Hospital Advisory – Provider Equity Committee Meeting

Wednesday, 23 June 2021

2:30pm

A + Trust
Auckland City Hospital
Grafton

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Published 21 June 2021

Agenda
Hospital Advisory – Provider Equity Committee
23 June 2021

Venue: A+ Trust **Time: 2:30pm**
Auckland City Hospital, Grafton

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

Agenda

Please note that agenda times are estimates only

2.30pm	**1.**	**Karakia**
		Attendance and Apologies
		Committee members:
		Executive staff: A Claire, D Holdsworth, K Bartholomew, M Wilsher
	2.	**Register and Conflicts of Interest**
2.35pm	**3.**	**Confirmation of 21 April Minutes 2021**
	4.	**Action Points 21 April 2021**
2:40pm	**5.**	**PERFORMANCE REPORTS**
	5.1	Provider Arm Operational Update (Michael Shepherd)
	5.2	Financial Update (Justine White)
	5.3	Director Equity Update – Cancer & Blood (Richard Sullivan)
	5.4	Director Equity Update – Patient Management Services (Alex Pimm)

	5.5	Director Equity Update – Perioperative Services (Nigel Robertson)
	5.6	Director Equity Update – Surgical Services (Duncan Bliss)
3.10pm	**6.**	**RESOLUTION TO EXCLUDE THE PUBLIC**

Next Meeting:	Wednesday, 18 August 2021 at 8.30am A+ Trust Room, Clinical Education Centre Level 5, Auckland City Hospital, Grafton

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

Karakia

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

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

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of life

To the ancient realms of the Creator

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

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

Well Being to All.

Attendance at Hospital Advisory Committee Meetings

Members	12 Feb 2020	18 March 2020	22 April 2020	3 June 2020	15 July 2020	26 August 2020	7 October 2020	18 Nov 2020	17 Feb 2021	21 April 2021	23 June 2021
William (Tama) Davis (Chair)	1	1	c	c	c	c	1	1	X	1	
Joanne Agnew (Deputy Chair)	1	1	c	c	c	c	1	1	1	1	
Michelle Atkinson	1	1	c	c	c	c	1	1	1	1	
Doug Armstrong	1	1	c	c	c	c	1	1	1	1	
Heather Came	NM	NM	NM	NM	NM	NM	1	1	1	1	
Bernie O'Donnell	1	1	c	c	c	c	x	x	1	1	
Michael Quirke	1	1	c	c	c	c	1	1	1	X	
Peter Davis	1	1	c	c	c	c	1	1	1	X	
Zoe Brownlie	1	1	c	c	c	c	1	1	1	1	
Fiona Lai	1	1	c	c	c	c	1	1	1	1	

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

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

Conflicts of Interest Quick Reference Guide

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

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

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

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

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

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

IMPORTANT

If in doubt – declare.

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

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

Register of Interests – Hospital Advisory Committee – Provider Equity

Member	Interest	Latest Disclosure
Jo AGNEW (Deputy Chair)	Professional Teaching Fellow – School of Nursing, Auckland University Casual Staff Nurse – Auckland District Health Board Director/Shareholder 99% of GJ Agnew & Assoc. LTD Trustee - Agnew Family Trust Shareholder – Karma Management NZ Ltd (non-Director, majority shareholder) Member – New Zealand Nurses Organisation [NZNO] Member – Tertiary Education Union [TEU]	30.07.2019
Michelle ATKINSON	Director – Stripey Limited Trustee - Starship Foundation Contracting in the sector Chargenet, Director & CEO – Partner	21.05.2020
Doug ARMSTRONG	Trustee – Woolf Fisher Trust *(both trusts are solely charitable and own shares in a large number of companies some health related. I have no beneficial or financial interest* Trustee- Sir Woolf Fisher Charitable Trust *(both trusts are solely charitable and own shares in a large number of companies some health related. I have no beneficial or financial interest* Member – Trans-Tasman Occupations Tribunal Daughter – *(daughter practices as a Barrister and may engage in health related work from time to time)* Meta – Moto Consulting Firm – (*friend and former colleague of the principal, Mr Richard Simpson)*	20.08.2020
Zoe BROWNLIE	Co-Director – AllHuman Board Member – Waitakere Health and Education Trust Partner – Team Leader, Community Action on Youth and Drugs Advisor – Wellbeing, Diversity and Inclusion at Massey University	26.05.2021
Peter DAVIS	Retirement portfolio – Fisher and Paykel Retirement portfolio – Ryman Healthcare Retirement portfolio – Arvida, Metlifecare, Oceania Healthcare, Summerset, Vital Healthcare Properties Chair – The Helen Clark Foundation	22.12.2020
Fiona LAI	Member – Pharmaceutical Society NZ Casual Pharmacist – Auckland DHB Member – PSA Union Puketapapa Local Board Member – Auckland Council Member – NZ Hospital Pharmacists' Association	26.08.2020
Bernie O'DONNELL	Chairman Manukau Urban Māori Authority(MUMA) Chairman UMA Broadcasting Limited Board Member National Urban Māori Authority (NUMA) Board Member Whānau Ora Commissioning Agency National Board-Urban Maori Representative – Te Matawai Board Member - Te Mātāwai. National Māori language Board Owner/Operator– Mokokoko Limited Senior Advisor to DCE – Oranga Tamariki Engagement Advisor – Ministerial Advisory Panel – Oranga Tamariki	05.03.2021
Michael QUIRKE	Chief Operating Officer – Mercy Radiology Group Convenor and Chairperson – Child Poverty Action Group Director of Strategic Partnerships for Healthcare Holdings Limited	27.05.2020
Teulia PERCIVAL	Director Board of Trustees – Pasifika Medical Association Group Employee Clinician – Counties Manukau Health DHB	01.10.2020

Member	Interest	Latest Disclosure
	Chairman, Board of Trustees – South Seas Healthcare Trust, Otara Board Member – Health Promotion Agency (te Hiringa Hauora) Senior Lecturer Researcher – University of Auckland Director Researcher – Moana Research	
Heather CAME	Primary Employer – Auckland University of Technology Contractor – Ako Aotearoa Acting Co-President – Public Health Association of New Zealand Fellow – Health Promotion Forum Co-Chair – STIR (Stop Institutional Racism) Member – Tamaki Tiriti Workers	01.10.2020
William (Tama) DAVIS (Chair)	Director/Owner – Ahikaroa Enterprises Ltd Whanau Director/Board of Directors – Whai Maia Ngati Whatua Orakei Director – Comprehensive Care Limited Board Director – Comprehensive Care PHO Board Board Member – Supporting Families Auckland Board Member – District Maori Leadership Board Iwi Affiliations – Ngati Whatua, Ngati Haua and Ngati Tuwharetoa Director - - Board of New Zealand Health Partnerships Elected Member – Ngati Whatua o Orakei Trust Board	31.05.2021
Krissi HOLTZ (Board Observer)	To be advised	
Shannon IOANE (Board Observer)	To be advised	

Minutes
Hospital Advisory Committee – Provider Equity Meeting
21 April 2021

Minutes of the Hospital Advisory Committee – Provider Equity meeting held via a Zoom meeting commencing at 9:00am

Committee Members Present	**Auckland DHB Executive Leadership Team Present**	
Tama Davis (Chair)	Ailsa Claire	Chief Executive Officer
Jo Agnew	Dr Mark Edwards	Chief Quality, Safety and Risk Officer
Bernie O'Donnell	Dr Michael Shepherd	Interim Director Provider Services
Doug Armstrong	Sue Waters	Chief Health Professions Officer
Fiona Lai	Justine White	Chief Financial Officer
Heather Came	Dr Margaret Wilsher	Chief Medical Officer
Michelle Atkinson	Margaret Dotchin	Chief Nursing Officer
Zoe Brownlie	**Auckland DHB Senior Staff Present**	
	Jo Brown	Funding and Development Manager, Hospitals
	Dr Barry Snow	Director, Adult Medical Directorate
	Jess Patten	General Manager, Adult Medical Directorate
	Joanne Bos	General Manager, Cardiovascular Services
	Ian Costello	Director, Clinical Support Services
	Sam Titchener	Director, Adult community and Long Term Conditions
	Vanessa Duthie	Māori Patient Whānau Experience Lead, ADHB
	Jane Drumm	Co-Chair Consumer Experiences Council
	Iani Nemani	Consumer Advisor, Consumer Experience Council
	Kay Sevillano	EA to Board Chair and Governance Admin
	(Other staff members who attend for a particular item are named at the start of the minute for that item)	

KARAKIA

The Karakia was led by Board member Bernie O'Donnell.

1. APOLOGIES

That the apologies of Peter Davis (Board member) and Michael Quirke (Board member) be received.

That the apologies of Executive Leadership Team members Mel Dooney, Chief People Officer, Dr Debbie Holdsworth, Director of Funding – Auckland and Waitematā DHBs, and Shayne Tong, Chief Digital Officer be received.

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

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

Heather Came

Heather Came, Board member advised that she regularly undertook contract and training work at a number of District Health Boards (DHBs)in regard to racism. Put in context this is part of her regular business. The Committee did not see that this raised a conflict of interest.

Heather asked that diagrams and graphs in reports should use a reasonable font size for ease of reading. Further, she asked that there be consistency in defining acronyms for the benefit of those who were not familiar with the meaning of these abbreviations.

Doug Armstrong, Board member requested that Māori words carry an English translation alongside. He understood that this country was bilingual however, felt that many people would be at a disadvantage when only the Maori is used with no English translation alongside. He doubted the public's ability to fully understand the content in our Open HAC reports.
Bernie O'Donnell, Board Member commented that Te Reo Māori is an official language of New Zealand and translation should no longer be required. Bernie added that most of the Māori words and phrases used in board reports have been used in previous reports for over a year now and board members should be familiar with them by this time.

Tama Davis, HAC Chair acknowledged the variable capability of the different Board members in terms of fluency in Te Reo Māori. Tama commented that continuous socialisation of the use of Te Reo Māori among Board members will help with learning the language so that translation in reports will eventually no longer be required in future.
In the mean time we will continue to include translation included to ensure engagement of Board members. Acronyms will also be defined clearly and consistently in future reports

Actions:

1) **The Hospital Advisory Committee will continue to socialise the use of Te Reo Māori to its members to support learning the language with English translation.**
2) **Report writers will ensure fonts are of a readable size when providing graphs and illustrations in reports.**
3) **Report writers are to provide clear definitions of acronyms consistently throughout their reports.**

3. CONFIRMATION OF MINUTES 17 February 2021 *(Pages 9-24)*

Resolution: Moved Jo Agnew / Seconded Zoe Brownlie

That the minutes of the Hospital Advisory Committee meeting held on 17 February 2021 be approved.

Carried

4. ACTION POINTS *(Page 25)*

Kaiārahi Nāhi rōpū and Pacific Care Navigation Service Evaluation

Dr Michael Shepherd, Interim Director Provider Services reported that the evaluation of the Pacific Care Navigation Service has been completed and the review will be presented at the next Hospital Advisory Committee meeting.

The results of the evaluation of the Kaiārahi Nāhi rōpū service will be available by the middle of June 2021. If the review is completed on time, it may also be presented at the next Hospital Advisory Committee meeting. Otherwise, the review will be circulated to the committee for review.

There were no other action points to consider.

5. PERFORMANCE REPORTS

5.1 Provider Arm Operational Exceptions Report (*Pages 26-28)*

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

He drew the Committees attention to an error on page 27, bullet 6 of the report. The sentence should read, “manage the relationship between Ngāti Whātua” instead of “manage the relationship between Ngāti Whātua Ōrākei”.

Dr Shepherd said that he would report on COVID and occupancy issues at the confidential Hospital Advisory Committee meeting but was prepared to answer any other questions the committee may have.

Bernie O’Donnell, Board member queried the origin of the concept of “Kaiārahi Nāhi”. Tama Davis, Hospital Advisory Committee Chair explained that it was gifted by Māori senior nurses along side Dame Naida Glavish, Chief Advisor Tikanga, Auckland and Waitematā DHBs.

Zoe Brownlie, Board member asked about the launch of the Women’s Health Engagement Plan and how it was received by those present at the event. Dr Shepherd replied that following on from the initial hui, there was some unfavourable feedback received around hosting the event via Zoom. Although we recognised that the modality of Zoom was suboptimal, it was important to start the engagement process. The event received mixed feedback from staff. Some were pleased to see the progress taking place, while others felt frustration about issues not being dealt with straight away. Dr Shepherd said it was important not to lose momentum despite the challenges of dealing with COVID and other pressures. He added that further discussion on Women’s Health would be provided at the confidential Hospital Advisory Committee meeting.

Jo Agnew, Hospital Advisory Committee Deputy Chair said that she was present at the initial Women’s Health Engagement hui. Jo said the event was emotive and signified what the Auckland DHB was setting out to achieve. She witnessed Māori and Pacific experiences

and wished that Asian and European experiences were also presented. Over the years as a board member, she had received feedback about the services provided by Women's Health, and feedback was at times suboptimal.

Zoe Brownlie, Board member asked whether all Auckland DHB employees would receive an invitation to get the COVID vaccine by the end of the week. Dr Shepherd explained that this was not the case because of challenges around data matching and the database available. Employees that have been data matched and entered into the database have been invited to get vaccinated. Approximately 85% of staff are now vaccinated, with about 90 to 95% having been invited. However, there still exists a cohort that has not been captured through data matching. Various forms of communication have been used to reach out to staff who have not received invitations. He explained that there are employees with multiple employment arrangements who are employed as shift workers, who are on leave, or who may have received their vaccination elsewhere, and all this will need to be verified. Overall, the uptake of the COVID vaccine from staff has been positive.

Zoe Brownlie asked if it was possible to find out whether each and every staff member had been invited to get vaccinated. Dr Shepherd explained the data available shows that not everyone has been invited and that it is unlikely that matching data will be available for a small group of employees. A walk-in service, which started this week, has been provided for employees who have not received an invitation. Cascades within the organisation have also been used to reach out to these employees. The second dose of the COVID vaccine will begin next week.

Fiona Lai, Board member asked whether the vaccination centre on level 4 of Auckland City Hospital would remain open to the public after all employees had received their second dose. Dr Shepherd advised that the area would be returned to Clinical training by the end of May and a smaller vaccination centre may be set-up for staff who are late in getting the vaccine and for new employees. A community vaccination site will not be set up in the hospital because of logistical and transport issues.

Resolution:

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

Carried

5.2 Financial Update *(Pages 29-38)*

In the absence of Justine White, Chief Financial Officer, Dr Shepherd asked that the report be taken as read. He advised that the report was presented at the last Board meeting and since then, no updates had been made.

There were no questions raised.

Resolution:

That the consolidated statement of financial performance for April 2021 be received.

Carried

5.3 Director Equity Update – Adult Medical *(Pages 39-50)*

Dr Barry Snow, Director – Adult Medical Services introduced Jess Patton, General Manager – Adult Medical Services to the committee. He then asked that the report be taken as read, advising as follows:

Adult Medicine, which includes the Emergency Department (ED), General Medicine, Intensive Care, Infectious Diseases, and Respiratory, are where possible and confirmed adult COVID cases are received. Adult Medical Services focused on COVID all of last year with support from the Incident Management Team (IMT). They successfully established within a short period of time, structures to control patient flow, and changed call rosters as required. No healthcare worker from these services were infected by COVID. Despite the low number or absence of cases of COVID in the community, patients with fever or respiratory illness are required to be treated as if they had COVID. The process was resource intensive and at times exhausting for the teams.

The new integrated stroke unit on level 5 opened and early outcome data is currently being reviewed. The length of stay of patients has dropped by approximately 4 days, which was the set target. Based on initial findings, integration appears to be working well.

The service is also prepared for the National Bowel Screening programme.

There has been a change in the Adult Medical Leadership team. Jess Patton and Anne-Marie Pickering joined the team this year.

In terms of developing Resilient Services, the Directorate are in the process of replacing 3 Senior Clinical Directors. Gillian Bishop and Robyn Toomath are retiring. Anil Nair has resigned and accepted the role of Chief Medical Officer at Tairawhiti . Jo Mack who has served as Operations Manager and Service Manager of the hospital for over 40 years is also retiring. Recruitment is ongoing to fill these positions.

The directorate is establishing its own priority plans based on the hospital's overall strategy, with particular focus on resilient services and equity.

Adult Medical services have returned to working to reach the 6- hour ED target which was not strictly adhered to last year due to COVID. However, the unexpected increase in patient numbers has resulted in the need to use 14 more general medical beds compared to 2019 and impacted on patient flow. A new acute flow group has been established to address acute patient flow in the face of increased patient numbers.

Equity and data are essential partners in measuring the actions being taken by the service to address inequity. Based on current data, the measured clinical outcomes for Māori and Pacific patients admitted to hospital are similar to that of patients admitted who are of different ethnicities. The directorate is concerned about current DNA rates and will present a plan at their next HAC presentation. Māori and Pacific patient experience are being actively measured and reviewed.

Jo Agnew asked whether DNA rates were the biggest issue the directorate was dealing with. Dr Snow replied that DNA rates are certainly a significant challenge that needs to be addressed.

Jo Agnew queried whether patients initially go to their outpatient appointment before coming to hospital. Dr Snow replied that for Adult Medical services a large part of acute work involves patients that come to hospital unexpectedly. The planned care elements of the service are those that send appointments for instance those booked at the Neurology clinic and the Renal clinic. The DNA rates of Māori and Pacific in these areas are around 20% compared to other ethnicities that sit under 10%.

Jo Agnew asked what the baseline is for DNAs and suggested perhaps a 10% baseline. Dr Snow responded the he would at least like to see an equitable baseline that is indistinguishable.

Heather Came, Board member commented that although it is good that the report mentions Te Tiriti O Waitangi, it should include the preamble. The 5 Articles of Te Tiriti o Waitangi should be included in future reports. Heather suggested that reports should also include a table mapping out progress to date in terms of work undertaken, achievements, and future plans. Work plans are currently being presented to the committee with no timeframes allocated to be able track progress. Heather added that this should apply to all directorates submitting reports to the committee.

Fiona Lai, Board member asked whether the plan for reaching the 6-hour target had started and when targets were expected to be met in anticipation of the winter season. Dr Snow explained that the target had started however it does not apply just to ED but to the entire hospital. The target requires an all of hospital response and for this reason a group has been formed to ensure that this is managed.

Resourcing is another significant challenge due to the unexpected rise in patient numbers coming into hospital. It is estimated that the hospital will require an additional 70 beds by the middle of the year which will be a major issue in terms of financial and staffing resources. The situation will be exacerbated if the hospital is faced with a tough winter and if flu patients return to hospital.

Fiona Lai commented that smart strategic plans needed to be put in place to prepare for the shortage in beds and the likelihood of COVID, flu or other acute cases that the hospital may need to deal with. Dr Shepherd explained that as discussed at the last Board meeting, a risk-based approach in managing hospital occupancy will be established. The 6-hour target is an all of hospital measure and he believes it is unlikely that the 95% target will be met by next year. Risk is thus being managed across a number of areas, where work-ons for acute flow will be to minimise the impact of not being able to meet the 95% target. This includes looking after patient safety, patient experience and balancing financial and staffing resources in addition to other pressures.

Bernie O'Donnell, Board member acknowledged how the report aspired to be inclusive in meeting the needs of Māori. However, he wanted to know how Kāwanatanga, Tino

Rangatiratanga, Ōritetanga and Te Ritenga have come to be included in the report. He said there appears to be a disconnect with the Auckland DHB trying to be culturally appropriate (in terms of language and culture) without understanding the journey and pathway of Māori. Bernie's korero is that the narrative suggests that inequity has been addressed when that is not the case. There is a need to truly understand the principles of the Treaty.

Ailsa Claire, Chief Executive ADHB clarified that about 2 years ago a decision was made that as an organisation, Auckland DHB would make a significant contribution to inequity. The organisation started using language to address institutional racism in the system. Ailsa acknowledged that people's experiences were important and the organisation has taken steps to address inequity and has taken action as best as it could to begin to have the required conversation and raise awareness.

