2017 results. These are important areas for services to focus on as areas for improvement and building blocks for health literacy.

OVERALL RESULTS

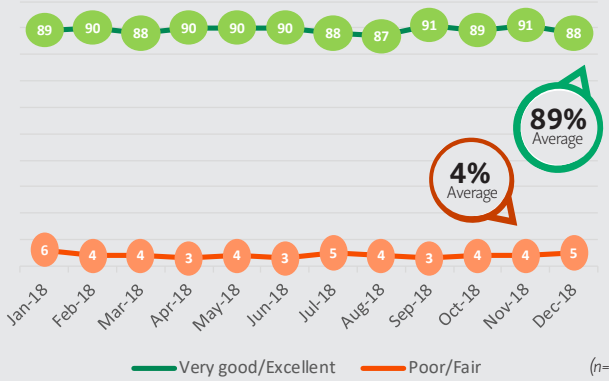
We aim to have 90% of patients rating their overall care as either "very good" or "excellent."

HOW DO WE RATE? (JAN 2018- DEC 2018)



(n=9668)

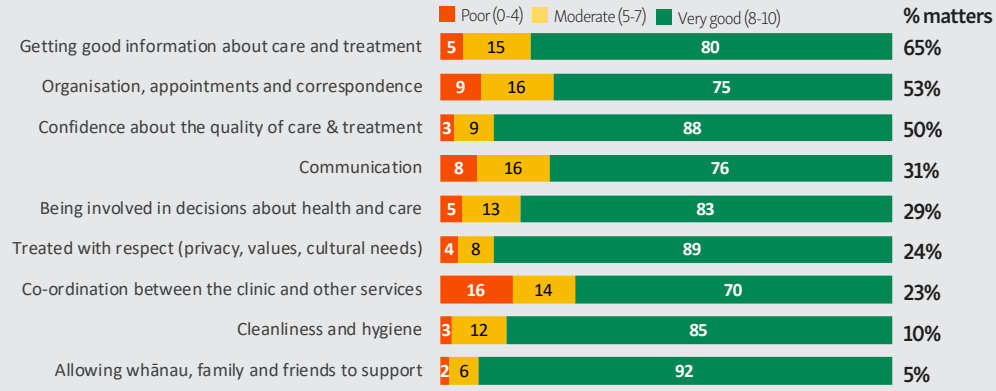
OVERALL CARE RATINGS JAN 2018- DEC 2018



(n=9668)

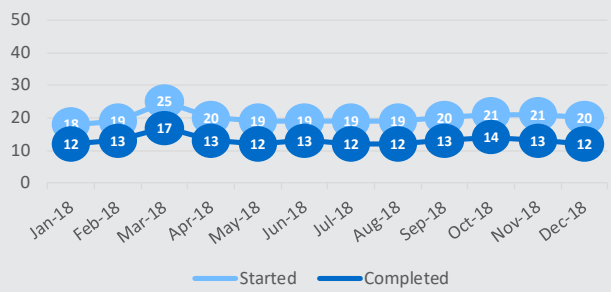
DIMENSIONS

The dimensions of care are ordered according to what matters most to our outpatients.



RESPONSE RATE

The response rate for the Outpatient Experience Survey averaged 20% in 2018.



CHANGES TO THE ONLINE PORTAL

We are making changes to our online portal for reviewing survey results and will be launching our new look portal in late March.

If you already have access we will be in touch with a new link; to get access to our new portal contact:

Sarah Devine
SarahD@adhb.govt.nz

REPORT KEYS

Each graph in the report is colour coded. **Green** indicates where we are doing well, and **gold** and **orange** indicate where there is room for improvement.

YEAR ON YEAR DIFFERENCES

All information in this report is from the 2018 calendar year (01 January 2018- 31 December 2018). The data has been compared with data from the same period in 2017 (01 January 2017- 31 December 2017). Any statistically significant differences (<p.05) are noted.

FEEDBACK

If you have any questions about or feedback on patient experience, please contact:

Sarah Devine
SarahD@adhb.govt.nz
or
Jing Yin
jingy@adhb.govt.nz

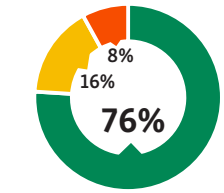
COMMUNICATION

01 January 2018- 31 December 2018

COMMUNICATION MATTERS

31% of outpatients tell us that communication is one of the three things that matter most to their care and treatment.