Bernie O'Donnell commented that his view was different in term of where the responsibility lies around managing resources and ensuring wellbeing for the district. Everything should resonate from the organisation. The majority of resources go to DHBs and for this reason, the organisation should be conscious about how it is developing its own eco system of wellness. Ailsa explained that while the reports where focused on providers, the organisation continues to take steps to make change in other parts of the eco system as well.

Heather Came, Board member commented that the report needs to clarify what Ōritetanga and Tino Rangatiratanga mean. Changes need to be made in the way reports are written.

Tama Davis, Hospital Advisory Committee Chair thanked Dr Snow for his report and acknowledged everyone who provided commentary. He explained that everyone is on a journey to understand Te Reo Māori, Māori concepts, and its delivery within the hospital administration and within the service that Auckland DHB delivers. He asked that future reports submitted to the committee include where relevant frameworks with intention, process and timelines.

Bernie O'Donnell added that quality reporting inspires quality conversations and thanked Dr Snow for the report which gave him the opportunity to express his views.

Dr Snow commented that he welcomed the conversation and acknowledged that the process is new to his team and they have approached it with some awkwardness and uncertainty but also with great consciousness that at some level, it may not be appropriate for Māori, and that they should not be deciding systems for Māori. He recognised the need for more assistance, governance and guidance but equally he came to present the work they have done with pride, and looked forward to guidance for further improvement.

Dr Shepherd responded to Heather Came's previous comment on measuring performance and success. He explained that they are in the process of establishing directorate and provider level business plans for 2021/22 which will be included in future reports. These were not completed last year due to COVID.

Doug Armstrong, Board member queried the number of people unable to get flu vaccinations and the delays in administering these which he considered could result in more work for the hospital. Ailsa Claire explained that this is an issue being balanced across the region. COVID vaccination is currently being rolled out to vulnerable groups across the region and people within these groups are the same as those on the flu vaccination list. They are being reviewed on a practice-by-practice basis in terms of where they sit on the schedule to determine when they receive their vaccine.

Action:

That future reports submitted to the Hospital Advisory Committee will include a framework with intention that includes process and completion time.

Resolution:

That the Director Equity Update – Adult Medical report for April 2021 be received.

Carried

5.4 Director Equity Update – Cardiovascular *(Pages 51-59)*

Joanne Bos, General Manager – Cardiovascular (on behalf of Mark O'Carroll, Director – Cardiovascular) asked that the report be taken as read and advising as follows:

The directorate's quarterly hui for Māori staff has received positive feedback. Improvements are being made to the recruitment process for Māori in terms of attracting staff to apply for roles within the service.

The directorate was impacted by COVID and there has been a significant post-COVID service demand over the last 6 months which has affected ESPI compliance and waitlists. DNAs are a major issue where Māori and Pacific make up 20-25% of patients, with around 8% from other ethnicities.

The Heart Failure team has successfully rolled out a project to address multi-factorial issues which include poor communication from the hospital (e.g. patients not understanding appointment details), patients not being able to take time off work and not being able to afford transport costs. The service increased staffing resources to better engage with patients which has brought the DNA rate down to 11%. This exercise has proven that with appropriate communication the hospital can assist people to make their appointments that have previously been difficult for them to come to.

The equity adjuster has been applied to Planned Care which has brought down the number of Māori and Pacific patients on waiting lists, bringing numbers closer to that of other ethnicities. There is no evidence that clinical outcomes for Māori and Pacific patients treated at hospital are different from that of other ethnicities. However, it is difficult to get people to come to hospital.

In terms of Resilient services, Vascular has been identified as a vulnerable service across the region due to its size. The service is reliant on a team of 6, 3 of whom are due to retire

in 2 years. Similarly, Middlemore Hospital also has a small Vascular service A regional service will be created for Vascular and Andrew Hill, Clinical Director – Vascular is leading the project. This is anticipated to result in a single service, multi-site model with Auckland providing the most complex services and other localities providing other services.

Heather Came, Board member acknowledged the recruitment of Māori staff and asked about a retention strategy. Joanne Bos explained that regular Hui now take place to find out what would entice Māori staff to stay and work within the organisation. this had resulted in a number of initiatives that the service has adopted. For instance, the karakia has been introduced at the start and close of meetings and education for senior managers in Tikanga Māori is ongoing.

Bernie O'Donnell, Board member queried the presence of Māori leadership in the directorate. Joanne Bos advised that Dawson Ward, Manager of Kāiarahi Nāhi was providing guidance to the service. However, they are open to receive advice from other Māori leadership if necessary. Tama Davis explained that Nigel Chee, Acting General Manager – Māori Health meets with Māori leadership across the directorates to discuss programmes they are involved with in the different areas. The leadership receive regular feedback from Dawson Ward, and Māori clinicians working in the 7 directorates.

Action: Tama Davis (Hospital Advisory Committee Chair), Ailsa Claire (Chief Executive Auckland DHB and Bernie O'Donnell (Hospital Advisory Committee member) to discuss Māori leadership involvement in the different directorates.

Resolution:

That the Director Equity Update – Cardiovascular for April 2021 be received.

Carried

5.5 Director Equity Update – Clinical Support *(Pages 60-69)*

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

The service has adopted a multi-layer approach to recruitment of Māori and Pacific staff including the Rangitahi programme where students are being encouraged to consider health career opportunities through Career First. Targeted visits to particular institutions (most recently Waitakere College) are another means to attract applicants. This was impacted by COVID for a time but the process carried on virtually.

The service is also working with tertiary institutions identifying and ring-fencing internships for Māori and Pacific students. Recruitment within the DHB workforce is also being looked into, particularly for entry-level roles where a pathway has been mapped to allow staff to move from unqualified to qualified roles and eventually towards leadership positions.

Talent mapping across the services is taking place to identify potential Māori and Pacific Leadership.

There are a number of issues around capacity and demand particularly in the Radiology, Diagnostics, Genetics and Anatomical Pathology services. These services are managing an increase in patient numbers by extending staff hours and outsourcing. However, outsourcing capacity is also limited because external providers are also busy.

The directorate is focused on staff capability in terms of Te Tiriti, which is an important part of the service's metrics. Te Reo is used in meetings and everyday conversations. Meetings now open and close with a karakia and the leadership teams and staff are encouraged to develop their own pepeha as part of normal practice.

Doug Armstrong, Board member asked about CAMRI magnets (page 63 of the report) and the arrangement that the Auckland DHB has in relation to its partnership with the University of Auckland.

Ian explained that Auckland DHB has a contract with CAMRI (University of Auckland) for a fixed number of sessions. Auckland DHB has capability to increase sessions under the contract which has been utilised to support the demand from Cardiology. However, the sessions were not able to be efficiently utilised so the directorate is working with Cardiology on alternative options.

Jo Brown, Funding and Development Manager – Hospitals, explained further that Auckland DHB had been allocated additional funding to address MRI waiting times and the level of funding received is for as much volume as needed to correct waiting times. The revenue received covers the cost of the arrangements to get the additional MRIs done by a number of providers.

Ian explained further that there is regional work underway which has been funded by the Ministry of Health. The purpose is to look at capacity and demand and investment in new equipment on a regional basis across the four DHBs, and to identify where equipment is best placed to support both equity and demand.

Zoe Brownlie, Board member asked about eliminating inequity particularly around recruitment and whether retention was a focus to ensure Māori and Pacific staff feel a sense of belonging and safety. Ian explained that regular huis for Māori staff have been put in place to support Māori and to encourage them to provide feedback on what the service can do better to support retention.

Bernie O'Donnell, Board member commented the recruitment pathway should support Māori from Kōhanga Reo (early childhood education) right up to tertiary studies. This is a long-term solution but there are ways of supporting Māori pathways now. Bernie suggested making connections with the 3 main Wānanga (institutions of higher education equivalent to mainstream universities) in Tāmaki Makaurau, Te Whare Wānanga o Awanuiārangi, Te Wānanga o Raukawa and Te Wānanga o Aotearoa. It is significant to focus on Wānanga as they will bring the Māori world view to the organisation. Ian said that they are keen to have that conversation and to make this a part of their multi-layer recruitment and retention programme.

Jo Agnew, Hospital Advisory Committee Deputy Chair asked about Māori leadership in the directorate. Ian explained that it is currently very limited. The service has a small number

of Māori staff who are in middle level leadership positions in Pharmacy and in the Laboratory. They have identified a number of junior staff with leadership potential and the service is looking to support them by providing management development courses and other proactive approaches to help them into leadership positions.

Action: Tama Davis and Bernie O'Donnell will provide Ian Costello contacts from the 3 major Wānanga in support of creating Māori pathways at Auckland DHB.

Resolution:

That the Director Equity Update – Clinical Support for April 2021 be received.

Carried

5.6 Director Equity Update – Adult Community and Long Term Conditions *(Pages 70-83)*

Sam Titchener, Director – Adult Community and Long Term Conditions asked that the report be taken as read, advising as follows:

The report has been contributed to by a range of staff within the directorate and is about their mahi, there has been fantastic feedback.

The directorate has engaged a coordinator to work with Māori patients in the community who suffer from diabetes. The coordinator engages with patients and helps them with self-determination of their care, working to actively eliminate inequity. Prior to this role starting, the service was failing to engage with 181 Māori and Pacific patients, resulting in 374 DNAs (patients have multiple appointments). The numbers have been reduced by 71%.

Fiona Lai, Board member asked how the directorate managed to engage with the patients that they had previously failed to engage. Sam explained that these were Māori and Pacific patients they failed to engage with in the past that they have since focused on reconnecting with. This will also allow them to review whether the new measures put in place are effective. The service adopted one holistic approach in dealing with patients. For instance, they arrange Podiatry appointments on the same day for patients who have come in for dialysis or are elsewhere having treatment.

The service is working closely with Surgery in terms of patients with high blood sugars. Virtual clinics with primary care providers have been established to ensure that when patients come for surgery they are feeling well, have been informed of what to expect and are prepared for the procedure, thus also resulting in less procedural cancellations because of high blood sugar.

The service is also working with the Rapid Community Access team, a multi-disciplinary team that provides acute care to patients and whānau in the acute phase. Working hours have now been extended and a single point of triage in the service has been established. The purpose is to be able to take referrals later in the day and also to be able to talk and engage with patients and families and where possible to prevent admission.

Zoe Brownlie, Board member asked whether the pilot programme with the recruitment team was within the service or a part of the wider organisation. Sam Titchener confirmed that it was an organisational recruitment initiative. Zoe asked about the support provided at pre-interview stage and asked whether there was a risk that the focus was to prepare applicants to interview in a pakeha way. Sam Titchener explained that this was not the objective, it was to make the recruitment process comfortable and ensure applicants feel supported and prepared, but it was noted that further work was needed to review the interview process organisationally.

Bernie O'Donnell, Board member acknowledged the report and story-telling as it made him feel like he knew the team and it provided insight of the patient journey. He acknowledged the importance of social determinants as it allows providers to successfully deliver the services they are meant to carry out. Stories help in developing the road map to improve services.

Resolution:

That the Director Equity Update – Clinical Support for April 2021 be received.

Carried

5.7 Patient and Whānau Voice Report *(Pages 84-87)*

Jane Drumm, Co-Chair – Consumer Experiences Council asked that the report be taken as read, advising as follows:

The proposed Te Tiriti framework has now been incorporated into the patient and whānau centric care work programme. It is hoped to successfully contribute to improving the patient journey in Te Toka Tumai by providing consumer insights that will have a significant impact on governance.

Vanessa Duthie, Māori Patient and Whānau Experience Lead said she was proud of how Te Tiriti has been incorporated into the framework of patient whānau centred care. The working group helped to iterate the framework which involved engagement with the organisational development team. She hoped it would serve as a practical tool for people to refer to and use in the organisation.

Iani Nemani, Consumer Advisor – Consumer Experiences Council shared his positive experience with Auckland DHB staff and highlighted the need for aroha and for everyone to continue to live the values of the organisation.

Bernie O'Donnell, Board member commented on the importance of insights. He said that telling stories in reports gives the patient and whānau a voice to share their experiences which in turn helps to better understand the patient journey.

Michelle Atkinson, Board member acknowledged the report and expressed support for aroha and said that Manaakitanga underpins both good and bad experiences.

Jane Drumm said that their work moved from a structured, compliant framework, to a model that had incorporated patient and whānau experience. She hoped that through the

communications plan, Champions group, Hospital Advisory Committee and the Consumer Experiences Council, the framework can be utilised throughout the organisation.

Jo Agnew, Hospital Advisory Committee Deputy Chair asked how patient voices are heard in the council. Jane advised that they are involved in various projects across the organisation (e.g. recent hui in ED) where they provide input on how to improve Māori experience in the hospital.

Resolution:

That the Patient and Whānau Voice – Te Tiriti o Waitangi based framework for April 2021 be received.

Carried

6. RESOLUTION TO EXCLUDE THE PUBLIC (*Pages 88-89)*

Resolution: Moved Jo Agnew / Seconded Michelle Atkinson

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

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

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

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

The meeting closed at 10.30 am.

Signed as a true and correct record of the Hospital Advisory Committee meeting held on Wednesday, 21 April 2021

Chair: _____ Date: _____

Tama Davis

Action Points from Previous Open Hospital Advisory Provider Equity Committee Meeting

As at Wednesday, 21 April 2021

Meeting and Item	Detail of Action	Designated to	Action by
21 April 2021 Item 2	**Register and Conflicts of Interest** 1) The Hospital Advisory Committee will continue to socialise the use of Te Reo Māori to its members to support learning the language with English translation. 2) Report writers will ensure fonts are of a readable size when providing graphs and illustrations in reports. 3) Report writers are to provide clear definitions of acronyms consistently throughout their reports.	M Shepherd	TBA
21 April 2021 Item 5.3	**Director Equity Update – Adult Medical** That future reports submitted to the Hospital Advisory Committee will include a framework with intention that includes process and completion time.	M Shepherd	TBA
21 April 2021 Item 5.4	**Director Equity Update – Cardiovascular** Tama Davis (Hospital Advisory Committee Chair), Ailsa Claire (Chief Executive Auckland DHB) and Bernie O'Donnell (Hospital Advisory Committee member) to discuss Māori leadership involvement in the different directorates.	T Davis	TBA
21 April 2021 Item 5.5	**Director Equity Update – Clinical Support** Tama Davis and Bernie O'Donnell will provide Ian Costello contacts from the 3 major Wānanga in support of creating Māori pathways at Auckland DHB.	T Davis	TBA

Provider Arm Operational Exceptions Report

Recommendation

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

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

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

1. Exceptions Report

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

- The 'Building cultural safety to achieve Pae Ora' online hub launched in May. This hub contains resources to build knowledge in Te Tiriti o Waitangi, the history of Aotearoa (New Zealand), Māori Health Equity, Institutional Racism, cultural safety and self-awareness. The online hub has engaged 97 employees over 3 weeks. Further opportunities to build learning in these areas are under development and will include guest speakers and journal clubs. This module is domain one, domain two will make available resources to support learning in Tikanga (Māori protocols or customs), Te Reo (the Māori language and its associated protocols) and worldview knowledge. A baseline survey is available for Directorates to use to measure shifts in confidence levels as a result of participating in learning opportunities. Supporting the Provider Directors to build leadership and capability in Te Tiriti o Waitangi began in May, with a view for similar development to take place within Directorate Leadership Teams.
- Directorate business planning for 2021/2022 is progressing, for completion by the end of June and execution from 1 July 2021. Engagement with Māori leaders and the Māori Health team continues to inform this process.
- Transplant volumes total 82 heart, lung and liver and 122 renal transplants, totalling 204 transplants or 101% of YTD plan .

Women's Health Engagement Plan

- The Women's Health engagement is progressing. Engagement with Te Rūnanga o Ngāti Whātua continues. An additional resource to support the engagement approach is currently being recruited to.
- Moana Research presented a summary report of a rapid stocktake of relevant literature and discussions with key Pacific stakeholders for the Women's Health Equity Engagement Plan. Moana Research will continue to develop the in-depth review.

- Engagement with self-employed midwives and Senior Medical Officers has commenced, with four hui (meetings) held so far. The Women's Health Leadership Team has also been dropping into meetings and co-ordinating with Charge Midwives to ensure staff have opportunities to contribute to the discussion. Approaches to engage with units outside of maternity within the Women's Health Directorate, Community Midwives, Resident Medical Officers, Primary Care Providers, Paediatricians and Anaesthesiologists are in development, with hui (meetings) planned across June and July 2021.
- Work to improve resourcing to support the service is underway, with initiatives being developed to improve the service while we work towards understanding what the way forward is.
- The Women's Health Leadership Team are dropping into hui (meetings) across the directorate to provide updates and opportunities for staff to provide feedback. To compliment this work, two new communications channels for Women's Health have been developed - Women's Health – Leaders Update and Women's Health Matters (a general update for whole Directorate).

Hospital occupancy

- All Te Toka Tumai (Auckland DHB) hospitals have observed an increase in occupancy during May 2021. For Te Papakāinga Atawhai o Tāmaki (Auckland City Hospital) adult health services, there was a 5.3 per cent increase in midnight occupancy during April and 3.6 per cent increase in May compared to 2019 (during 2020 the country was at alert levels 4, 3 and 2, and hospital occupancy was significantly lower than expected). Beds reserved for winter flex capacity were utilised to maintain safe patient care, and additional staff resource utilised.
- A temporary 14-bedded inpatient ward utilising vacant ward space was opened at the beginning of May to provide additional capacity. This ward is opened as required during the week to support patient flow and meet patient demand. When not required, the ward is closed and staff deployed to other areas.
- Planning for winter 2021 continues. Forecast demand based on current observed occupancy suggests that inpatient capacity will be under significant pressure during August 2021. Further action is underway to reduce this risk, including reviewing opportunities to reduce patient length of stay and reduce avoidable admissions and improve staffing.

COVID-19

- Te Toka Tumai (Auckland DHB) continues to manage the impacts of COVID-19 on our hospitals and provider services. A significantly reduced COVID-19 response team remains in place to coordinate activity and respond to any increased community transmission. The team continues to work closely with the Northern Region Health Coordination Centre and the other DHBs in the region to ensure regional consistency where appropriate.
- An appropriate screening tool is in use to identify patients presenting with higher index of suspicion or with COVID-19 symptoms, which support the appropriate clinical management of patients and use of personal protective equipment. Although the level of community transmission is very low, a number of patients continue to be identified with symptoms each day and are managed as such until test results and other clinical information is available. A small number of patients with COVID-19 are admitted to hospital from managed quarantine and

isolation facilities – well-embedded processes and clinical practice ensures that patients, staff and visitors are safe whilst we appropriately care for patients.

- The vaccination centre at Te Papakāinga Atawhai o Tāmaki (Auckland City Hospital) was highly successful. Over 88 per cent of employees (paid via our payroll) have been vaccinated with at least one dose, 84 per cent have had both doses.
- The on-site clinic (which has now closed) administered 23,676 doses of the vaccine to our staff, volunteers, contractors, students and partner employees.
- New employees and others that haven't yet taken-up the vaccination offer are able to be vaccinated in one of the many vaccination clinics in the city.
- Te Toka Tumai (Auckland DHB) provider continues to support the community roll-out of the vaccine, including providing leadership to the programme as well as vaccinators, other clinical staff and admin and 'back office' support.
- We are working with the Ministry of Health, unions and other DHBs regarding how unvaccinated workers are managed. In the meantime, we continue to encourage all staff to be vaccinated to protect themselves, their patients, their colleagues and whānau (family, including extended).

Supply Chain

- There are significant challenges for supply chains globally. The various national lockdowns caused by COVID-19 continue to slow or even temporarily stop the flow of raw materials and finished goods, disrupting manufacturing as a result. This has highlighted the need to build supply chain resilience capabilities within the Health Supply Chain. For now, some medical products are centrally managed by the Ministry and allocated to DHBs. This allocation model allows national visibility across the system while we are in disrupted mode. Other scarce products for the northern region are tracked through the HealthSource team and proactively managed. The disruption to clinical practice is continuing but the patient impact has been minimised.
- Te Toka Tumai (Auckland DHB) continues to work closely with the Ministry of Health, our Regional and National DHB partners and with HealthSource New Zealand to plan and mitigate for ongoing supply disruptions.

ESPI Performance

- Both ESPI 2 and ESPI 5 have deteriorated slightly between March and April 2021.
- ESPI 2 position is 6.2% (1041 patients) noncompliant, compared with 6% noncompliant at the end of March 2021.
- April 2021 ESPI 5 position is 16.1% (1229 patients) noncompliant, compared with 14.6% noncompliant at the end of March 2021.
- Internal data show improvements for May 2021 with ESPI 2 down to 739 from 1041 and ESPI 5 1091 from 1229 with further validation to follow.

Industrial relations

- The national DHB collective bargaining process to renew the DHB Collective Agreements with our union partners is on-going and there is a significant amount of activity. Te Toka Tumai

(Auckland DHB) is party to 13 multi-employer collective agreements which have expired or are due to expire before July 2021. All are currently under negotiation, except one which is due to commence shortly. In addition Te Toka Tumai (Auckland DHB) is party to two single-employer collective agreements current under negotiation.

- In addition to the significant amount of bargaining activity occurring, there are some significant pressure points emerging, in particular with regarding to the Public Service Commission's direction on pay restraint which limits the scope for pay increases for any employees other than the lowest paid (below $60,000 pa).
- The nurses and midwifes covered by the multi-employer collective agreement between the national DHBs and the New Zealand Nurses Organisation have rejected an offer from the DHBs on the basis that they are seeking a significantly greater increase in pay and have voted to take strike action. The planned strike action will occur on 9 June 2021 between 11am and 7pm and will be a full withdrawal of labour for that period. Te Toka Tumai (Auckland DHB) has worked with the New Zealand Nurses Organisation over the past weeks to agree on the minimum service levels that will be maintained during the strike and work has been carried out to fill those rosters.

Financial Performance

Consolidated Statement of Financial Performance - April 2021

Provider	Month (Apr-21)			YTD (10 months ending Apr-21)		
$000s	Actual	Budget	Variance	Actual	Budget	Variance
Income						
Government and Crown Agency sourced	13,934	9,851	4,083 F	111,447	100,117	11,331 F
Non-Government & Crown Agency Sourced	7,040	8,776	(1,736) U	85,425	88,109	(2,685) U
Inter-DHB & Internal Revenue	9,281	1,565	7,715 F	22,624	15,112	7,513 F
Internal Allocation DHB Provider	129,617	130,465	(848) U	1,302,588	1,304,648	(2,060) U
	159,872	**150,657**	**9,215 F**	**1,522,084**	**1,507,986**	**14,098 F**
Expenditure						
Personnel	110,266	103,584	(6,682) U	1,033,359	975,501	(57,857) U
Outsourced Personnel	3,856	1,559	(2,297) U	29,721	15,589	(14,132) U
Outsourced Clinical Services	4,109	4,080	(29) U	39,901	37,800	(2,101) U
Outsourced Other	6,095	6,106	10 F	60,686	61,057	371 F
Clinical Supplies	27,095	25,750	(1,344) U	276,660	270,529	(6,131) U
Infrastructure & Non-Clinical Supplies	19,573	18,411	(1,161) U	179,922	182,774	2,852 F
Internal Allocations	804	805	0 F	8,046	8,047	1 F
Total Expenditure	**171,798**	**160,295**	**(11,503) U**	**1,628,294**	**1,551,297**	**(76,998) U**
Net Surplus / (Deficit)	**(11,926)**	**(9,637)**	**(2,288) U**	**(106,210)**	**(43,311)**	**(62,899) U**
Covid-19 Net Impact on Bottom Line	4,202	(2)	4,204 F	(23,298)	(2)	(23,297) U
Holidays Act Net Impact on Bottom Line	(3,333)	0	(3,333) U	(33,333))	0	(33,333) U
BAU Net Impact on Bottom Line	**(12,795)**	**(9,635)**	**(3,159) U**	**(49,579)**	**(43,309)**	**(6,269) U**

Consolidated Statement of Personnel by Professional Group – April 2021

Employee Group $000s	Month (Apr-21)			YTD (10 months ending Apr-21)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical Personnel	38,491	36,754	(1,737) U	367,805	350,541	(17,264) U
Nursing Personnel	38,471	36,329	(2,142) U	355,086	330,387	(24,699) U
Allied Health Personnel	17,125	15,767	(1,358) U	159,776	152,244	(7,532) U
Support Personnel	3,239	3,018	(220) U	29,351	27,847	(1,504) U
Management/ Admin Personnel	12,939	11,716	(1,223) U	121,340	114,483	(6,858) U
Total (before Outsourced Personnel)	**110,266**	**103,584**	**(6,682) U**	**1,033,359**	**975,501**	**(57,857) U**
Outsourced Medical	1,357	1,039	(318) U	12,580	10,385	(2,195) U
Outsourced Nursing	97	66	(31) U	1,821	664	(1,157) U
Outsourced Allied Health	118	60	(58) U	1,069	598	(470) U
Outsourced Support	29	26	(3) U	373	260	(113) U
Outsourced Management/Admin	2,254	368	(1,886) U	13,878	3,682	(10,196) U
Total Outsourced Personnel	**3,856**	**1,559**	**(2,297) U**	**29,721**	**15,589**	**(14,132) U**
Total Personnel	**114,121**	**105,143**	**(8,979) U**	**1,063,080**	**991,091**	**(71,989) U**

Consolidated Statement of FTE by Professional Group – April 2021

FTE by Employee Group	Month (Apr-21)			YTD (10 months ending Apr-21)		
	Actual FTE	Budget FTE	Variance	Actual FTE	Budget FTE	Variance
Medical Personnel	1,585	1,542	(43) U	1,560	1,537	(23) U
Nursing Personnel	4,099	4,301	202 F	4,069	4,074	5 F
Allied Health Personnel	2,057	2,051	(6) U	2,029	2,032	2 F
Support Personnel	514	531	17 F	526	531	5 F
Management/ Admin Personnel	1,566	1,556	(10) U	1,537	1,554	17 F
Total (before Outsourced Personnel)	**9,822**	**9,981**	**159 F**	**9,721**	**9,728**	**7 F**
Outsourced Medical	45	29	(16) U	40	29	(11) U
Outsourced Nursing	0	3	3 F	0	3	3 F
Outsourced Allied Health	5	2	(3) U	5	2	(3) U
Outsourced Support	8	0	(8) U	10	0	(10) U
Outsourced Management/Admin	296	23	(273) U	184	23	(160) U
Total Outsourced Personnel	**355**	**58**	**(297) U**	**239**	**58**	**(181) U**
Total Personnel	**10,176**	**10,039**	**(137) U**	**9,960**	**9,786**	**(174) U**

Consolidated Statement of FTE by Directorate – April 2021

Employee FTE by Directorate Group (including Outsourced FTE)	Month (Apr-21)			YTD (10 months ending Apr-21)		
	Actual FTE	Budget FTE	Variance	Actual FTE	Budget FTE	Variance
Adult Medical Services	1,106	1,092	(14) U	1,070	1,061	(9) U
Adult Community and LTC	508	508	0 F	548	537	(10) U
Surgical Services	948	939	(9) U	934	908	(26) U
Women's Health	387	389	2 F	386	389	3 F
Child Health	1,385	1,392	8 F	1,396	1,365	(31) U
Cardiac Services	570	581	11 F	568	563	(5) U
Clinical Support Services	1,404	1,406	2 F	1,391	1,402	11 F
Patient Management Services	455	459	4 F	463	461	(2) U
Perioperative Services	788	817	29 F	786	811	25 F
Cancer & Blood Services	424	410	(14) U	420	411	(8) U
Operational - Others	225	201	(23) U	154	33	(121) U
Mental Health & Addictions	820	806	(14) U	786	806	20 F
Ancillary Services	1,158	1,039	(120) U	1,059	1,039	(20) U
Total Personnel	**10,176**	**10,039**	**(137) U**	**9,960**	**9,786**	**(174) U**

Month Result

The Provider Arm result for the month is $2.3M unfavourable. Excluding the impacts of Covid-19 and the Holidays Act, the underlying BAU result is $3.2M unfavourable, with the key variance being a $1.4M increase in the provision for staff related liabilities that are actuarially valued at the end of each year (e.g. Long Service Leave).

Total revenue for the month is $9.2M (6.1%) favourable. Variances relating to Covid-19 are $8.8M favourable, with BAU close to budget at $0.4M favourable. The key variances are as follows:

- Covid-19 funding $10.2M favourable, with most of this being backdated funding to cover year to date response costs.
- Non Resident revenue $1.4M unfavourable – primarily reflecting reduced Pacific contract cases as a result of Covid-19.

Total expenditure for the month is $11.5M (7.2%) unfavourable. Variances relating to Covid-19 are $4.6M unfavourable and the increase in the provision for Holidays Act liability is $3.3M unfavourable, leaving the underlying BAU variance $2.6M (1.6%) unfavourable. The key variances are as follows:

- Personnel/Outsourced Personnel costs $9.0M (4.8%) unfavourable, with the Covid-19 impact $4.1M unfavourable and the Holidays Act remediation $3.3M unfavourable. The BAU variance of $1.6M unfavourable reflects a $1.4M increase in the provision for actuarial revaluations for employee liabilities such as long service leave. Excluding unbudgeted Covid FTE, total FTE are 136 (1.4%) below budget.

- Clinical Supplies $1.3M (5.2%) unfavourable. Covid-19 costs are $0.4M unfavourable. Excluding these costs, the underlying Clinical Supplies variance is $0.9M unfavourable with the key variance being Haemophilia blood product $0.5M unfavourable (offset by additional revenue, nil impact on the bottom line), and the remaining $0.4M unfavourable variance reflecting overall volumes for the month slightly ahead of contract).
- Infrastructure & Non Clinical Supplies $1.2M unfavourable. Covid-19 costs are $0.4M unfavourable, with the underlying BAU variance $0.8M unfavourable due to cancellation of capital projects.

Year to Date Result

The Provider Arm result for the year to date is $62.9M unfavourable. This result is primarily driven by the impacts of Covid-19 ($23.3M) combined with an increase of $33.3M in the provision for Holidays Act liability. The underlying BAU result is $6.3M unfavourable.

Overall volumes (for total Auckland DHB and IDF Funders) are reported at 98.7% of the seasonally phased contract, equating to $15.6M below contract. The year to date result includes an $10.0M provision for estimated washup liability in relation to the Planned Care and IDF funding components of the YTD variance.

Total revenue for the year to date is $14.1M (0.9%) favourable, with a net $12.9M favourable variance attributable to Covid-19, and BAU $1.2M favourable. The key variances are as follows:

- Provision for planned care and IDF revenue washup - $10.0M unfavourable – reflecting significantly reduced volumes during the Covid-19 resurgence period in August, and lower acute volumes for the period immediately following the return to alert level 1.
- Non Resident revenue $8.4M unfavourable – primarily reflecting reduced Pacific contract cases as a result of Covid-19.
- Capital Charge income $7.2M unfavourable due to MOH claw back on capital charge funding to reflect the reduction of capital charge rate from 6% to 5% (offset by favourable expenditure).
- Public Health (base services excluding Covid-19) income $3.3M unfavourable due to assumed deficit support not received.
- Covid-19 funding $29.1M favourable for response costs - $21.4M for laboratory Covid-19 testing and $7.7M for other response costs.
- Retail Pharmacy revenue $5.3M favourable (mostly offset by additional cost of goods sold).
- New MOH funding for the Integrated Primary Mental Health Initiative $1.6M favourable.
- Research Income $2.8M favourable (offset by additional research costs so bottom line neutral).
- ACC Income $2.7M favourable, predominantly in Reablement for washup on the Non Acute Rehabilitation contract. This reflects a review of a change in the funding model.

Total expenditure for the year to date is $77.0M (5.0%) unfavourable. Most of this variance is attributable to additional costs arising from Covid-19 ($36.3M) and the increase in the provision for the Holidays Act liability ($33.3M), with the underlying BAU variance $7.4M (0.5%) unfavourable. The key variances are as follows:

- Personnel/Outsourced Personnel costs $72.0M (7.3%) unfavourable with the key variances as follows:

- Unbudgeted Covid-19 related expenditure of $25.3M.
- Increase in the provision for Holidays Act liability $33.3M unfavourable.
- Provision for actuarial revaluations for employee liabilities such as long service leave $13.4M.
- Excluding unbudgeted Covid FTE, total year to date FTE are exactly on budget.

- Outsourced Clinical Services $2.1M (5.6%) unfavourable, with the key variances as follows:
  - Unbudgeted Covid-19 related expenditure of $0.4M (for laboratory outsourced tests).
  - Diagnostic Genetics $0.6M unfavourable due to delayed repatriation of tests previously not done in house – this variance will reduce once repatriation is complete.
  - Planned outsourcing for colonoscopy has been completed earlier than budget phasing resulting in a $0.2M unfavourable variance which will correct by year end.
  - Additional MRI outsourcing $0.9M unfavourable for which additional one off MOH funding has been received to partially fund.
- Clinical Supplies $6.1M (2.3%) unfavourable. This variance is due to Laboratory consumable costs which are $5.7M unfavourable for the cost of Covid-19 tests. Excluding these costs, the underlying Clinical Supplies BAU variance is close to budget at $0.4M (0.2%) unfavourable.
- Infrastructure & Non Clinical Supplies $2.8M (1.6%) favourable, with the key variances being:
  - Unbudgeted Covid-19 related expenditure of $4.4M unfavourable.
  - Cost of Goods Sold $4.6M unfavourable for retail pharmacy, offset by additional retail revenue for the year to date.
  - Capital Charge $9.9M favourable due to the reduction in the capital charge rate from 6% to 5% combined with a lower crown equity balance.
  - Interest & Finance Charges $0.4M favourable.
  - All Other Operating Expenses such as Professional Fees, Training, Travel & Accommodation $1.5M favourable.

FTE

Total FTE (including outsourced) for April were 10,176 which is 137 higher than budget. Unbudgeted Covid-19 FTE totalled 274, with underlying BAU FTE 137 below budget – this is almost entirely due to Nursing BAU FTE being 127 under budget.

Volume Performance

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

		Apr-2021				YTD (10 months ending Apr-21)			
		$000s				$000s			
Directorate	**Service**	**Cont**	**Act**	**Var**	**Prog %**	**Cont**	**Act**	**Var**	**Prog %**
Adult Community & LTC	Ambulatory Services	1,363	1,469	106	107.8%	14,922	16,597	1,674	111.2%
	Community Services	1,803	1,957	154	108.6%	19,299	20,957	1,658	108.6%
	Diabetes	538	578	39	107.3%	5,650	6,226	576	110.2%
	Palliative Care	39	39	0	100.0%	390	390	0	100.0%
	Reablement Services	1,273	1,320	48	103.7%	17,000	17,700	700	104.1%
	Sexual Health	513	534	20	103.9%	5,415	5,408	(6)	99.9%
Adult Community & LTC Total		**5,528**	**5,896**	**368**	**106.6%**	**62,675**	**67,278**	**4,602**	**107.3%**
Adult Medical Services	AED, APU, DCCM, Air Ambulance	2,744	2,891	147	105.3%	27,997	28,307	310	101.1%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	13,516	14,401	885	106.6%	144,051	144,044	(7)	100.0%
Adult Medical Services Total		**16,260**	**17,292**	**1,032**	**106.3%**	**172,047**	**172,351**	**303**	**100.2%**
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	10,456	10,327	(129)	98.8%	109,042	109,152	110	100.1%
	N Surg, Oral, ORL, Transpl, Uro	10,751	10,976	226	102.1%	114,251	114,810	560	100.5%
	Orthopaedics Adult	4,904	5,157	253	105.2%	50,875	48,493	(2,382)	95.3%
Surgical Services Total		**26,111**	**26,461**	**350**	**101.3%**	**274,168**	**272,456**	**(1,712)**	**99.4%**
Cancer & Blood Services	Cancer & Blood Services	11,400	11,212	(188)	98.3%	118,880	117,650	(1,231)	99.0%
	Genetics	304	280	(24)	92.1%	3,267	3,502	235	107.2%
Cancer & Blood Services Total		**11,704**	**11,492**	**(213)**	**98.2%**	**122,147**	**121,151**	**(996)**	**99.2%**
Cardiovascular Services		**12,026**	**12,004**	**(22)**	**99.8%**	**136,601**	**129,110**	**(7,491)**	**94.5%**
Children's Health	Child Health Community Services	2,970	2,479	(491)	83.5%	31,088	24,521	(6,567)	78.9%
	Child Health Medical	6,008	5,266	(742)	87.6%	62,561	59,723	(2,839)	95.5%
	Child Health Surgical	10,034	10,490	455	104.5%	107,860	105,520	(2,340)	97.8%
Children's Health Total		**19,012**	**18,234**	**(778)**	**95.9%**	**201,510**	**189,764**	**(11,746)**	**94.2%**
Clinical Support Services		**3,718**	**3,860**	**142**	**103.8%**	**38,976**	**39,160**	**184**	**100.5%**
DHB Funds		**9,868**	**9,119**	**(749)**	**92.4%**	**99,960**	**98,648**	**(1,312)**	**98.7%**
Perioperative Services		**16**	**5**	**(11)**	**29.3%**	**166**	**99**	**(67)**	**59.8%**
Public Health Services		**155**	**155**	**0**	**100.0%**	**1,548**	**1,548**	**0**	**100.0%**
Support Services		**102**	**102**	**0**	**100.0%**	**1,023**	**1,023**	**0**	**100.0%**
Women's Health Total		**7,551**	**7,907**	**356**	**104.7%**	**81,106**	**83,764**	**2,658**	**103.3%**
Grand Total		**112,052**	**112,527**	**475**	**100.4%**	**1,191,927**	**1,176,351**	**(15,576)**	**98.7%**

2) Total Discharges for the YTD (10 Months to April 2021)

		Cases Subject to WIES Payment		All Discharges			Same Day discharges		Same Day as % of all discharges	
		Inpatient								
Directorate	**Service**	**2020**	**2021**	**Last YTD**	**This YTD**	**% Change**	**Last YTD**	**This YTD**	**Last YTD**	**This YTD**
Adult Community & LTC	Ambulatory Services	2,047	2,294	2,076	2,318	11.7%	1,976	2,245	95.2%	96.9%
	Community Services	0	6	0	23	0.0%	0	13	0.0%	56.5%
	Reablement Services	0	0	1,798	1,658	(7.8%)	91	85	5.1%	5.1%
Adult Community & LTC Total		2,047	2,300	3,874	3,999	3.2%	2,067	2,343	53.4%	58.6%
Adult Medical Services	AED, APU, DCCM, Air Ambulance	12,336	13,215	12,654	13,383	5.8%	8,790	9,406	69.5%	70.3%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	16,918	16,936	17,216	17,232	0.1%	2,907	2,939	16.9%	17.1%
Adult Medical Services Total		29,254	30,151	29,870	30,615	2.5%	11,697	12,345	39.2%	40.3%
Cancer & Blood Total		4,305	4,024	4,946	4,473	(9.6%)	2,591	2,132	52.4%	47.7%
Cardiovascular Services Total		6,676	7,132	6,917	7,340	6.1%	1,806	1,965	26.1%	26.8%
Children's Health	Child Health Community Services	2,168	1,738	2,179	1,744	(20.0%)	165	183	7.6%	10.5%
	Child Health Medical	9,289	9,816	10,340	11,077	7.1%	7,251	8,117	70.1%	73.3%
	Child Health Surgical	8,525	8,356	9,063	8,787	(3.0%)	3,627	3,406	40.0%	38.8%
Children's Health Total		19,982	19,910	21,582	21,608	0.1%	11,043	11,706	51.2%	54.2%
Clinical Support Services Total		0	0	9	0	0.0%	8	0	88.9%	0.0%
DHB Funds Total		1,309	1,779	1,312	1,780	35.7%	1,022	1,434	77.9%	80.6%
Perioperative Services		0	0	0	2	0.0%	0	2	0.0%	100.0%
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	14,995	15,414	16,151	16,525	2.3%	8,711	8,804	53.9%	53.3%
	N Surg, Oral, ORL, Transpl, Uro	9,672	10,367	10,371	11,045	6.5%	4,119	4,521	39.7%	40.9%
	Orthopaedics Adult	3,765	4,219	3,914	4,392	12.2%	656	884	16.8%	20.1%
Surgical Services Total		28,432	29,999	30,436	31,962	5.0%	13,486	14,209	44.3%	44.5%
Women's Health Total		17,074	16,834	17,676	17,397	(1.6%)	6,541	6,363	37.0%	36.6%
Grand Total		**109,079**	**112,130**	**116,613**	**119,185**	**2.2%**	**50,253**	**52,507**	**43.1%**	**44.1%**