COMMUNICATION RATINGS



High (8-10) Moderate (5-7) Poor (0-4) *(n=2955)*

> *"The Doctor had excellent partnership skills. Firstly introducing himself, then explaining what the appointment was about, then the assessment findings and then possible diagnosis and explained tests to be done and possible treatment. I felt listened to and taken seriously. I appreciated his excellent communication skills.."*
>
> RATED OVERALL CARE EXCELLENT

> *"Excellent communication and when further clarification was required a more senior member was asked for their opinion. Fabulous open team work and learning..."*
>
> RATED OVERALL CARE VERY GOOD

> *"I was told three different things of how I was to be treated by three different people over the course of an hour."*
>
> RATED OVERALL CARE FAIR

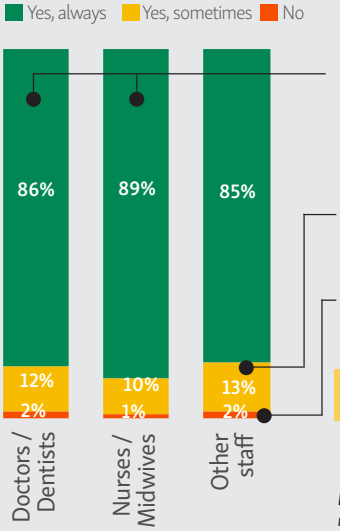
AVERAGE RATING OVER LAST FOUR QUARTERS

Outpatients ratings for communication are static, and have remained at an average of 8.2 / 10 in the 24 months since January 2017.

(n=2955)

LISTENED TO

We asked outpatients if they felt staff listened to what they had to say.



Most outpatients said that doctors / dentists (86%) , nurses / midwives (89%) and allied health (85%) **always** listened to what they had to say.

Around one in 10 outpatients said staff **sometimes** listened.

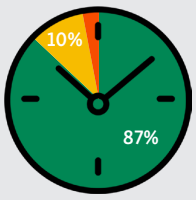
Very few outpatients said they did not feel staff listened to what they had to say.

There has been no significant change on any of these measures when compared with the same period in 2017.

Doctors/Dentists n=7089; Nurses/Midwives n=2315; Allied health n=2020.

ENOUGH TIME

We asked outpatients if they had enough time to discuss their health and treatment with clinic staff.



Most outpatients (87%) said they **definitely** had enough time with clinic staff.

One in ten outpatients (10%) said they had enough time, but could have done with a little more.

Three percent of outpatients said that they **did not** have enough time with clinic staff.

There has been no change on this measure when compared with the same period in 2017.

n=9726

PATIENTS ASK THAT STAFF...

Balance talking with active listening; a minority of outpatients tell us they do not feel heard, or feel as though clinic staff are disinterested or dismissive of what they have to say.

Ensure that, when multiple teams are involved, communication occurs across teams so important information is not missed and can be acted on if necessary.

Clearly communicate to the patient about next steps, what is expected of them, what they should or should not do between appointments and who they can contact if they have any questions or concerns.

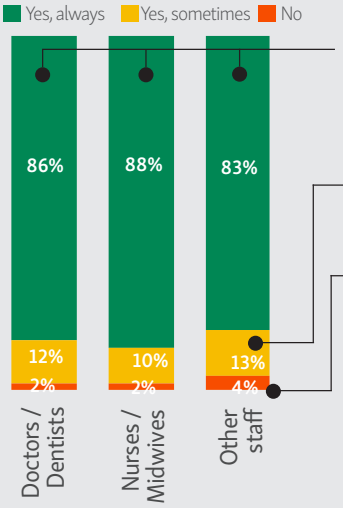
Communicate in ways that are respecful, warm, positive and direct. The majority of outpatients say this communication style is typical of most staff they come in contact with.

COMMUNICATION (cont...)

01 January 2018- 31 December 2018

UNDERSTOOD

We asked outpatients if staff talked to them about their condition and treatment in ways that made it easy for them to understand.



Most outpatients (83-88%) said that clinic staff **always** talked to them in ways they could understand.

Around one in 10 outpatients said staff **sometimes** did this.

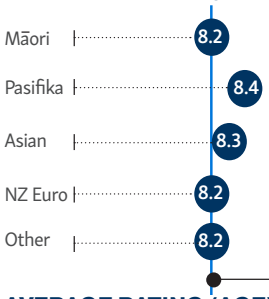
Very few outpatients (2-4%) said that staff did not talk to them in ways that were easy to understand.

There has been no significant change on any of these measures when compared with the same period in 2017.

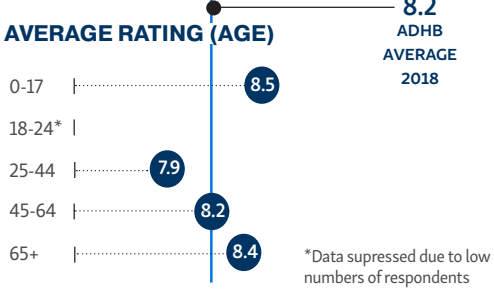
Doctors/Dentists n=6790; Nurses/Midwives n=2315; Allied Health n=1915.