3) Caseweight Activity for the YTD (10 Months to April 2021 (All DHBs))

		Acute							Elective							Total						
		Case Weighted Volume			$000s				Case Weighted Volume			$000s				Case Weighted Volume			$000s			
Directorate	Service	Con	Act	Var	Con	Act	Var	Prog %	Con	Act	Var	Con	Act	Var	Prog %	Con	Act	Var	Con	Act	Var	Prog %
Adult Community & LT Conditions	Ambulatory Services	1,027	1,124	97	5,695	6,234	539	109.5%	94	32	(62)	519	178	(342)	34.2%	1,121	1,156	36	6,214	6,411	197	103.2%
	Community Services	0	2	2	0	11	11	0.0%	0	11	11	0	61	61	0.0%	0	13	13	0	72	72	0.0%
Adult Community & LTC		**1,027**	**1,126**	**99**	**5,695**	**6,245**	**550**	**109.7%**	**94**	**43**	**(51)**	**519**	**239**	**(281)**	**45.9%**	**1,121**	**1,169**	**49**	**6,214**	**6,483**	**269**	**104.3%**
Adult Medical Services	AED, APU, DCCM, Air Ambulance	3,489	3,632	142	19,350	20,139	789	104.1%	0	0	0	0	0	0	0.0%	3,489	3,632	142	19,350	20,139	789	104.1%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	17,382	16,806	(576)	96,389	93,193	(3,195)	96.7%	28	0	(28)	153	0	(153)	0.0%	17,410	16,806	(604)	96,542	93,193	(3,348)	96.5%
Adult Medical Services Total		**20,872**	**20,438**	**(434)**	**115,738**	**113,333**	**(2,406)**	**97.9%**	**28**	**0**	**(28)**	**153**	**0**	**(153)**	**0.0%**	**20,899**	**20,438**	**(461)**	**115,892**	**113,333**	**(2,559)**	**97.8%**
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	8,720	8,837	117	48,354	49,005	650	101.3%	6,241	6,075	(166)	34,609	33,689	(919)	97.3%	14,961	14,913	(48)	82,963	82,694	(269)	99.7%
	N Surg, Oral, ORL, Transpl, Uro	8,476	9,237	761	47,000	51,220	4,220	109.0%	6,332	5,777	(555)	35,112	32,035	(3,077)	91.2%	14,808	15,014	206	82,112	83,255	1,143	101.4%
	Orthopaedics Adult	5,361	5,249	(112)	29,728	29,104	(624)	97.9%	3,163	2,598	(566)	17,540	14,404	(3,136)	82.1%	8,524	7,846	(678)	47,269	43,508	(3,760)	92.0%
Surgical Services Total		**22,557**	**23,322**	**766**	**125,082**	**129,328**	**4,247**	**103.4%**	**15,736**	**14,450**	**(1,286)**	**87,261**	**80,129**	**(7,133)**	**91.8%**	**38,293**	**37,772**	**(520)**	**212,343**	**209,457**	**(2,886)**	**98.6%**
Cancer & Blood Services		**5,541**	**5,377**	**(164)**	**30,728**	**29,817**	**(911)**	**97.0%**	**0**	**0**	**0**	**0**	**0**	**0**	**0.0%**	**5,541**	**5,377**	**(164)**	**30,728**	**29,817**	**(911)**	**97.0%**
Cardiovascular Services		**13,630**	**13,288**	**(343)**	**75,582**	**73,683**	**(1,900)**	**97.5%**	**8,365**	**7,209**	**(1,156)**	**46,383**	**39,974**	**(6,409)**	**86.2%**	**21,995**	**20,496**	**(1,498)**	**121,966**	**113,657**	**(8,309)**	**93.2%**
Children's Health	Child Health Community	3,132	1,946	(1,186)	17,370	10,791	(6,578)	62.1%	0	0	0	0	0	0	0.0%	3,132	1,946	(1,186)	17,370	10,791	(6,578)	62.1%
	Child Health Medical	6,975	6,563	(412)	38,680	36,395	(2,285)	94.1%	49	64	16	269	356	87	132.3%	7,024	6,627	(396)	38,949	36,751	(2,198)	94.4%
	Child Health Surgical	9,878	9,707	(171)	54,774	53,828	(947)	98.3%	6,014	5,723	(291)	33,352	31,738	(1,614)	95.2%	15,892	15,430	(462)	88,126	85,566	(2,560)	97.1%
Children's Health Total		**19,985**	**18,216**	**(1,769)**	**110,824**	**101,014**	**(9,810)**	**91.1%**	**6,063**	**5,788**	**(275)**	**33,621**	**32,094**	**(1,527)**	**95.5%**	**26,048**	**24,004**	**(2,044)**	**144,445**	**133,108**	**(11,337)**	**92.2%**
Women's Health Services		**8,466**	**8,331**	**(135)**	**46,946**	**46,198**	**(748)**	**98.4%**	**1,899**	**1,939**	**40**	**10,532**	**10,753**	**221**	**102.1%**	**10,365**	**10,270**	**(95)**	**57,479**	**56,951**	**(527)**	**99.1%**
DHB Funds		**225**	**0**	**(225)**	**1,248**	**0**	**(1,248)**	**0.0%**	**1,811**	**1,758**	**(53)**	**10,042**	**9,747**	**(296)**	**97.1%**	**2,036**	**1,758**	**(278)**	**11,290**	**9,747**	**(1,544)**	**86.3%**
Grand Total		**92,303**	**90,098**	**(2,205)**	**511,844**	**499,617**	**(12,227)**	**97.6%**	**33,995**	**31,186**	**(2,809)**	**188,513**	**172,936**	**(15,577)**	**91.7%**	**126,298**	**121,284**	**(5,014)**	**700,357**	**672,553**	**(27,804)**	**96.0%**
Excludes caseweight Provision																						

Acute Services

Year to date April acute performance to contract improved again – up 0.6% on last month. Year to date comparisons have become affected by Covid-19 as March and April last year were both significantly impacted (discharges were down 32% last year March/April compared to this year March/April).

Acute performance by service type:

- Acute medical discharges are now 2.3% higher than YTD last year, reflecting the decrease in volumes last year due to Covid. Average WIES remains 1.9% lower than the same period last year, while ALOS remains at the same level as last year.
- Acute surgical discharges are now 1% lower than YTD last year. Average WIES continues to drop slightly and is now only 3% higher. ALOS is unchanged at 3% higher than the same period last year.
- Obstetric discharges continue their slow improvement and are now just over 6% lower than YTD last year. There was a small increase in births in March and April compared to other months, but the average number of births is still down on the same period last year. ALOS has increased slightly and is now 4% up on the same period last year. Average WIES is at the same level as last year. Newborn discharges are 16% higher than same period last year, but with a lower average WIES (down nearly 8%) and LOS (down 6%).

Elective Services

Elective performance to contract improved in April and is now 91.7% of contract. The monthly average discharges are up by 3% compared to last year (from July 2019-February 2020, pre Covid-19), with lockdowns having minimal impact this financial year (except for August). It is difficult to compare average WIES or ALOS because March and April last year were so significantly impacted. However, when comparing July-February last year with July-April this year average WIES is down 1%, and ALOS is down nearly 5%.

4) Non-DRG Activity (ALL DHBs)

		Apr-2021				YTD (10 months ending Apr-21)			
		$000s				$000s			
Directorate	**Service**	**Cont**	**Act**	**Var**	**Prog %**	**Cont**	**Act**	**Var**	**Prog %**
Adult Community & LTC	Ambulatory Services	808	847	39	104.8%	8,708	10,186	1,477	117.0%
	Community Services	1,803	1,955	153	108.5%	19,299	20,885	1,586	108.2%
	Diabetes	538	578	39	107.3%	5,650	6,226	576	110.2%
	Palliative Care	39	39	0	100.0%	390	390	0	100.0%
	Reablement Services	1,273	1,320	48	103.7%	17,000	17,700	700	104.1%
	Sexual Health	513	534	20	103.9%	5,415	5,408	(6)	99.9%
Adult Community & LTC Total		**4,974**	**5,273**	**299**	**106.0%**	**56,461**	**60,794**	**4,333**	**107.7%**
Adult Medical Services	AED, APU, DCCM, Air Ambulance	848	833	(15)	98.2%	8,647	8,168	(480)	94.5%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	4,888	4,873	(15)	99.7%	47,509	50,851	3,342	107.0%
Adult Medical Services Total		**5,736**	**5,706**	**(30)**	**99.5%**	**56,156**	**59,018**	**2,862**	**105.1%**
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	2,421	2,327	(93)	96.1%	26,079	26,458	379	101.5%
	N Surg, Oral, ORL, Transpl, Uro	3,084	3,064	(20)	99.3%	32,139	31,555	(583)	98.2%
	Orthopaedics Adult	337	576	239	171.0%	3,607	4,985	1,378	138.2%
Surgical Services Total		**5,842**	**5,967**	**126**	**102.1%**	**61,824**	**62,998**	**1,174**	**101.9%**
Cancer & Blood Services	Cancer & Blood Services	8,693	8,262	(430)	95.0%	88,152	87,833	(319)	99.6%
	Genetics	304	280	(24)	92.1%	3,267	3,502	235	107.2%
Cancer & Blood Services Total		**8,997**	**8,542**	**(454)**	**94.9%**	**91,419**	**91,334**	**(84)**	**99.9%**
Cardiovascular Services		**1,331**	**1,401**	**71**	**105.3%**	**14,636**	**15,453**	**817**	**105.6%**
Children's Health	Child Health Community Services	1,336	1,319	(17)	98.8%	13,718	13,729	11	100.1%
	Child Health Medical	2,210	2,024	(186)	91.6%	23,612	22,972	(640)	97.3%
	Child Health Surgical	1,901	1,893	(7)	99.6%	19,734	19,955	220	101.1%
Children's Health Total		**5,447**	**5,237**	**(210)**	**96.1%**	**57,065**	**56,656**	**(409)**	**99.3%**
Clinical Support Services		**3,718**	**3,860**	**142**	**103.8%**	**38,976**	**39,160**	**184**	**100.5%**
DHB Funds		**8,882**	**8,873**	**(9)**	**99.9%**	**88,670**	**88,901**	**231**	**100.3%**
Perioperative Services		**16**	**5**	**(11)**	**29.3%**	**166**	**99**	**(67)**	**59.8%**
Public Health Services		**155**	**155**	**0**	**100.0%**	**1,548**	**1,548**	**0**	**100.0%**
Support Services		**102**	**102**	**0**	**100.0%**	**1,023**	**1,023**	**0**	**100.0%**
Women's Health Total		**2,215**	**2,248**	**33**	**101.5%**	**23,627**	**26,812**	**3,185**	**113.5%**
Grand Total		**47,414**	**47,368**	**(45)**	**99.9%**	**491,571**	**503,798**	**12,227**	**102.5%**

Non inpatient activity is slightly above contract at 102%. Most of the variance to contract is for Auckland DHB population patients.

Te Pūriri o Te Ora - Cancer and Blood Services

Prepared by: George Laking (Te Whakatōhea, Medical Oncologist, Kaihautū - Pou Ārahi); Rebecca Tapper (Interim General Manager)
Speaker: Richard Sullivan (Director)

Ki te kāhore he whakakitenga ka ngaro te iwi
Without vision or foresight the people are lost
Kīngi Pōtatau Te Wherowhero Tāwhiao

Kuputaka : Glossary

Acronym/term	Definition
Pou Ārahi	Guiding Post. Pou Ārahi is a rōpū (group) that was established in liaison with Kahurangi Rangimarie Naida Glavish within Te Pūriri O Te Ora (Cancer and Blood Services). The name Pou Ārahi was gifted for this rōpū (group) by Kahurangi Rangimarie Naida Glavish.

Bicultural partnership and Health System Reform

In the six months since our last Provider Equity/Hospital Advisory Committee report, Te Pūriri o Te Ora (Cancer and Blood Services) reconfigured it's peak leadership as a bicultural partnership between the Directorate Leadership Team and Pou Ārahi. This is in keeping with the DHB strategic plan that foregrounds Te Tiriti o Waitangi and Health Equity.

With reference to the Strategy to 2023 for Te Toka Tumai (Auckland DHB), we have re-imagined the structure and scope of cancer services across six dimensions: (1) geographical reach, (2) the cancer continuum, (3) community networks, (4) real-time data, (5) foundational change in culture, and (6) dissemination of skills. This thinking from Pou Ārahi has been warmly received by Te Aho o Te Kahu (the National Cancer Control Agency).

Here we outline our strategic thinking in more detail, as well as progress made.

1. Te Tiriti o Waitangi in Action

Geographical Reach

Minister Little stated the Government's support for anything that takes specialist services out of the hospitals and into the community. Much of our work in oncology is cognitive. It's only a minority of the time that we depend on material infrastructure such as operating theatres or scanners or radiation bunkers. Now there are reliable Citrix set-ups, we are able to work pretty much anywhere with a broadband connection.

Another thing Minister Little said he was warned about in his first week in the job, was never to underestimate parking. At Te Pūriri o Te Ora (Cancer and Blood Services) we believe we will do a better job, the more we take our work into community settings, such as primary care and marae. For too long, we have sat in isolation on our hill at Pukekawa - it's time we got out of the hospital to where the people are.

We have taken a first step by joining forces with Hāpai Te Hauora Tāpui, the community-based Māori Public Health organisation. Hāpai is a partnership between Mana Whenua (Te Rūnanga o Ngāti Whātua, Raukura Hauora o Tainui), and Te Whānau o Waipereira Urban Māori trust. We have jointly bid with Hāpai in the Health Research Council Equitable Cancer Outcomes round. Our project will evaluate the work of Whānau Ora Collective Cancer Navigators, in the setting of Local Delivery of Oncology.

Foundational change in workplace culture

Workplace cultural change has been a large part of our work this semester. At Te Pūriri o Te Ora (Cancer and Blood Services), we are increasingly aware of the contrast between our high level of technical expertise, yet relatively early stage of Mātauranga Māori (Māori knowledge). There is basic Māori knowledge that is essential for all health care workers to hold if they are to meet the commitment of Te Tiriti o Waitangi, eliminate racism, grow cultural safety, and achieve health equity. Such gaps exist for most people who had their education in this country during the last century. It is jarring to consider that our highly skilled and experienced DHB workforce is actually in need of remedial education, to be fit for work in the 21st century.

On the topic of racism, we have come to see this as baggage we all carry around, especially those of us of paler complexion. It usually found it's way into our being in early years. We didn't ask for it to be put there, but it's our responsibility to unload it. Life is a lot better without it. One way racism exists is as a set of assumptions about the superiority of "Western" models of thought. It's work in progress to let go of those assumptions, which really are coming from a place of personal insecurity. It's much better to consider how different cultures play to each others' strengths in weaving the world fabric.

So we have started a wānanga (workshop learning) programme that is built around 2 to 3 hours of learning every fortnight, interspersed with noho marae (marae stays). Topic areas include the history of Aotearoa, Te Reo Māori (the Māori language and its associated protocols) and Tikanga (Māori protocols or customs), Te Tiriti o Waitangi, communication and cultural competency skills. To see this through we have retained a course convenor with expertise in adult education. The purpose is to equip our workforce with the knowledge, skills, and awareness to bring a genuine shift to a therapeutic culture that works for all.

The wānanga series (workshop learning) started on Friday 16 April with presentations on the significance of Te Tiriti o Waitangi at a personal and civic level from Te Toka Tumai (Auckland DHB) Chair Pat Snedden, and Deputy Chair, Provider Equity/Hospital Advisory Committee Chair and Mana Whenua representative Tama Davis.

That day also saw the unveiling of the Mānea Stone now installed at the front entry to Te Pūriri o Te Ora (Cancer and Blood Services), Auckland City Hospital Building 8. The Mānea Stone was sourced, carved, and gifted to us by Ngāti Whātua. For those who seek it, the stone is a focal point for the unloading of spiritual and psychological burdens that people bring with them in cancer care.

There have now been four pōwhiri (formal Māori welcome) to welcome new staff into the Pūriri o Te Ora Whānau (Cancer and Blood Service's family). In this way, we are normalising pōwhiri (a formal Māori welcome) as a venue to grow cultural skills. Our intention is to extend the pōwhiri (formal Māori welcome) to all new whānau (family) coming into our care.

During June we have booked one hour meetings with each work area in the Directorate, to socialise the change in our identity and purpose.

A significant step on the path to effective bicultural work was a set of hui (meetings) under the kaupapa (protocol) of hohou i te rongo (renewal of peace), facilitated and hosted by Te Whetu Mārama marae at the Adult Mental Health Service on the Auckland City Hospital Campus. The hui (meetings) concerned a whānau (family) who had a poor experience in our care, meeting with staff involved, Directorate leadership, and the Kaiārahi Nāhi (Nurse Navigation service). As well as bringing healing to those involved, the insights from these hui (meetings) will help us improve future care for whānau (family).

2. Eliminate Inequity

The Cancer Continuum

The creation of Te Aho o Te Kahu (the National Cancer Control Agency), with a public health specialist at the helm, is a strong reminder that there is a continuum of cancer care that starts with prevention, and moves via screening and diagnosis, through to treatment. Hitherto, Te Pūriri o Te Ora (Cancer and Blood Services) has located itself at the end of the continuum. Many of the people we meet have cancer that became incurable due to avoidable diagnostic delay. As the service of record for cancer care and control, it is no longer satisfactory to say that these things are not our job. So a big part of our intent with the reforms is to be more involved in the guarantee that cancer prevention, screening, and diagnosis, happen as they should.

Transition from legacy systems

It is important to protect health equity in the context of legacy systems, while new models of care are being developed. During this time the Directorate is supporting employment of Navigators, to ensure Māori and Pasifika whānau (family) access and stay engaged with our service. This workforce will also preside over a fund to help whānau (family) cover immediate contingencies such as transport. In many cases immediate availability of just a few dollars is the necessary difference to keep people engaged with the service. One cannot depend on regular social agencies to be able to respond in time for this.

3. People, Patients and Whānau at the Centre

Community Networks

The new model will require closer integration into community organisations such as Whānau Ora collectives, Rūnanga, community trusts and NGOs. Historically we have linked in with the Cancer Society, but a strong social fabric cannot be bound by just one thread, and can't depend on having just one community partner.

Dissemination of skills

Historically at Te Pūriri o Te Ora (Cancer and Blood Services) there have been well-drawn lines of demarcation between the work of medical and non-medical staff. In particular, the outpatient assessments that guide patient and whānau (family) through their cancer journey have been

primarily the domain of doctors. A critique of plans to take our work out of the hospital is that we do not have the Senior Medical capacity to achieve this. Indeed, many Senior Medical Officers are already contending with symptoms of professional burnout. Arguably, the demarcation and protection of medical work is an important contributory factor. To achieve the necessary increase in our geographical range at the same time as remedying burnout, we need to disseminate key clinical skills beyond just the medical workforce.

Such change is already seen in progression to top of scope roles such as Clinical Nurse Specialists and Nurse Practitioners. We are aiming for an expansion of this cohort, with nurses trained to conduct oncology clinics. A large class will minimise feelings of professional exposure and isolation, will offer mutual support in training and practice, and indeed will form a politically relevant force in consolidating the new model of care.

Another set of skills are the unique interpersonal skills carried intrinsically by a culturally representative workforce. Te Toka Tumai (Auckland DHB) historically has a low rate of employment of Māori and Pacific staff, even in comparison to other DHBs. So in keeping with the aspirations of Pūmanawa Tāngata (the People Plan), we will seek to increase employment of Māori staff and Pacific staff in clinical roles, proportionate to the structure of the population we serve.

4. Digital Transformation

Real time data

A decade ago, we had a project to study barriers to access in care of lung cancer. That started with DHB billing data recording each clinical episode for patients investigated for and diagnosed with lung cancer. We built a bespoke model of time to key episodes, including CT scans, biopsies, specialist assessments, and treatments. It was a one-off work that to replicate would require re-assembly of a 20+ person research team. In 2021 our Faster Cancer Treatment team is working with the DHB Business Intelligence Unit to access the DHB data in real-time. That will let us continually update these endpoints, and see how they vary by ethnicity and in response to change in service delivery and practice. As at June 2021 we still have yet to achieve real-time data.

Summary of our strategic thinking

This is a summary of the strategic intentions of Te Pūriri o Te Ora (Cancer and Blood Services) as at June 2021. Success would not be possible without the willing help of many. Ehara taku toa, ko te toa takitahi, engari ko te toa takitini. The project is a Directorate-wide reform that is defined by the kaupapa (purpose) of Pou Ārahi. Our word to our staff is that by being engaged with this plan, we all become a part of Te Pou Ārahi.

Whānau (Family)

The Chair of Te Pou Ārahi is Dr George Laking (Te Whakatōhea) Medical Oncologist. Membership includes Tame Hauraki (Ngāti Whātua, Ngāpuhi, Ngāti Whānaunga) our Kaumātua at Te Pūriri o Te Ora (Cancer and Blood Services), Ingo Lambrecht (Ngāi Tiamani, whāngai nā Ngāti Whātua) Clinical Psychologist, and Troydyn Raturaga (Ngāti Whātua, Ngāpuhi) Business Manager Provider Services.

Since the November meeting, Dr Richard Sullivan has been seconded in part to the Directorial role in Surgical services. Accordingly, Dr Fritha Hanning (Medical Oncologist) is now Associate Director of Te

Pūriri o Te Ora (Cancer and Blood Services). Dr Deirdre Maxwell PhD has left Te Toka Tumai to work with Kupu Taurangi Hauora o Aotearoa (the Health Quality and Safety Commission New Zealand), and Ms Rebecca Tapper is now the Acting General Manager.

Regional Oncology Electronic System

Te Pūriri o Te Ora (Cancer and Blood Services) continues to work with regional colleagues to establish a regional electronic cytotoxic prescribing system to replace current paper based systems. The implementation of this system will enable safer cytotoxic medication prescription and administration, whilst also enabling more consistent and efficient practice. A preferred vendor has been identified and the clinical project team are working closely with them to build a system that meets the requirements of the region.

5. Resilient Services

COVID-19

Te Pūriri o Te Ora (Cancer and Blood Services) continues to monitor and manage the impacts of COVID-19 on our whānau (family). In the current very low risk setting, patient screening occurs at our reception desks and there is on-going work underway to refine our screening processes for times of higher risk. Our in-house COVID-19 Incident Management Team is currently stood down but we are confident in our service led responses, should we need to stand these up again. There has been good uptake of the COVID-19 vaccination amongst the team in Te Pūriri o Te Ora (Cancer and Blood Services).

Northern Region Closed System Transfer Device Project

The team in Te Pūriri o Te Ora (Cancer and Blood Services) continue to work with Health Source and regional colleagues to procure and implement a Closed System Transfer Device for the administration of chemotherapy across the region. Closed System Transfer devices are used in conjunction with personal protection equipment to reduce the potential exposure to cytotoxic medications. Clinical evaluations of potential systems are anticipated to commence in the next month.

Aspergillus/Fungal Spore Mitigation for Immuno-compromised Patients

Facilities Infrastructure Renewal Programme work located near the Cancer and Blood Building (Building 8) continues to pose a potential risk of aspergillus exposure for vulnerable patient groups. To mitigate this risk, the Haematology service has relocated away from Building 8 to Rangitoto Ward.

Integrated Cancer Service

Work by Te Pūriri o Te Ora (Cancer and Blood Services), the University of Auckland and our Building for the Future Programme colleagues continues to progress the rebuild of the Cancer and Blood Building (Building 8). We seek a fit for purpose environment that will include outpatient and inpatient services that meet the current and future needs of our population and enables Māori health equity. This will include specialised facilities to meet the cultural and physical needs of our patients and whānau (family), whilst improving our academic/research capability.

6. Financial Sustainability

STATEMENT OF FINANCIAL PERFORMANCE

($000s)	YEAR TO DATE (10 months ending Apr-21)		
	Actual	Budget	Variance
REVENUE			
Government and Crown Agency	2,639	2,935	(296) U
Funder to Provider Revenue	91,531	92,012	(480) U
Other Income	647	724	(77) U
Total Revenue	**94,817**	**95,671**	**(854) U**
EXPENDITURE			
Personnel			
Personnel Costs	43,484	42,353	(1,131) U
Outsourced Personnel	401	548	147 F
Outsourced Clinical Services	4,492	3,121	(1,370) U
Clinical Supplies	14,695	12,792	(1,903) U
Infrastructure & Non-Clinical Supplies	1,472	1,561	89 F
Total Expenditure	**64,545**	**60,376**	**(4,168) U**
Contribution	**30,272**	**35,295**	**(5,022) U**
Allocations	8,087	7,883	(204) U
NET RESULT	**22,185**	**27,412**	**(5,227) U**

Commentary:

Te Pūriri o Te Ora (Cancer and Blood Services) are tracking $5.227m unfavourable to budget after 10 months into the current financial year. This is largely driven by;

- Personnel Costs mainly due to higher than budgeted Medical FTE required to meet increased volume demand particularly in Medical Oncology and Haematology.
- Outsourced services mainly due to higher than budgeted cost of Bone Marrow Transplant Registry – due to COVID no donors can fly to NZ so a lot of donors are worked up now by NZ bone marrow registry and collected and frozen from the donor in the overseas city.
- Clinical Supplies – primarily due to linear accelerators completing warranty period and attracting increased cost of service contracts.

7. Scorecard and Exceptions

Auckland DHB - Cancer & Blood Services

HAC report for April 2021

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

Safety

Metric		Actual	Target	Previous
Medication errors with major harm	PR215	0	Lower	0
Nosocomial pressure injury point prevalence (% of in-patients)	PR097	0%		0%
Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	PR185	0.5%		0.6%
Number of falls with major harm	PR199	1	Lower	0
Number of reported adverse events causing harm (SAC 1&2)	PR084	1	Lower	0
Unviewed/unsigned Histology/Cytology results >=30 days	PR596	3	Lower	2
% Hand hygiene compliance	PR195	95.05%	>=80%	89.64%

Patient-centred

Metric		Actual	Target	Previous
% Patients cared for in a mixed gender room at midday - Adult	PR175	42.21%	Lower	37.45%
% hospitalised smokers offered advice and support to quit	PR129	88.46%	>=95%	100%
% DNA rate for outpatient appointments - Māori	PR057	7.05%	<=9%	7.74%
% DNA rate for outpatient appointments - Pacific	PR058	10.94%	<=9%	7.96%
% DNA rate for outpatient appointments - Other	PR809	3.13%	<=9%	2.97%
% DNA rate for outpatient appointments - Deprivation Scale Q5	PR338	8.05%	<=9%	7.42%
% Very good and excellent ratings for overall inpatient experience	# PR154	85.7%	>=90%	72.2%
% Very good and excellent ratings for overall outpatient experience	# PR179	92%	>=90%	96.2%
% Very good and excellent ratings for coordination of care after discharge	# PR493	100%	>=90%	50%
% Response rate to ADHB patient experience inpatient survey	# PR315	14%	>=25%	17%
Number of CBU Outliers - Adult	PR173	87	<=300	73

Timeliness

Metric		Actual	Target	Previous
31/62 day target - % of non-surgical patients seen within the 62 day target	PR181	91.07%	>=90%	92.66%
31/62 day target - % of surgical patients seen within the 62 day target	PR182	86.67%	>=90%	94.94%
62 day target - % of patients treated within the 62 day target	PR184	89.11%	>=90%	93.62%
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Total	PR328	0	Lower	0
BMT Autologous Waitlist - Patients currently waiting > 6 weeks	PR186	R/U	Lower	0
% Cancer patients receiving radiation/chemo therapy treatment within 4 weeks of DTT	PR070	99.23%	100%	100%
% Chemotherapy patients (Med Onc and Haem) attending FSA within 4 weeks of referral	PR059	90.13%	100%	92.19%
% Chemotherapy patients (Med Onc and Haem) attending FSA within 2 weeks of referral	PR508	53.46%	100%	63.68%
% Radiation oncology patients attending FSA within 2 weeks of referral	PR509	44.5%	100%	34.78%
% Radiation oncology patients attending FSA within 4 weeks of referral	PR064	76.47%	100%	77.31%
% Patients from Referral to FSA within 7 days	PR180	19.29%	TBC	20.22%

Effectiveness

Metric		Actual	Target	Previous
28 Day Readmission Rate - Māori	# PR079	38.46%	<=6%	14.29%
28 Day Readmission Rate - Pacific	# PR080	29.41%	<=6%	32.26%
28 Day Readmission Rate - Total	# PR078	26.52%	TBC	28.22%
28 Day Readmission Rate - Deprivation Scale Q5	# PR322	29.27%	<=6%	26.09%

Efficiency

Metric		Actual	Target	Previous
Average LOS for WIES funded discharges (days) - Acute	PR219	4.17	TBC	4.78
Average LOS for WIES funded discharges (days) - Elective	PR220	0		0

Equitable: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Safety: Avoiding harm to patients from the care that is intended to help them.

Patient-centred: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

Timeliness: Reducing waits and sometimes harmful delays for both those who receive and those who give care.

Effectiveness: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).

Efficiency: Avoiding waste, including waste of equipment, supplies, ideas, and energy.

Amber	Variance from target not significant enough to report as non-compliant. This includes percentages/rates within 1% of target, or volumes within 1 value from target.
#	Actual is the latest available result prior to April 2021
R/U	Result Unavailable

BMT Autologous Waitlist - Patients currently waiting > 6 weeks

Results Unavailable

Patient Management Services

Prepared by: Alex Pimm (Director)
Speaker: Alex Pimm (Director)

1. Te Tiriti o Waitangi in Action

Patient Management Services is committed to upholding Te Tiriti o Waitangi and is at the beginning stages of action.

- **Kāwanatanga**

The directorate's focus has been on supporting our leaders to undertake the Leading for Equity module of the Management Development Programme. Uptake was initially slow, however in the past two months has improved, with nine managers now having completed the module, six currently in progress, and eight having enrolled but not progressed. A further 11 people in non-manager roles in the directorate have completed or are in progress with the module. Completion of this module (alongside Roles and Responsibilities of Being a Manager) is incorporated into managers' and leaders' annual objectives for this year.

- **Tino Rangatiratanga**

There are no staff that identify as Māori in the directorate's senior leadership team, however there are Māori staff working in tier four and below leadership roles that provide genuine and active contribution to decision-making.

Opportunities for Māori staff to be supported to leadership roles within the directorate are in their infancy. This is in part due to wishing to participate in an organisational-wide approach of career development for Māori staff. Whilst this work continues, the directorate continues to offer guaranteed interviews to all Māori candidates that meet essential criteria for all roles.

The graduate nurse positions within the transition lounge and transit team have successfully focussed on Māori graduates.

- **Ōritetanga**

A number of policies owned by Patient Management Services are due for review. As part of the review (and re-write) process, the directorate is committed to ensuring that they uphold Te Tiriti o Waitangi through the use of a Tiriti analysis tool.

- **Te Ritenga**

To support embedding Māori values and beliefs, Patient Management Services has encouraged the use of Te Reo (the Māori language and its associated protocols) – both written and verbal – as well as introducing karakia (prayer or incantation) to meetings. Each day, the daily operational capacity planning hui (meeting) starts and closes with a karakia (prayer or incantation). This has been well received and will be extended into other forums.

2. Eliminate Inequity

Overall, Māori representation across the directorate is 5.9 per cent, whilst Pacific representation is 28.9 per cent. This rises to 6.6 per cent Māori representation and 36.7 per cent Pacific representation for To Thrive services only, suggesting that the majority of Māori and Pacific peoples employed in the directorate are within our lower paid roles. This is something that the directorate leadership team are acutely aware of.

The To Thrive programme continues to operate across key service areas in the directorate. Most aspects of the programme are now fully embedded into the services' regular progresses. There are a further 40 staff graduating with New Zealand Qualifications Authority level 3 qualifications in either cleaning or orderly services in June. A small number of people are enrolled on the level 4 leadership course. This year, as the majority of existing supervisors have completed the qualification, applications were opened to aspiring leaders to support them to be ready when the next opportunity arises. All of Patient Management Services vacant leadership roles in the past year have been filled by internal candidates.

With the support of colleagues in the Human Resources/Organisation Development Team, the directorate continues to offer a range of career and personal development opportunities for people in the To Thrive programme, in addition to New Zealand Qualifications Authority qualifications, including: English as a second language; digital familiarisation/literacy; financial capability.

Members of the To Thrive group engage with the employee support centre, especially with support with food. The directorate currently has four employee support centre 'champions' – this number is being reviewed given the high usage of the space and services on offer. The champions provided a valuable service to their colleagues over the past year, particularly during the COVID-19 lockdowns, providing a voice for staff that may have been struggling and needed some support. They were able to advocate for them and connect them with the right people and services available at the time to access the support available through the centre.

Staff continue to engage with free gym memberships for people earning less than $55k. Within Patient Management Services, there are currently 23 active participants. Green prescriptions for health lifestyle appointments have also been offered, with 11 employees attending for individual appointments in May. Lunchtime sessions on healthy eating are planned for later this year.

Patient Management Services continues to support career pathways, with particular focus on Māori, Pacific peoples, and rangatahi (youth). The following services within the directorates have committed to all three stages (introduction days, work experience, and cadetship) or the rangatahi programme: temporary staffing bureau; transition lounge; level 5 reception; patient at risk service; and orderly service.

3. People, Patients and Whānau at the Centre

The majority of key Human Resources indicators remain relatively static. There has been considerable focus within the directorate to reduce peoples' annual and other leave (e.g. time in lieu, statutory time in lieu, etc.) balances. This has had some limited success but has largely kept the level of liability steady rather than making significant reductions. This does mean that whilst historic leave balances may not have been eliminated, staff are taking a break from work.

Sickness absence rates in the past quarter were 3.0 per cent for all disciplines compared to 3.5 per cent for the prior quarter. Sickness continues to be higher within the To Thrive groups but has reduced over the past 12 months as the services have provided focussed support to individuals with high sickness absence rates.

Turnover has reduced from the high levels seen during 2019/20, with voluntary turnover at 1.7 percent (0 per cent Māori; 1.3 per cent Pacific) compared to 10.3 per cent (13.6 per cent Māori; 7.6 per cent Pacific) during the previous year.

The directorate continues to actively engage with union partners. Regular (minimum monthly) union organiser and delegates hui (meetings) are held to discuss key issues and resolve any challenges. These are also opportunities for delegates to provide suggestions and support key initiative across the directorate. The hui (meetings) are usually well attended and positive. FIRST Union has recently initiated bargaining for their collective agreement, primarily covering staff working in the orderly service.

4. Digital Transformation

The orderly service rely on a 20+ year old system to request and track orderly requests. The software is beyond service support and requires replacing. A comprehensive business case has been developed and will shortly be presented to Board for consideration.

The live dashboards in place, now covering all areas of the hospitals (adults, children's, maternity and mental health) have made a considerable difference to daily operational decision-making. They have improved the quality of decisions made and the speed at which information is available to support decisions. Focus continues on data accuracy and timely input of information at source.

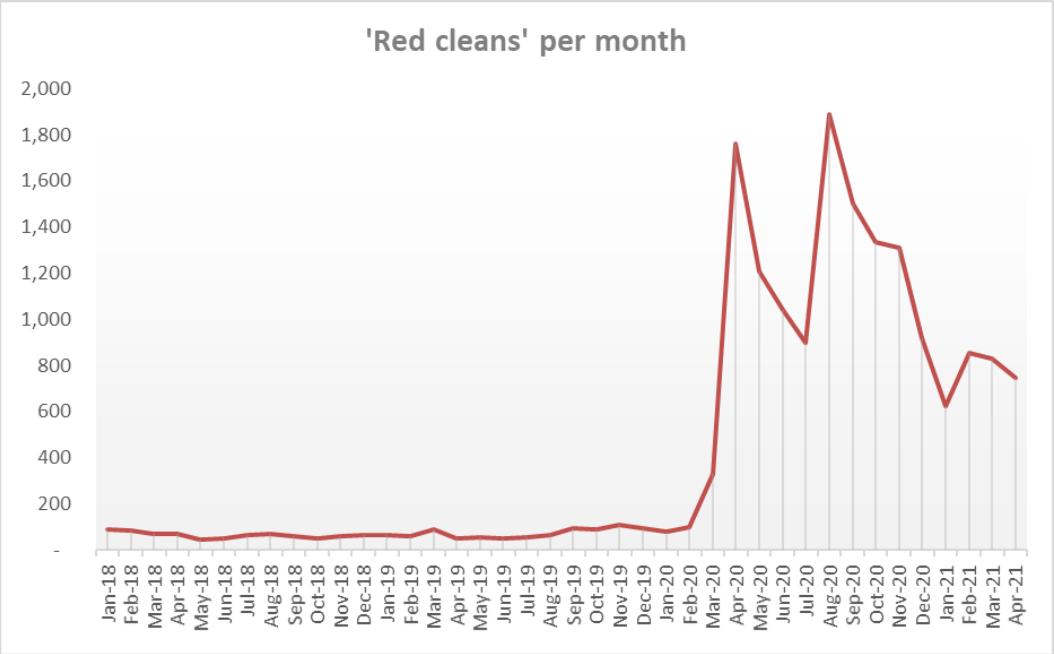
The health information and technology team are support Patient Management Services with the automation of 'POP packs' currently produced by the production planning team for directorates. Moving to an automated and self-service model will significantly reduce the collation team on the production planning team, improve access to information for clinical services and build operational planning capability within directorates. It is expected that the roll-out will occur over the remainder of the 2021 year.

5. Resilient Services

Many of the directorate's services could be described as support services, and there can sometimes be delays for service to respond to changes in demand. To improve planning across services, demand modelling has been conducted for the orderly service. This has identified days and times of peak demand, enabling the roster to be adjusted to better match this.

The cleaning service has seen one of the largest increases in demand due to COVID-19. Despite this audit performance remains relatively positive. For April 89.5 per cent of areas achieved the audit performance relevant for their area (91 per cent in March). The number of 'red cleans' – requested for spaces used by most infectious or suspected to be infectious patients – significantly increased during 2020, from an mean of 73 per month during 2019 to a height of 1,890 in August 2020. Despite reducing slightly more recently, the number of red cleans requested has not reduced to pre-

COVID-19 levels. Whilst it is unlikely that the demand on the cleaning service will reduce to that seen prior to COVID-19, work is on-going to review the usage of red cleans as well as how the team is structured to enable rapid response to areas requesting additional cleaning.



Patient Management Services are also involved in work to improve patient flow and safety over winter. This will include additional Patient At Risk (PAR) staff and resource Staff (Nurses and Health Care Assistants).