COMMUNICATION BY PATIENT GROUPS

AVERAGE RATING (ETHNICITY)



AVERAGE RATING (AGE)



8.2 ADHB AVERAGE 2018

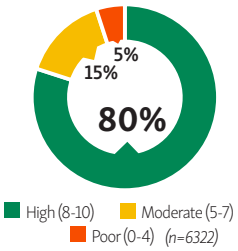
*Data supressed due to low numbers of respondents

INFORMATION

INFORMATION MATTERS

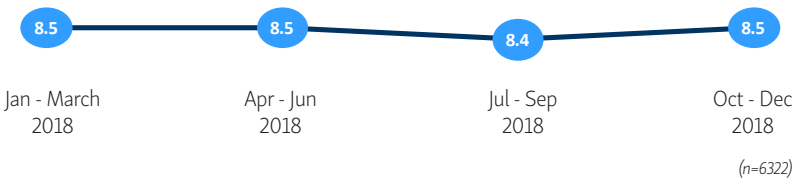
65% of ourpatients tell us that getting good information about their condition and treatment is one of the three things that matter most to them.

INFORMATION RATINGS



AVERAGE RATING OVER LAST FOUR QUARTERS

Outpatients who say getting good information matters most rate our performance an average of 8.5 out of 10.



(n=6322)

> *"My doctor always shares any new information with me. He also discusses all options open to me regarding my ongoing treatment. I feel fully informed of how best to address any issues and what to possibly expect and I know I can talk easily and openly to him."*
>
> RATED OVERALL CARE EXCELLENT

> *"In my case, I could have benefited from a pamphlet / website link or similar to explain any short term side effects to the treatment. There was information available online, but being pointed in the right direction would be good."*
>
> RATED OVERALL CARE VERY GOOD

> *"My doctor made me feel like I was totally wasting her time. I should have been more insistent but I felt my doctor was completely dismissive of my concerns."*
>
> RATED OVERALL CARE POOR

OUTPATIENTS ASK THAT STAFF...

- Ensure they have all the information they need about procedures and treatments, including specifics on where to go for more information.
- Allow time for them to absorb and digest the information they have been given and check for understanding before proceeding with the conversation.
- Share information, such as test results, as it comes to hand so they can make fully informed decisions about their day-to-day health.
- Keep them up to date about administrative information, such as wait times, appointments and anticipated treatment time-frames.

INFORMATION (cont...)

01 January 2018- 31 December 2018

AMOUNT OF INFORMATION

We asked outpatients how much information was given to them about their condition and treatment.

Most (89%) said they got **the right amount.**

One in ten (10%) said they weren't given **enough** information

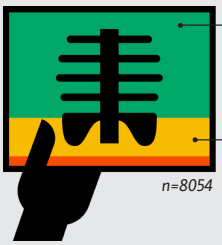
Less than 1% of patients (56 out of 9727 outpatients) said they were given **too much** information.

n=9727

There has been no change on this measure when compared with the same period in 2017.

TIMELINESS

We asked outpatients whether information, such as x-rays and test results, was shared in a timely manner.



n=8054

Seven in 10 (70%) said **it was.**

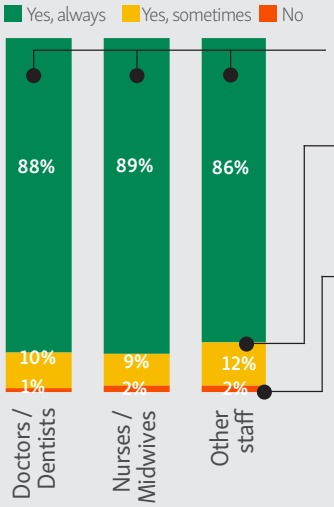
One-quarter (24%) said it was, to **some extent.**

Six percent said they **were not** given their results in a timely manner.

There has been no change on this measure when compared with the same period in 2017.

ANSWERING QUESTIONS

Did staff answer outpatients' questions in ways they could understand?



Most outpatients (88% average) said that clinic staff **always** did this.

Around one in 10 outpatients said staff **sometimes** answered their questions in ways they could understand.

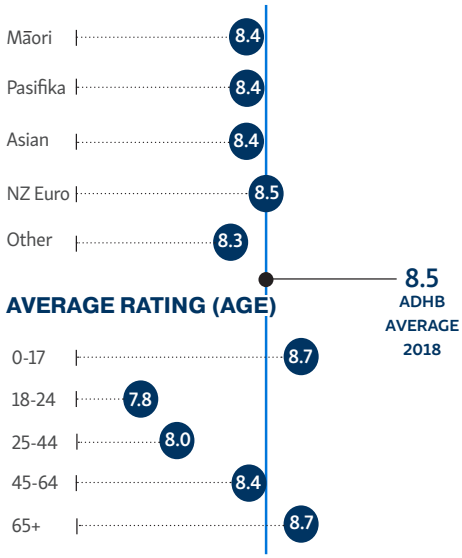
Very few outpatients (1-2%) said that staff **did not** answer their in ways that were easy to understand.