6. Financial Sustainability

STATEMENT OF FINANCIAL PERFORMANCE
Patient Management Services

Reporting Date: Apr-21

($000s)	MONTH			YEAR TO DATE (10 months ending Apr-21)		
	Actual	Budget	Variance	Actual	Budget	Variance
REVENUE						
Government and Crown Agency	1	5	(4) U	88	50	38 F
Funder to Provider Revenue	0	0	0 F	0	0	0 F
Other Income	88	82	6 F	866	818	48 F
Total Revenue	**88**	**87**	**1 F**	**954**	**868**	**86 F**
EXPENDITURE						
Personnel						
Personnel Costs	2,924	3,032	108 F	26,599	27,706	1,107 F
Outsourced Personnel	122	4	(118) U	1,183	42	(1,141) U
Outsourced Clinical Services	0	0	0 F	0	0	(0) U
Clinical Supplies	32	42	10 F	450	443	(7) U
Infrastructure & Non-Clinical Supplies	366	292	(74) U	2,861	2,844	(17) U
Total Expenditure	**3,444**	**3,370**	**(74) U**	**31,093**	**31,036**	**(56) U**
Contribution	**(3,356)**	**(3,283)**	**(73) U**	**(30,139)**	**(30,169)**	**29 F**
Allocations	(68)	(65)	3 F	(674)	(652)	23 F
NET RESULT	**(3,288)**	**(3,218)**	**(70) U**	**(29,465)**	**(29,517)**	**52 F**

Paid FTE

	MONTH (FTE)			YEAR TO DATE (FTE) (10 months ending Apr-21)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	0.3	0.5	0.3 F	0.3	0.5	0.3 F
Nursing	80.9	84.3	3.4 F	80.3	84.3	4.0 F
Allied Health	0.0	0.0	0.0 F	0.0	0.0	(0.0) U
Support	312.6	316.2	3.6 F	320.2	318.0	(2.2) U
Management/Administration	53.2	57.8	4.6 F	51.7	57.8	6.1 F
Total excluding outsourced FTEs	**446.9**	**458.8**	**11.9 F**	**452.4**	**460.6**	**8.2 F**
Total :Outsourced Services	7.9	0.0	(7.9) U	10.1	0.0	(10.1) U
Total including outsourced FTEs	**454.8**	**458.8**	**4.0 F**	**462.5**	**460.6**	**(1.9) U**

Year to date result is $52K favourable despite the small unfavourable FTE variance to budget. There are no material variances to comment on as Patient Management Services is tracking close to budget and is expected to do so at year end.

Leave management remains a key focus for the directorate. Waste costs continue to be an area of concern with price and volume being higher than budget. There are other cost pressures within the directorate, however these are largely being managed across the directorate's overall budget this financial year. Further investment in some services, particularly to support increased demand on hospital services has been included in the 2021/22 budget setting round but remains subject to further discussions and prioritisation.

7. Scorecard

Auckland DHB - Patient Management Services

HAC report for April 2021

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

Safety

Metric		Actual	Target	Previous
Medication errors with major harm	PR215	0	Lower	0
Number of falls with major harm	PR199	0	Lower	0
Number of reported adverse events causing harm (SAC 1&2)	PR084	0	Lower	0
Areas audited passed the cleaning audit standard relevant for their area	PR795	89.54%	>=90%	91.45%
High risk areas achieved 100% cleaning audit compliance	PR796	90.29%	>=90%	90%
Proportion of shift requests filled by the temporary Staffing Bureau	PR797	72.67%	>=85%	71.21%

Timeliness

Metric		Actual	Target	Previous
Bed request from adult level 2 to bed allocated within 30 minutes	PR798	R/U	>=80%	R/U
Orderly service – jobs completed within 30 minutes of request	PR799	72.24%	>=80%	74.78%
Transit nursing – jobs completed within 30 minutes of request	PR800	59.43%	>=80%	64.2%

Effectiveness

Metric		Actual	Target	Previous
Percentage of target staff attendance through service POP meetings	PR801	92.16%	>=90%	90.2%
Adult hospital occupancy forecast accuracy	PR802	87.8%	>=90%	87.99%

Efficiency

Metric		Actual	Target	Previous
Staff residence occupancy	PR803	76.8%	>=70%	76.8%

Equitable: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Safety: Avoiding harm to patients from the care that is intended to help them.

Patient-centred: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

Timeliness: Reducing waits and sometimes harmful delays for both those who receive and those who give care.

Effectiveness: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).

Efficiency: Avoiding waste, including waste of equipment, supplies, ideas, and energy.

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.

R/U Result Unavailable

Bed request from adult level 2 to bed allocated within 30 minutes

Results Unavailable

Āhua Tohu Pōkangia - Perioperative Services

Prepared by: Nigel Robertson (Interim Director, Perioperative Services); Wendy Guthrie (Interim General Manager); Elizabeth Kanivatoa (Nurse Consultant); Leigh Anderson (Nurse Director); Prue Hames (Associate Nurse Director); Jay van der Westhuizen (Specialist Anaesthetist); Kate Birrane (HR Manager); Alison West (Finance Manager)

Speaker: Nigel Robertson (Interim Director, Perioperative Services)

1. Te Tiriti o Waitangi in Action

Kāwanatanga

Kaupapa	*Tātou mahi tahi (Our work together)*	*Current status*	*Target state*
Tikanga whakaaro - Governance	**Te Tiriti Article 1: Governance. Ensuring Māori oversight and ownership of decision making processes necessary to achieve Māori health equity. Active partnerships with iwi and Māori communities will ensure that Māori health equity drives, and Māori knowledge informs, the work that we do at Te Toka Tumai**	• Process redesign of having leadership opportunities side by side with appropriate Tika Rōpū members such as interviews for anaesthesia fellows/SMOs • Te Kaa education / Mana whenua cultural competency course for leadership	• Process by next intake of interviews July/August 2021 • Interviews questionnaire review by July 2021 as to aiming for equity need and understanding of equity • Te Kaa- plan to participate by 2021 November
Kaiārahi Nāhi	Fast pathway to planned care in clinics and preadmission -prioritising and waiting time evaluation. Regular review of waitlist and working towards transparency for patients as to where they are in the process with more regular communication. Analysis of barriers to proceed to surgery- identifying and optimising health related barriers to surgery. Working closely with Kaiārahi Nāhi.	• Sharing of success stories and patient experiences with all teams • A/W review of service as to next steps and collaboration • Getting feedback from Kaiārahi Nāhi as to improvements for our service	• Getting up to date reports and utilising barriers to improvement plans by August 2021. Strengthening relationships with Kaiārahi Nāhi • Implementation of improvement plans July 2021 • Asking for Kaiārahi feedback into our processes being part of redesign
Te Reo	Perioperative leaders booked onto Te Wānanga o Aotearoa –Tikanga Papa Reo course to build up knowledge of Te Ao Māori to use every day with staff and patients.	• Using greetings with staff and in emails • Reorua/Bilingual signage in the public spaces and on OR doors • To discuss with GM Māori regarding toi/art for the OR areas. • Wananga for te reo	• In progress with leadership • Action points for Tika Rōpū • Plan for Toi/art work and more permanent signage by September 2021
Ko Awatea	Engaging with Māori training day to be added to mandatory learning for all staff.	• Review of mandatory training for staff. Managers to follow up completion of	• Better staff engagement in Ko Awatea learning • Monitoring of learning

Kaupapa	*Tātou mahi tahi (Our work together)*	*Current status*	*Target state*
		• All leadership to complete Leading for Equity Ko Awatea Learn & face to face training	modules from Kiosk by August 2021 • KPIs set for mandatory training

Tino Rangatiratanga

Kaupapa	*Tātou mahi tahi*	*Current status*	*Target state*
Tikanga whakaaro: ***tino Rangatiratanga***	**Te Tiriti Article 2. Self-determination. Creating opportunities for Māori leadership, engagement and co-design across all of our activities at Te Toka Tumai, especially those with the potential to impact Māori health**	• Membership of Tika Rōpu at interview processes and selections processes for new roles • Equity lens on programmes currently in place and opportunities to be redesigned • Commitment to rangatahi programme/cadetship and providing, health experiences and insights into the patient journey Cultural advocacy for Māori candidates for roles	• Processes in place by November 2021 • Continued support and engagement with rangatahi program and cadetship initiatives encouraging a health career / employment within Perioperative service.
Equity immersion	Āhua Tohu Pokāngia Tika rōpū created from perioperative Māori workforce hui. Whakawhanaungatanga with 7 members working on creating space for equitable opportunities /processes for perioperative services. Using hui kawa from Tika rōpū to be used in each member's own forums. Starting and ending hui with karakia, whakawhanaungatanga-using pepeha. Leadership using tikanga in any space to demonstrate the direction and role modelling to their teams. Education on tikanga given from Tika Rōpū members at in-service education schedules and sharing the kaupapa of our rōpū. **CHALLENGES**: trying to get communications out and connecting to all our people.	• Achieving equity prioritised. • Increased membership of Tika Rōpū to include all our areas and more people to disseminate our kaupapa and assist equity mahi. • Hui kawa/meeting protocol • Leadership role modelling hui tikanga and kawa as normalisation • Having an equity lens on our mahi • Being more connected with the staff at the clinical frontline • Equity role has been discussed as a complementary to building profile of shifting equity challenges	• Monthly action points seen by staff • Design about communication strategies to reach all our people • Senior nurses working in the OR to impart leadership actions with front line kaimahi • Disrupting/dismantling bias, discrimination, racism with interjecting with solutions, education sessions and work from Leading for Equity Ko Awatea learn module • Equity role plan by August 2021

Kaupapa	*Tātou mahi tahi*	*Current status*	*Target state*
Optimal health for surgery	The required HbA1c level and hypertension management for optimal non-urgent elective surgery working with the improvement team to reach out to the community and the GP's to commence optimisations earlier in the patient's surgical pathway-upon FSA.	• Project team established to analyse barriers to planned care , including GP, diabetes specialist and whānau/ consumer advocate • Wrap around services and pre emptive referrals involved • Pathway cancellations report to send data straight to Kaiārahi Nāhi rōpū • Kaiārahi getting involved - early in the perioperative pathway	• Reduce deferral or suspension of planned care and improve patient care through early intervention • Follow up with patients affected by cancellations in a timely manner, community supports • Communication trails with GP, scheduler documented interventions so able to be tracked
Surgery cancellations	Data showing higher rates of day of surgery cancellations in Māori. Having data sent straight from data analysts daily and weekly to Kāiarahi Nāhi rōpū of surgery cancellations for Māori. **OPPORTUNITIES:** To keep working towards reducing cancellations for Māori patients.	• Process established to refer Māori patients cancelled for surgery to navigators • Data collection improved showing the data and raising profile of how we are doing with cancellation rates is improving. Working on an improvement plan to reduce cancellations	• Reduced cancellations in Māori to be reported on monthly or quarterly- July 2021 targeting services with larger issues • New pathways through pre-admit, messaging and scheduler education and whānaungatanga • Senior nursing to assist to reduce surgery cancellation when staffing issues likelihood to cause cancellations

Ōritetanga

Kaupapa	*Tātou mahi tahi*	*Current status*	*Target state*
Tikanga whakaaro-Ōrietetanga	**Te Tiriti Article 3. Equity. Demonstrating our performance in the pursuit of Māori health equity for key Māori health areas. Presenting meaningful and insightful information to Māori will support, guide and target our work at Te Toka Tumai to make advances in Māori health**	*Utilising data through HR to show our employment and retention rates*	• MoH equity posters up in spaces • Equity focus on top of agenda of quality hui
Prioritisation visible	Patients who are prioritised are identifiable on every OR elective list and all clinicians should understand coded data and provide the care that is needed to enhance Māori health outcomes.	• Patient booking grids reviewed and improved. E4P will reduce gaps in booking and scheduling • Review of prioritisation regularly and ensuring on all elective lists	• All Māori patients prioritised appropriately and with clarity • Prioritisation placed onto operating room elective lists, unsure as to acute management.
Review of pre-admit clinics	Strategies initiated with text messaging, letters about surgery on day.	• Fast tracking triage opportunities identified and implemented	• Engaged with navigator team. Clear understanding of pre-admit process for

Kaupapa	*Tātou mahi tahi*	*Current status*	*Target state*
			patients • All patient information available in Te Reo Māori • Whakawhānaungatanga between planned care navigators

Te Ritenga

Kaupapa	*Tātou mahi tahi*	*Current status*	*Target state*
Tikanga whakaaro: Te Ritenga	**Te Tiriti Article 4. Right to belief and values. Honouring the beliefs and values of Māori patients, staff and communities. The services we fund and provide at Te Toka Tumai honour the right of Māori to practise tikanga Māori**	• Being open to providing and referring to services to enable recognition of rights and beliefs and practising Tikanaga Māori with karakia/blessing when and where suitable for patient/whānau. • Disrupting/dismantling any kōrero that shows disrespect and addressing front on with kaimahi. Providing education	• Whole team involved adding values and beliefs in culturally safe care package. • Clinician-patient interaction through the hui process and embedded in Tikanga Māori. Gaining insight into patient's life and drawing meaning, asking what they need from service. • Allowing sharing of self and reducing power imbalances, using uplifting language with actions.
Tikanga practices	Karakia being respected alongside the OR team working with the patient. Karakia conducted on the ward or in the OR so team looking after patient included in tikanga practice of karakia. When karakia occurs in the OR this is conducted before the sign in (surgical safety checklist component).	• Already in practice for some hui- mostly leadership hui, forums and ADHB pain service study days • Quality team setting up process for the ORs • Efforts by staff to respect cultural requests and team able to meet these needs with ward and whānau	• Surgeons leading this to date • Whanāungatanaga in the OR in te reo Māori • SSH asked for signage on whiteboard • Support staff how to coordinate this care
Whānau support	Whānau support is optimised in all settings.	• Extending to the needs of the patient with whānau alongside journey • Whānau included in care in a partnership role	• Maintain and enhance current practice • Support person for local cases in the OR, PACU lines • PACU a place of a healing destination
Forensics instrumentation	Instrumentation pathways follow Tikanga best practice.	• Issue identified in April 2020 and reviewed with clinical support • Forensics have stopped previous practice through SPSS • Donor retrieval instruments used in other hospitals to find a process to close the	• Mutually agreeable solution agreed and enacted • Ongoing SPSS support to find a suitable solution for forensic instruments by February 2021- resolved

Kaupapa	*Tātou mahi tahi*	*Current status*	*Target state*
		loop of a karakia/blessing before return instruments to SPSS	• Work on solutions with transplant teams by August 2021
Care of Tūpapaku	Māori tikanga alongside Te Toka Tumai guidelines for care of Tūpapaku. Tūpapaku not to be left alone. Whānau able to view their loved one in an appropriate space and be with them with their whānau. Karakia /blessing performed upon patient leaving the OR to honour and respect the patient and whānau , staff involved and all the future patients who will use the OR (tapu and noa).	• Already in practice but requires ongoing staff education and review of information pack • Tikanga upheld for tūpāpuku and karakia in OR. • Whānau made welcome part of process in private area	• Maintain and enhance current practice • Frontline staff conducting karakia/blessing • Tūpāpuku resource box with standardised blessing • Care of deceased updated as SOP resource for SSH 2020

2. Eliminate Inequity

Tikanga	*Tātou mahi tahi*	*Current status*	*Target state*
ADHB Values	**Welcome – Haere Mai** **We are welcoming of patients and their families/whānau/supporters at all times.** We greet patients and their familes/whānau in a manner that is culturally appropriate. We use 'equity-based practice' to work with families/whānau to identify and support what is already working well for them and to build on these. **Challenges**: Level of understanding of Te Ao Māori not up to level it should be.	• Immerse into staff orientation • Used in professional development discussions • Make space for whānau – think about empowering not disempowering activities • Māori worldview alongside Pākehā worldview	• Advertise the values poster and the behaviours that are expected with these values • Place values and education fundamentals and get new people to read on line • Use the values to speak to with challenging conversations and in professional development 1:1 opportunities
	Respect – Manaaki **We respect people's inherent dignity and the responsibility we have to act in a way that is caring and respectful of others' beliefs and culture.** We partner with patients and their families in all aspects of care, and support patients and their families/whānau to identify goals and care aspirations. We champion the voice of patients and families/whānau at all levels of organisational decision-making. We work	• Living our ADHB values in all our mahi	• Tikanga Māori with manaakitanga improving coordination of care and communication so patient/whānau not adversely affected by our processes • Assisting each other across the directorate when needed to provide optimum patient safety and culturally safe care • Strengthen staff training through Ko Awatea. Links to primary and iwi based

Tikanga	*Tātou mahi tahi*	*Current status*	*Target state*
	in partnership with the women and their families/whānau in a relationship of trust, shared decision-making and responsibility, negotiation, and shared understanding.		organisations • Consolidate and embed the Tika rōpū's recommendation into business as usual.
	Together – Tūhono **We encourage and welcome togetherness, and family/whānau involvement in the planning, implementation and evaluation of care.** We support patients and families/whānau to navigate the healthcare system and create the opportunity to gain confidence in our service and care. We ensure that a patient's safety is a significant consideration in their healthcare journey and that where patients are unable to voice their concerns, families/whānau/supporters can act in their interests.	• Using concept and waiata of "Tutira mai ngā iwi "to extend unity and collectivism	• Checking on Leading for Equity, Just Culture, attendance by end of May • Whakamaua health report • HQSC Window into Pacific Health due at the end of May
	Aim High – Angamua **We aim to provide patient and family/whānau centered models of care that deliver the outcomes important to patients and their families/whānau**. We ensure the needs of patients and families/whānau are at the centre of new developments in service design and provision. We work in collaboration with colleagues to explore innovative models of practice that improve patient and family/whānau determined. Outcomes, and redress inequalities in access and service provision.	• Celebrating our successes and sharing with all our people. • Aiming to understand concepts of Te Whare Tapa Whā • Look at the Meihana Model for clinician/patient interactions	
Wellness	Development of information on perioperative/anaesthesia web pages and the identification of staff welfare officers within each department.	• Incorporate the Kia Ora Tō Wāhi Mahi - look at tool - to fit with our team	
Planned care Māori and Pacific nurse specialist navigators	Whanāungatanaga - Building relationships and working closely with these	• Continue to strengthen relationships • Learn and share the	• Await review of service and see where we can work together moving

Tikanga	*Tātou mahi tahi*	*Current status*	*Target state*
	teams. Getting expert cultural specific nursing advice on how to achieve equity and what we can do better. Appointments this quarter (December 2020 to February 2021) have included five Māori and eight Pacific Peoples). Appointments for Pacifc candidates are at a higher rate than the rate of applications for the priority pools. This is the desired approach to increase representation in the workforce for both Māori and Pacific. Perioperative Directorate has this quarter increased its representation of Pacific employees to 75 from 67 Pacific employees last quarter and and the represention of kaimahi Māori (staff) has increased to 24 from 20 last quarter. The **Leading for Equity** training programme has been completed by 3 of the 42 People Leaders in the Perioperative Directorate. Directorate senior leaders are aware of their reponsibility to complete the training programme and we will continue to monitor, actively encourage completion and report on progress.	barriers for our Māori and Pacific patients • Role modelling Māori and Pacific staff in their professional groups, build relationships with Rangatahi programme leaders and Health Sciences Academy for secondary students to advance study into health science careers and towards Health Sciences and Rangatahi cadetships • Further explore benefits of Nurse Practitioner roles in pre-assessment and Pain clinics and the potential to link these into Te Toka Tumai's Kaiārahi Nāhi and the Pacific planned care navigation teams	forward • Receiving feedback as to where we can apply actions for improvements • Māori and Pacific patients are prioritised so that perioperative care is delivered to patients in an equitable way • Māori and Pacific staff numbers rise to reflect greater equity in recruitment
Welcome greeting words	Poster to be placed in clinical areas, ORDA , pre-op in regard to identifying Māori and Pacific ethnicity on front sheet and matching by using appropriate greeting. This reaffirms the haere mai ADHB value- I welcome you, I see you and your whānau are welcome too.	• Start using greeting words • Post up "greet people in their language" poster created by GSU CN and team administrator	• Kaimahi to use appropriate welcome words and to ask about pronunciation of patient's whānau name
Pronunciation of Māori and Pacific names	Asking how to say a person's name and making the effort to say it. Using the Māori AkeAke app to learn sounds. Not	• Don't be whakamā to korero Māori	• Active participation by teams to try to kōrero names and greetings

Tikanga	*Tātou mahi tahi*	*Current status*	*Target state*
	feeling whakamā (ashamed/shy) to speak Māori, encouraging and supporting learning te reo.		

3. People, Patients and Whānau at the Centre

Tātou mahi tahi	*Current status*	*Target state*
• Invest in a greater range of supports that 'stand beside' patients and whānau, and actively support self-directed care. • Connections and partnerships exist with communities, to achieve shared health service planning and delivery, focussed on areas and groups with the highest need (our localities approach). • Improve experience by partnering with people and service users in the design, in the delivery and evaluation of services (co-design).	• Surgical & Perioperative Service Review – contributed to Discovery Report for Te Toka Tumai (ADHB) • Pre-assessment clinics initiatives • Caring for our workforce under current initiatives of the 'To Thrive Program' at Sterile Sciences Processing Services (SPSS). • Texting patient booking information (BAU) at Greenlane Surgical Unit. • Working with deteriorating patient pathway project – introducing EWS (Early Warning Score) in PACU • Bi-lingual signage implemented	• New ways of working and structures supporting the themes, opportunities and vision statements of the review are embedded. • Creating extended roles to support the patients through their surgical journey i.e. nurse prescribers x1 appointed for Level 9 pain team. • Sterile Sciences Processing Services (SPSS) is safe, effective and fit for purpose and embeds the 'To Thrive programme' outcomes • Plan to roll out to Level 8 ORDA patients • EWS/MEWS/PEWS/NEWS applied to all patients prior to discharge in PACU • Multi-translated documents and video's to support better informed tāngata whaiora and whānau.
• Patient preparation for surgery is flexible. Tele health used optimally. Patients and whānau find navigating process easy and this results in optimal outcomes.	• Working with Kaiārahi Nāhi rōpū to develop better pathways and navigation of process. Establishing better partnerships with primary care and iwi- based healthcare • Exploring nurse practitioner, nurse specialist and nurse prescriber roles	• Better compliance on wait times for surgery, fewer late cancellations and better surgical outcomes for Māori • Enhancing relationships with the navigation teams and reviewing benefits of senior nursing roles.

4. Digital Transformation

Tātou mahi tahi	*Current status*	*Target state*
• Insights and Intelligence - enhance data management and data analytics (Digital Health Services) • Integrate care solutions – digital solutions that support integrated care • Core clinical systems – integrated paper-lite core clinical information systems • Workforce and Business systems – enhance tools to foster organisational effectiveness	• Working to improve data veracity to reduce poor decision-making and information 'WT16'. Using 'WT25' for visibility on pre-admission bookings • Using systems that are cumbersome that are not well integrated and require transcribing information, resulting in ongoing risk and impact on efficiencies and safety • Commenced setting up tele health in anaesthesia pre-assessment clinics and pain service • SSPS/OR project - Introduction of Single Instrument Tracking (SIT) and implementation to Neuro service • Implemented the SAFERSleep	• Tele health in anaesthesia pre-assessment clinics extended. • Safer sleep maternity module in place across delivery suite and theatres • Data utility across Perioperative services improved and drives services decisions. E.g Equity cancellation trend report • e4P and perioperative pathway technical patient management platforms are embedded • Single Instrument tracking enabled across the service • Technically enabled systems to support Perioperative pathways • Enable the successful development of the digital components of the Surgical Integrated Operations Centre and

Tātou mahi tahi	*Current status*	*Target state*
	module for pain service • Exploring software platforms to support patient pathways including planned care bookings • Patient pathway digital project underway.	the Elective Preoperative Patient Preparation Pathway.

5. Resilient Services

Tātou mahi tahi	*Current status*	*Target state*
• Deliver safe and flexible health care with our population in the Covid-19 pandemic response. • Deliver sustainable benefits from the agile and rapid adaption programmes across the provider, focussing on step-change. • Implement agreed continuous improvement initiatives. • Deliver regional approaches in planned care, including changes to vulnerable services and gains in the equity pathways. • Deliver large scale capital investments on time and budget.	• SCRUM process linked to SIOC projects provides a transparent and collaborative approach including all work streams integral to the patients surgical journey versus single use instruments • Providing training and education fit for the workforce and the roles they work in, including COVID training • Planning for flexible workforce across nursing and allied health teams • Ongoing SSI(Surgical site infections) and hand hygiene projects within the quality team • Working to maximise use and utilization of OR sessions for planned care • Increasing OR weekend sessions to accommodate increased acute workload. Weekend capacity has been increased as of April 2021. • Review ability to continue providing safe service during digital platform failure • Budget FTE approved for addressing kidney transplant cases in the weekend impacting on acute service.	• SIOC process matured to determine efficiency and effectiveness to prioritise strategic allocation of services. • Additional training and occupational health mandatory requirements are built into MOC • 5 Registered Nurse Anaesthetic Assistants to start in June. Pilot for Anaesthetic Technicians expanding into PACU in September. Model Of Care uplifts completed for all departments • Achieve national benchmarks for Surgical Safety checklists, SSI and hand hygiene quality KPIs • 6 day operating service embedded at GSU and Level 4 as BAU • Monitoring and review of benefits of increased weekend acute sessions • Resource kits available in each dept.

6. Financial Sustainability

Tātou mahi tahi	*Current status*	*Target state*
• Delivering our services within budget. A focus on service improvement which adds value to our patients and stakeholders.	• Capex process that is robust and transparent for equipment, instruments and facilities • Ongoing review of costs for repairs and replacements • Continually monitoring and working within our budget • Contributing to planned care projects • Managing leave balances • Managing FTE and impacts of PVS changes	• Major capex projects, long-term and fleet replacement projects identified and planned • Ongoing replacement of all significantly ageing/failing major equipment items on capex list by Q4 2020/21 and 2021/22 FY. • FTE/ budget balanced and congruous • Cost savings and efficiencies identified • Excess leave balances identified and managed • Manage risks of global shortage and supply chain

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 Apr-21

($000s)	MONTH			YEAR TO DATE (10 months ending Apr-21)		
	Actual	Budget	Variance	Actual	Budget	Variance
REVENUE						
Government and Crown Agency	176	172	4 F	1,796	1,725	71 F
Funder to Provider Revenue	7	16	(8) U	110	166	(56) U
Other Income	29	17	12 F	521	170	350 F
Total Revenue	**212**	**205**	**7 F**	**2,427**	**2,061**	**366 F**
EXPENDITURE						
Personnel						
Personnel Costs	8,787	9,170	384 F	85,578	87,109	1,531 F
Outsourced Personnel	60	71	11 F	617	710	93 F
Outsourced Clinical Services	0	0	(0) U	3	1	(2) U
Clinical Supplies	3,627	3,333	(293) U	36,295	35,416	(879) U
Infrastructure & Non-Clinical Supplies	146	149	3 F	1,543	1,484	(59) U
Total Expenditure	**12,620**	**12,724**	**103 F**	**124,035**	**124,719**	**684 F**
Contribution	**(12,408)**	**(12,519)**	**111 F**	**(121,607)**	**(122,657)**	**1,050 F**
Allocations	19	11	(8) U	185	126	(59) U
NET RESULT	**(12,427)**	**(12,530)**	**103 F**	**(121,793)**	**(122,784)**	**991 F**

Paid FTE

	MONTH (FTE)			YEAR TO DATE (FTE) (10 months ending Apr-21)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	146.8	145.3	(1.5) U	147.6	144.5	(3.1) U
Nursing	396.7	430.6	34.0 F	399.3	426.0	26.7 F
Allied Health	113.6	112.2	(1.4) U	106.3	111.5	5.2 F
Support	104.4	115.3	11.0 F	105.8	115.3	9.5 F
Management/Administration	23.7	13.7	(10.0) U	23.5	13.7	(9.8) U
Total excluding outsourced FTEs	**785.1**	**817.1**	**32.0 F**	**782.5**	**811.0**	**28.5 F**
Total :Outsourced Services	2.8	0.0	(2.8) U	3.4	0.0	(3.4) U
Total including outsourced FTEs	**787.9**	**817.1**	**29.2 F**	**785.9**	**811.0**	**25.1 F**

Comments on major financial variances

Volumes

Table 1:

Perioperative Theatres (Excl SSOR)	Year to date				
	Actual	Budget	Variance to budget	Prior year Actual	Variance year on year
Minutes	3,029,345	3,006,576	100.8%	2,894,306	104.7%
Cases	30,655	31,764	96.5%	29,937	102.4%
Cost per minute	$ 40.20	$ 40.84	98.4%	$ 39.74	101.2%
Average minutes per case	98.8	94.7	104.4%	96.7	102.2%
Median minutes per case	70.0	76.0	92.1%	76.0	92.1%

Year to Date

The result is $991K F favourable for the year to date.

Production is slightly ahead of plan YTD in minutes 101% and cases are behind at 96.5%. This indicates that although fewer cases have been completed, they have been more complex. Average minutes per case are over budget 104.4%.

Revenue

- Other Income is $350K F due to equipment donations and salary recharges.

Expenditure

- Personnel costs are $1,531k F YTD with the main drivers being:
    - budgeted savings targets $798K U
    - Medical Costs $111k U due to over recruitment in Fellows and House Officers,
    - Vacancies in Nursing $1,231k F and Allied Health $750k F
- Clinical supplies spend $879k U YTD. The main drivers being:
    - Instruments & Equipment $1,024k U from high repair costs and servicing of aging equipment. Reviews are underway of repair costs and mitigations with a focus on handling and alternatives for equipment with high breakages. Loss on disposal of scopes requiring replacement before end of useful life.
- Infrastructure costs are $59K U with the main drivers being:
    - Consultants fees fir Surgical and Perioperative Review $22k U
    - Stationery & Printing $29k U

The actual cost per minute (Table 1) YTD is $40.20 against a budget of $40.84. Favourable variances in Personnel and Revenue offsetting clinical supplies overspend along with a small increase in production minutes, are responsible for this favourable result.

Table 2 below demonstrates the cost per minute for all theatres across ADHB provider.

Including Starship OR's, results in an overall theatre cost of $38.45 per minute against a budget of $38.88

Table 2

All Theatres (Incl SSOR)	Year to date				
	Actual	Budget	Variance to budget	Prior year Actual	Variance year on year
Minutes	3,690,770	3,669,888	100.6%	3,519,673	104.9%
Cases	38,961	40,766	95.6%	37,785	103.1%
Cost per minute	$ 38.45	$ 38.88	98.9%	$ 38.12	100.9%
Average minutes per case	94.7	90.0	105.2%	93.2	101.7%
Median minutes per case	67.0	72.0	93.1%	72.0	93.1%

7. Scorecard and Exceptions

Auckland DHB - Perioperative Services

HAC report for April 2021

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

Safety

Metric		Actual	Target	Previous
Medication errors with major harm	*PR215*	0	Lower	0
Number of reported adverse events causing harm (SAC 1&2)	*PR084*	0	Lower	1
% Hand hygiene compliance	*PR195*	**85.7%**	>=80%	82.37%
Wrong site surgery	*PR255*	0	Lower	0

Patient-centred

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

Timeliness

Metric		Actual	Target	Previous
% Cases with unintended ICU / other area stay	*PR258*	**0.65%**	<=3%	0.57%
% CSSD incidents	*PR260*	**3.67%**	<=2%	3.49%
% Acute index operation within acuity guidelines	*PR254*	**79.66%**	>=90%	86.25%

Effectiveness

Metric		Actual	Target	Previous
% 30 day mortality rate for surgical events	*PR259*	**0.64%**	<=2%	0.49%
% Patients with Hypothermia in PACU	*PR271*	**3.16%**	<=1%	1.66%
% Patients with PONV in PACU	*PR272*	**2.47%**	<=5%	2.49%

Efficiency

Metric		Actual	Target	Previous
% Elective sessions planned vs actual	*PR261*	**94.94%**	>=97%	95.94%
% Adjusted theatre utilisation - All suites (except CIU)	*PR262*	**86.09%**	>=85%	85.04%

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

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

Scorecard Commentary

- There were 5 medication incidents reported for April 2021. 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.
- Ringa Horoia - Hand hygiene compliance is good overall at 85.7%.
- There were no open complaints for Perioperative services for April 2021.
- 2 Severity Assessment Code (SAC 1) incidents, and 3 always report and review (SAC 3 & 4) were reported in the three months from 1 February to 30 April 2021.
- Recommendations from previous Root Cause Analysis have been implemented. Formal auditing of the surgical safety check list is ongoing, with good rates of engagement and compliance.
- Sterile Sciences Processing Services (SPSS) incidents are up due to production pressure as a result of vacancies. Recruitment is underway.

Exceptions

Kaupapa	***Tātou mahi tahi***	**Current status**	**Target**
Surgical & Perioperative services review	ADHB project to establish a strategic leadership structure for the Surgery and Perioperative Services Information gathering with employees in relation to the Vision statements for the surgical patient care pathway started in September 2020. The Vision statements are: 1. Quality outcomes and experiences for patients, whānau and employees 2. Surgical system designed to achieve equitable outcomes; we deliver on our obligations under Te Tiriti o Waitangi 3. We are united in our commitment and aligned in our approach to the surgical patient care pathway 4. We take a systems approach to optimise long term solutions and eliminate siloed thinking	• Interim Management group leading the directorates and stakeholder process underway • A Discovery Review Group was established with 18 people representing professions across the two directorates to strengthen engagement and validate themes for reporting. • Post the Discovery review report release, co-design was completed with feedback requested from DLTs on two proposed leadership models. This feedback stage was completed with DLTs and a consultation paper will be released in due course.	• Consultation document to be released to the Directorates for feedback in June 2021. • Final recommendations to executive by July 2021

Kaupapa	*Tātou mahi tahi*	Current status	Target
	and behaviour		
COVID-19	Disruption to planned care service. Major risk to staff and anxiety during lock-down. Ongoing complex pathways to manage for actual or potential cases. Planned care recovery now in progress but capacity constraints exacerbated. Staff turnover / hiring impeded by labour market.	• OR's delivering normal to increased volumes. Staff much better trained. Long-term change embedded in practice • Ongoing training program for staff to respond to	• Complete planned care recovery project. Keep staff safe and well in event of another community outbreak • Embed new safe practices for dealing with hazards in the OR • Provision of Health and safety for staff

Surgical Services

Prepared by: Rebecca Stevenson (Interim General Manager)
Speaker: Duncan Bliss (Interim Associate Director)

1. Te Tiriti o Waitangi in Action

Kāwanatanga

- The Kaiārahi Nāhi rōpū (Nurse Navigator group) have been walking alongside our Māori patients on their journey to surgery since this rōpū (group) was established in June 2021. This service was developed to ensure fast pathways for care for Māori and to mitigate the known and exacerbated inequities in the planned care journey for patients and their whānau (family, including extended). The Kaiārahi Nāhi rōpū (Nurse Navigator group) continue to identify opportunities for Surgical Services to improve, learn and redesign services. There is an opportunity to share more patient experience and success stories with all teams across Surgical Services moving forward.
- An evaluation of Kaiārahi Nāhi (Nurse Navigators) is currently being drafted, with a final report due mid-June 2021.

Tino Rangatiratanga

- Two members of our Surgical rōpū (group) are our Champions for Māori patient experience. The role of our Champions include implementing the five truths of a gold standard Māori patient and whānau (family, including extended) experience, monitoring Māori workforce participation and progression in our Directorate, and applying Te Reo (the Māori language and its associated protocols) and Tikanga (Māori protocols or customs) across our Directorate which includes the capability of our workforce to correctly pronounce Māori names and words.
- Since its commencement in March 2021, four surgical staff regularly attend the Kāhui Hononga Network hui (meeting). This is a safe space for kaimahi Māori to showcase Māori intelligence and connect champions of Māori health gains.
- Late cancellations for surgery are currently being looked into at a service level across Surgical Services. The three highest reasons for late cancellations were cancelled by patient, operation not needed and DNA (Did Not Attract/Service failed to engage). We will continue to work with Kaiārahi Nāhi (Nurse Navigators) to support our Māori patients that our services have failed to engage/attract for their surgery and work towards reducing the number of late cancellations of surgery. One change that has been implemented this quarter is to include more information in the booking system to identify our patients who are being supported by Kaiārahi Nāhi (Nurse Navigators) and those who have had their surgery deferred previously to inform decision making.

Ōritetanga

- As reported previously, an equity adjusted weighting tool for surgical booking has been trialled and implemented in the Urology Service. Patients on the waitlist accumulate points for the number of days they have been waiting over the clinically appropriate treatment time. Higher priority patients accumulate more points per day than lower priority. Māori patients receive an

equity adjustor so they accumulate points at a higher rate. The equity adjustor has been added to the waitlist report for the Ophthalmology and Orthopaedics Services and will be implemented over the coming weeks. Ophthalmology and Orthopaedics have been prioritised for implementation due to high volumes and the number of long waiting patients.

- We recognise that significant further work is required to attract Māori whanau to our Outpatient appointments. We will be working with the Kaiārahi Nāhi rōpū (Nurse Navigator group) to improve this part of our service, including seeking to implement Patient Focused Booking.

Te Ritenga

- As a Directorate we see an opportunity to support our teams to complete the 'building cultural safety to achieve Pae Ora' online hub, available via Ko Awatea LEARN. All new Senior Medical Officer appointments in Surgical are being encouraged to complete this training as part of their on-boarding process.

2. Eliminate Inequity

- As reported previously the Patient Access, Booking and Choice policy for Te Toka Tumai (Auckland DHB) is being reviewed by members of the Māori and Pacific Fast Pathway Planned Care Regional Response. The updated policy is due to be presented to the Senior Leadership team in August 2021. Following approval, the revised version will be implemented by Surgical Services.
- The 'Leading for Equity' training programme has been completed by 9 people leaders in the Surgical Directorate. A focus is for all people managers to complete this course next quarter.
- For the Nursing Entry to Practice Registered Nurses intake, Māori and Pacific candidates are prioritised to attend our assessment centres.
- The Pacific Care Navigation team continue to support our Pacific patients on the planned care pathway. This team was established at the same time as the Kaiārahi Nāhi rōpū (Nurse Navigator group) to improve the patient journey, identify and address system issues and barriers to access and reduce the waiting time for our Pacific patients. An evaluation of the team has recently been completed, with findings to be circulated this month.
- We recognise that significant further work is required to attract Pacific and low income patients and families to our Outpatient appointments. We will be working with the Pacific Care Navigation to improve this part of our service, including seeking to implement Patient Focused Booking.

3. People, Patients and Whānau at the Centre

- In order to create capacity and reduce wait times for our patients, particularly in the recovery from COVID-19, outsourcing has commenced or is being considered in Surgical Services. In the Ophthalmology service, offsite clinics on the North Shore have been agreed to proceed. Details are currently being worked through prior to implementation.
- A joint project between General Surgery and Dermatology has commenced to transform the patient pathway for our skins patients. Over 5,000 patients are referred for skin lesion

treatment each year. Many of these patients are eligible for the GP with a Special Interest pathway but are not referred. These patients are instead referred to Dermatology or General Surgery unnecessarily. This results in a delay for patients who require Dermatology and General Surgery from receiving treatment and increasing pressure on both services. Additionally, some patients are referred to multiple services which create duplication and can impact on patient experience. This project aims to create a single point of entry for skin referrals, reduced wait time for treatment, more equitable outcomes with better access to care closer to home, increased capacity within General Surgery and Dermatology, and reduced inefficiencies.

- The MSK-CAT pathway (musculoskeletal clinical assessment and triage team) has been successfully implemented within the Orthopaedic service at Te Toka Tumai (Auckland DHB) in quarter three. The pathway uses the skills of a multidisciplinary team to triage referrals to the right care, whether that is an appointment with an Orthopaedic surgeon, physiotherapist or management in primary care. The pathway includes the establishment of expanded physiotherapy capacity embedded within the orthopaedic service based at the Greenlane Clinical Centre. Priority for the rest of calendar year 2021 will be to continue to embed and expand the pathway.
- Appointments in Surgical Services this quarter have included four Māori (3 Nursing, 1 Administration) and eleven Pacific (5 Nursing, 2 Allied Health and 4 Administration) staff.