There has been no significant change on any of these measures when compared with the same period in 2017.

Doctors/Dentists n=7109; Nurses/Midwives n=2364; Allied Health n=2050.

INFORMATION BY PATIENT GROUPS

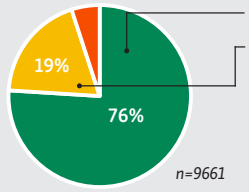
AVERAGE RATING (ETHNICITY)



AVERAGE RATING (AGE)

INFORMED CHOICES

We asked outpatients whether they had the information they needed to make informed choices.



n=9661

Three-quarters (76%) said they **did.**

One in five (19%) said they did, to **some extent.**

Five percent said they **did not** have the information they needed to make informed choices.

There has been no change on this measure when compared with the same period in 2017.

MEDICATION

We asked outpatients whether staff discussed their medication in ways they could understand.

Most outpatients (85%) said clinic staff **did** discuss their medication, including what it is for and how to take it.

n=6275

10% did, to **some extent,** 5% **did not.**

There has been no change on this measure when compared with the same period in 2017.

PLAN OF CARE

We asked outpatients whether staff discussed their plan of care in ways they could understand.

85% said they **did.**

12% said they did, **in part.**

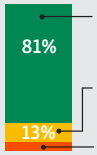
3% said they **did not.**

n=8717

There has been no change on this measure when compared with the same period in 2017.

WHAT TO DO

Did staff discuss what outpatients should and should not do in ways they could understand?



Eight out of 10 (81%) said they **did.**

13% said they did, **in part.**

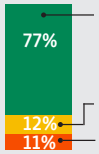
6% said they **did not.**

n=8063

There has been no change on this measure when compared with the same period in 2017.

WHO TO CONTACT

Did staff discuss what to look out for and who to contact in ways outpatients could understand?



Just over three-quarters of outpatients (77%) said they **did.**

12% said they did, **in part.**

11% said they **did not.**

n=7789

There has been no change on this measure when compared with the same period in 2017.

Resolution to exclude the public from the meeting

Recommendation

That in accordance with the provisions of Clauses 34 and 35, Schedule 4, 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. Apologies	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]
2. Register and Conflict of Interests	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 13 February 2019	**Confirmation of Minutes** As per the resolution(s) from the open section of the minutes of the above meeting, in terms of the New Zealand Public Health and Disability Act [NZPH&D Act 2000]	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 Update from Ministry Of Health Performance Champion for Emergency Departments	**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)] **Obligation of Confidence** Information which is subject to an	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]

	express obligation of confidence or which was supplied under compulsion is enclosed in this report [Official Information Act 1982 s9(2)(ba)]	
5.2 Capacity Update – Half Year Review	**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)] **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]s	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 Orthopaedic Services Oversight Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Prejudice to Health or Safety** Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time. **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]s	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 Perioperative Services – Shortage of Anaesthesia Technicians Oversight Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Prejudice to Health or Safety** Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time. **Negotiations** Information relating to commercial	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]

	and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]s	
6.3 Women's Health – Midwifery Recruitment and Retention Oversight 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. **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)] **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]s	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.4 Commercial Contract Management Food Services (FMEA) Oversight Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]s	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.5 Security for Safety Oversight Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Prejudice to Health or Safety** Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

6.6 Head and Neck Oversight Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Prejudice to Health or Safety** Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.1 Complaints	**Privacy of Persons** Information relating to natural person(s) either living or deceased is enclosed in this report [Official Information Act s9(2)(a)] **Obligation of Confidence** Information which is subject to an express obligation of confidence or which was supplied under compulsion is enclosed in this report [Official Information Act 1982 s9(2)(ba)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.2 Compliments	**Privacy of Persons** Information relating to natural person(s) either living or deceased is enclosed in this report [Official Information Act s9(2)(a)] **Obligation of Confidence** Information which is subject to an express obligation of confidence or which was supplied under compulsion is enclosed in this report [Official Information Act 1982 s9(2)(ba)]	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]
7.3 Incident Management	**Commercial Activities** Information contained in this report related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	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]
7.4 Policies and Procedures (controlled document management)	**Commercial Activities** Information contained in this report related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.1 Infection Prevention and	**Commercial Activities** Information contained in this report	That the public conduct of the whole or the relevant part of the meeting would

Control Report	related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Prejudice to Health or Safety** Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time [Official Information Act 1982 s9(2)(c)]	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]