4. Digital Transformation

- Surgical Services have recently commenced an options analysis to improve the digital platforms supporting the surgical journey post decision to operate. Progressing patients through their planned care journey and maximising valuable operating room capacity depend on robust digital platforms. These must capture critical patient and facility information, support efficient workflow for clinicians and bookers and provide access to reliable data to inform clinical and operational decisions. Currently the digital platforms supporting this journey are inadequate with key gaps in information capture, lack of key workflow tools, lack of automation, components that don't talk to each other, double/triple handling of information, fragile systems with limited development potential, poor data visibility and frequent manual workarounds. These problems lead to patient delays, rework, inequity, poor facility utilisation and hamper improvement efforts. The goal of this piece of work is to improve the planned care digital platforms to seamlessly progress patients through their surgical journey while enabling the most efficient use of resources. It aligns and supports the current work in SIOC (Surgical Integrated Operations Centre) and E4P (Elective Preoperative Patient Preparation Pathway).
- After a successful proof of concept trial, a business case is also under development related to the Healthcare Logic suite of reporting tools called System View. This package contains a number of useful and easily accessible performance and planning tools related to surgical services. As this platform may be some time away and need further enhancements the SIOC project is also commencing development of some interim surgical dashboards to explore trends and drivers related to use, utilisation, efficiency, rework, and equity.

5. Resilient Services

- Vulnerable Services within the Surgical Services Directorate have been identified as Ophthalmology, ORL, Sarcoma and Auckland Regional Hospital Specialist Dentistry. Plans are in place for each of these services to ensure that they are more resilient moving forward. Progress on implementation of these plans is reported through to the Planned Care Steering Group via Exec Leads for each service.
- The SIOC (Surgical Integrated Operations Centre) weekly meeting provides a transparent and collaborative approach to improve the surgical pathway, improve efficiencies, prioritise allocation of services and maximise the use and utilisation of operating room sessions for planned care.
- Expanded weekend acute service provision for Level 8 has commenced on 1 April 2021 with an additional acute theatre being run Saturday and Sunday. The aim is to reduce the acute load overflowing from the weekend into the beginning of the week, and reduce the likelihood of deferring planned care.

6. Financial Sustainability

Summary Net Result

STATEMENT OF FINANCIAL PERFORMANCE
Surgical Services

Reporting Date Apr-21

($000s)	MONTH			YEAR TO DATE (10 months ending Apr-21)		
	Actual	Budget	Variance	Actual	Budget	Variance
REVENUE						
Government and Crown Agency	548	681	(133) U	7,473	6,808	665 F
Funder to Provider Revenue	26,676	26,111	565 F	271,925	274,168	(2,242) U
Other Income	322	476	(153) U	3,981	4,757	(776) U
Total Revenue	**27,547**	**27,267**	**279 F**	**283,380**	**285,733**	**(2,353) U**
EXPENDITURE						
Personnel						
Personnel Costs	11,197	10,560	(637) U	102,830	98,912	(3,919) U
Outsourced Personnel	419	341	(78) U	4,426	3,410	(1,016) U
Outsourced Clinical Services	556	353	(203) U	4,519	3,534	(985) U
Clinical Supplies	2,670	2,908	238 F	29,054	30,439	1,384 F
Infrastructure & Non-Clinical Supplies	283	265	(18) U	2,860	2,642	(217) U
Total Expenditure	**15,125**	**14,427**	**(697) U**	**143,690**	**138,937**	**(4,753) U**
Contribution	**12,422**	**12,840**	**(418) U**	**139,690**	**146,796**	**(7,106) U**
Allocations	2,955	2,691	(263) U	29,983	28,235	(1,748) U
NET RESULT	**9,467**	**10,149**	**(681) U**	**109,707**	**118,561**	**(8,854) U**

Paid FTE

	MONTH (FTE)			YEAR TO DATE (FTE) (10 months ending Apr-21)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	259.5	242.5	(17.0) U	255.2	241.6	(13.7) U
Nursing	521.9	533.7	11.8 F	513.9	505.7	(8.3) U
Allied Health	42.3	50.6	8.4 F	41.4	49.7	8.3 F
Support	0.5	0.0	(0.5) U	0.4	0.0	(0.4) U
Management/Administration	111.1	104.8	(6.4) U	108.8	103.7	(5.1) U
Total excluding outsourced FTEs	**935.3**	**931.6**	**(3.7) U**	**919.9**	**900.6**	**(19.2) U**
Total :Outsourced Services	13.1	7.5	(5.6) U	14.4	7.5	(6.9) U
Total including outsourced FTEs	**948.4**	**939.1**	**(9.3) U**	**934.3**	**908.1**	**(26.2) U**

Comment on major financial variances

- Surgical Services result is $8,854k U for the year to April 2021.
- The key drivers are personnel costs for Medical $3,406k U and in Nursing $1,601k U, outsourced employees and clinical service $2,002k U and clinical supplies $1,384k F and infrastructure costs $217k U. Revenue YTD is $2,353k U, predominantly under delivery of PV contracts.

Revenue

- Total volumes delivered are 99.4% of contract for the YTD. Demand for acute services is 103.1% and elective volumes at 90% against contract YTD. The revenue adjustment of $2,242k U is reflected in the financial result for Funder to Provider revenue, recognizes the under delivery to

end of March 2021. Non-resident revenue is $158k F for the year to date.

Expenditure

Expenditure including Internal Allocations $6,501k U. The key drivers to the result are;

- Personnel costs are $3,919k U mainly driven by:
    - Resident Medical Officer $1,974k U covering over allocations and additional duties
    - Nursing $1,601k U due to the need for patient attenders to monitor high acuity patients. Nursing FTE calculations under Care Capacity & Demand Management (CCDM) are almost complete and implementation and recruitment is underway.
    - The Annual leave impact $202k U
- Clinical supplies $1,384k F mainly due to:
    - Instruments and equipment $125k U due to high repair costs and increased use of disposable instruments
    - Implants & Prostheses $1,131k F under delivery of elective PV volumes
    - Pharmaceuticals $412k F driven mainly by volume and case mix
- Infrastructure costs $217k U
    - Bad debt write offs and provisions against non-resident billing $102k F
    - Cleaning supplies $68k U and
    - Medirota and clinical audit software licenses $230k U
- Internal Allocations $1,708k U, driven mainly by
    - Interpreters $380k U
    - Lab testing $298k U and
    - Radiology imaging including MRI $1,022k U.

7. Scorecard and Exceptions

Auckland DHB - Surgical Services

HAC report for April 2021

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

Safety

Metric		Actual	Target	Previous
Medication errors with major harm	PR215	0	Lower	0
Nosocomial pressure injury point prevalence (% of in-patients)	PR097	0%		3.2%
Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	PR185	2.8%		3%
Number of falls with major harm	PR199	3	Lower	0
Number of reported adverse events causing harm (SAC 1&2)	PR084	5	Lower	0
Unviewed/unsigned Histology/Cytology results >=30 days	PR596	59	Lower	65
% Hand hygiene compliance	PR195	86.55%	>=80%	86.55%

Patient-centred

Metric		Actual	Target	Previous
% Patients cared for in a mixed gender room at midday - Adult	PR175	52.01%	TBC	49.98%
% hospitalised smokers offered advice and support to quit	PR129	98.77%	>=95%	97.5%
% DNA rate for outpatient appointments - Māori	PR057	17.82%	<=9%	18.53%
% DNA rate for outpatient appointments - Pacific	PR058	16.41%	<=9%	17.96%
% DNA rate for outpatient appointments - Other	PR809	5.96%	<=9%	6.66%
% DNA rate for outpatient appointments - Deprivation Scale Q5	PR338	12.54%	<=9%	14.55%
% Very good and excellent ratings for overall inpatient experience	# PR154	84.8%	>=90%	85.2%
% Very good and excellent ratings for overall outpatient experience	# PR179	88.3%	>=90%	87.4%
% Very good and excellent ratings for coordination of care after discharge	# PR493	57.4%	>=90%	56.1%
% Response rate to ADHB patient experience inpatient survey	# PR315	18%	>=25%	25%
Number of CBU Outliers - Adult	PR173	317	<=300	372

Timeliness

Metric		Actual	Target	Previous
31/62 day target - % of non-surgical patients seen within the 62 day target	PR181	91.07%	>=90%	92.66%
31/62 day target - % of surgical patients seen within the 62 day target	PR182	86.67%	>=90%	94.94%
62 day target - % of patients treated within the 62 day target	PR184	89.11%	>=90%	93.62%
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Māori	PR329	30	Lower	25
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Pacific	PR330	35	Lower	31
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Total	PR328	313	Lower	261
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Deprivation Scale Q5	PR332	80	Lower	65
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Māori	PR323	94	Lower	83
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Pacific	PR324	167	Lower	161
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Total	PR327	1,051	Lower	930
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Deprivation Scale Q5	PR326	275	Lower	232

Effectiveness

Metric		Actual	Target	Previous
28 Day Readmission Rate - Māori	# PR079	12.14%	<=6%	10.56%
28 Day Readmission Rate - Pacific	# PR080	10.79%	<=6%	10.13%
28 Day Readmission Rate - Total	# PR078	10.53%	<=10%	11.1%
28 Day Readmission Rate - Deprivation Scale Q5	# PR322	9.09%	<=6%	10.8%

Efficiency

Metric		Actual	Target	Previous
Elective day of surgery admission (DOSA) rate	PR048	80.98%	>=68%	82.88%
% Day Surgery Rate	PR052	55.85%	>=70%	57.12%
Average LOS for WIES funded discharges (days) - Acute	PR219	3.65	TBC	3.29
Average LOS for WIES funded discharges (days) - Elective	PR220	1.15	TBC	1.12
HT2 Elective discharges cumulative variance from target	PR035	0.94	>=1	0.94
Inhouse Elective WIES through theatre - per day	# PR053	65.92	TBC	71.71

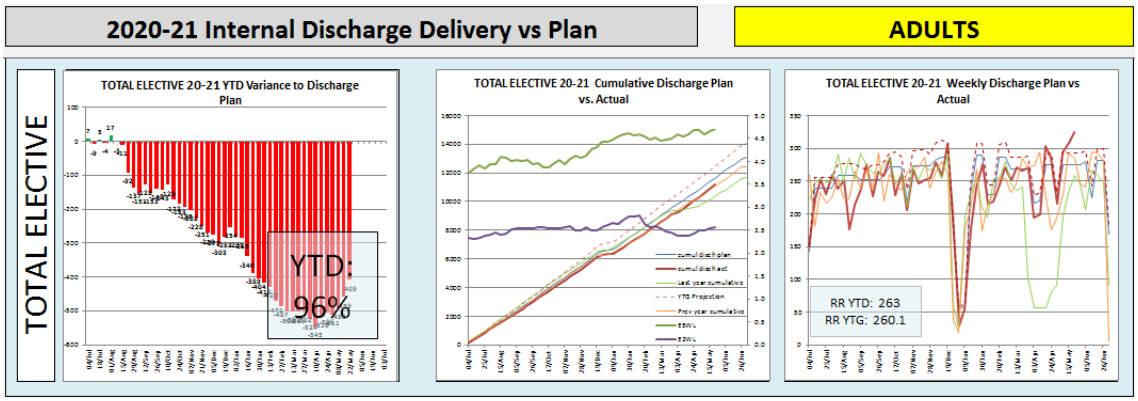
Equitable:	Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.
Safety:	Avoiding harm to patients from the care that is intended to help them.
Patient-centred:	Providing care that is respectful of and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

Amber	Variance from target not significant enough to report as non-compliant. This includes percentages/rates within 1% of target, or volumes within 1 value from target.
#	Actual is the latest available result prior to April 2021

ESPI performance

- ESPI 2 and ESPI 5 performance has deteriorated slightly from March to April 2021.
- April ESPI 2 position is 313 for Surgical Services; this is an increase of 52 patients. Our ESPI 2 position for our Māori and Pacific patients also increased slightly for April (four and five patients respectively).
    - DNA rate for outpatient appointments for our Māori and Pacific patients have both improved for April (17.82% and 16.41% respectively) but both are still above the target of <=9%
- April ESPI 5 position is 1,051 for Surgical Services (930 for March 2021). The number of patients breaching ESPI 5 has increased very slightly for our Māori and Pacific patients in April.

2020/21 Planned Care – Year to Date performance



- Adult Surgical Services internal delivery against the PVS is currently at 96%
- A recovery plan scorecard which includes performance against the Ministry of Health Planned Care Recovery Plans has been developed and is being utilised across Surgical Services.
- Planned Care recovery trajectories are currently being reviewed and revised across Surgical Services for year 2 (2021/22). Revised trajectories will be submitted to the Ministry of Health.

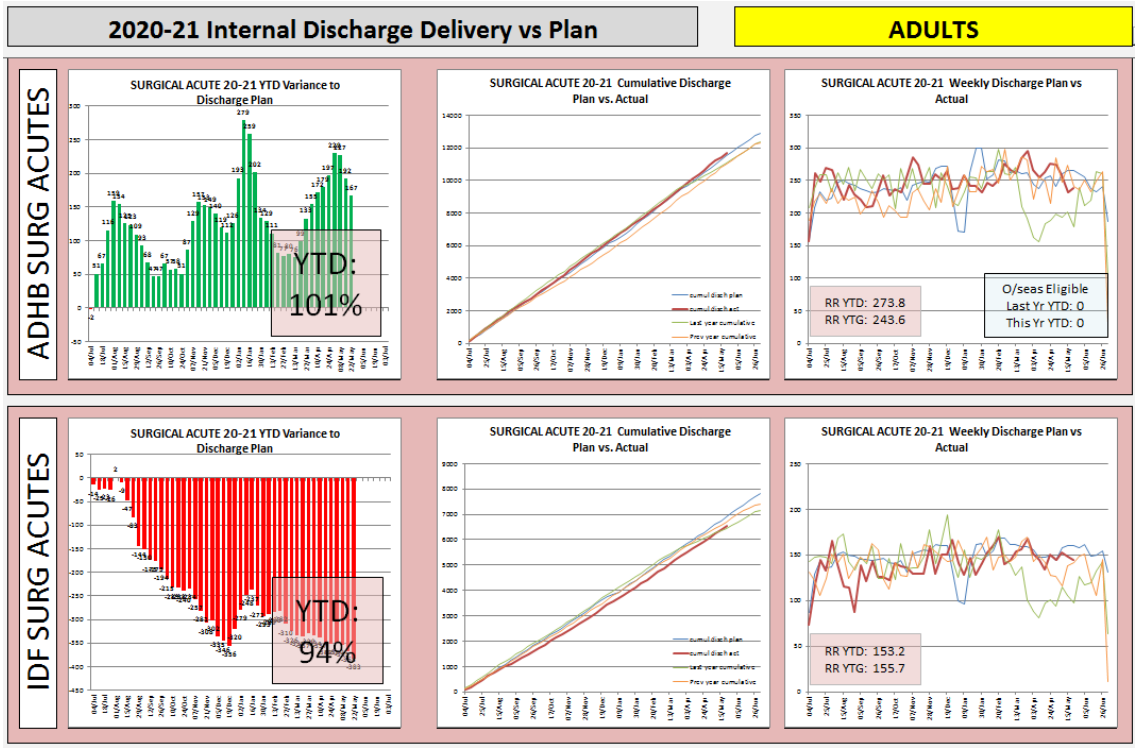
Standby Lists

- A key issue raised by clinicians on level 8 is the challenge of making tough cross-service decisions on which patients or sessions to defer when acute demand is high, staffing is low or transplants occur. Patients impacted by these decisions also receive little warning and may have gone to considerable effort with family and employers to make this time work.
- The standby list is an alternative to deferrals being determined on the day. Instead there would be a predetermined standby list which would be deferred when additional capacity was required.
- The standby list would rotate across services to share the load fairly and patients and surgeons would be aware of the possibility of deferral at the time of booking. Patients would be selected for the standby list according to a set of criteria aimed at minimising clinical risk and rework from deferrals.
- A clinical/managerial working group have explored a number of allocation options and developed criteria for use of the standby list. This has now gone to the Surgical Board for approval.

Surgical Integrated Operations Project (SIOC) 2.0

- The Surgical Integrated Operations Centre (SIOC) is an operational management framework designed to maximise use and utilisation of operating theatre sessions. It is currently live for GSU. This project looks to refine that model and scale it to other theatre suites starting with level 8.
- The SIOC model focuses on leading indicators of session use and utilisation e.g. session allocation, session recycling, level of booking etc. These are monitored several weeks before the theatre event and targets set. Issues are detected early enabling mitigation through a weekly meeting structure and assigned accountabilities. Subsequent performance is reviewed and systemic issues identified for continuous improvement.
- Data shows this model has improved use and utilisation at GSU. As part of scaling the model to level 8, improvements have been identified to the original model. These include enhancing its ability to identify issues early and supporting real time decision making in the busy acute environment of level 8.
- Other than the Standby List concept described above, most of these enhancements are digital solutions described in the Digital Transformation section above.

Acute performance



- Acute presentations of ADHB patients are tracking slightly ahead of plan (101%). IDF acute volumes are tracking lower than plan (94%).
- Internal WIES delivery for both ADHB and IDF acutes are tracking well ahead of plan (104% and 103% respectively). This indicates an increased complexity of acute presentations to Surgical Services.
- Acute average LOS for WIES funded discharges has increased to 3.65 days (3.29 days for March) which aligns with the increased complexity of our acute presentations.
- The increased complexity and LOS of our acute patients is placing pressure on both hospital occupancy and planned care operating theatres.

Surgical and Perioperative Review

- Te Toka Tumai (Auckland DHB) project to establish a strategic leadership structure for the Surgery and Perioperative Services
- Information gathering with employees in relation to the Vision statements for the surgical patient care pathway started in September 2020. The Vision statements are:

    1. Quality outcomes and experiences for patients, whānau (family, including extended) and employees
    2. Surgical system designed to achieve equitable outcomes; we deliver on our obligations under Te Tiriti o Waitangi
    3. We are united in our commitment and aligned in our approach to the surgical patient care pathway

4. We take a systems approach to optimise long term solutions and eliminate siloed thinking and behaviour

- The Interim Management group are leading the directorates and stakeholder process underway.
- A Discovery Review Group was established with 18 people representing professions across the two directorates to strengthen engagement and validate themes for reporting. Post the Discovery review report release in February; co-design was completed with feedback requested from DLTs on two proposed leadership models.
- This feedback stage was completed with DLTs and a consultation paper will be released in due course to the Directorates in June 2021.
- Final recommendations to Executive by July 2021

Resolution to exclude the public from the meeting

Recommendation

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

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
1. Karakia Attendance and Apologies	N/A	N/A
2. Conflicts of Interest	As per that stated in the open agenda	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3. Confirmation of Confidential Minutes 21 April 2021	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4. Confidential Action Points	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.1 Community Anatomical Pathology	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was	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

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	made public [Official Information Act 1982 s9(2)(i)]	reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.2 Provider A3 Business Plan	**Obligation of Confidence** Information which is subject to an express obligation of confidence or which was supplied under compulsion is enclosed in this report.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.1 Major Risks & Issues – Verbal Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time [Official Information Act 1982 s9(2)(k)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.2 Mental Health Facilities Plan	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time [Official Information Act 1982 s9(2)(k)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.1 Expert Advisory Review Panel – Women's Health Update	**Obligation of Confidence** Information which is subject to an express obligation of confidence or which was supplied under compulsion is enclosed in this report. **Privacy of Persons**	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

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	Information relating to natural person(s) either living or deceased is enclosed in this report.	section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.2 Winter Plan	**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. **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]
7.3 Clinical Quality and Safety Report	**Prejudice to Health or Safety** Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]