



# **Hospital Advisory Committee Meeting**

**Wednesday, 15 March 2017**

**1.30pm**

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

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Published 08 March 2017





# Agenda Hospital Advisory Committee 15 March 2017

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

**Time:** 1.30pm

<b>Committee Members</b> Judith Bassett (Chair) James Le Fevre (Deputy Chair) Jo Agnew Michelle Atkinson Doug Armstrong Dr Lee Mathias Gwen Tepania-Palmer	<b>Auckland DHB Executive Leadership</b> Ailsa Claire Chief Executive Officer Karen Bartholomew Acting Director of Health Outcomes – ADHB/WDHB Margaret Dotchin Chief Nursing Officer Joanne Gibbs Director Provider Services Naida Glavish Chief Advisor Tikanga– ADHB/WDHB Dr Debbie Holdsworth Director of Funding – ADHB/WDHB Fiona Michel Chief Human Resources Officer Riki Nia Nia General Manager Māori Health Dr Andrew Old Chief of Strategy, Participation and Improvement Rosalie Percival Chief Financial Officer Shayne Tong Chief of Informatics Sue Waters Chief Health Professions Officer Dr Margaret Wilsher Chief Medical Officer  <b>Auckland DHB Senior Staff</b> Dr Vanessa Beavis Director Perioperative Services Dr John Beca Director Surgical, Child Health Anna Schofield Acting Director Mental Health and Addictions Judith Catherwood Director Long Term Conditions Ian Costello Director of Clinical Support Services Dr Mark Edwards Director Cardiovascular Services Dr Sue Fleming Director Women’s Health Mr Arend Merrie Director Surgical Services Rachel Lorimer Director Communications Auxilia Nyangoni Deputy Chief Financial Officer Dr Michael Shepherd Director Medical, Children’s Health Dr Barry Snow Director Adult Medical Dr Richard Sullivan Director Cancer and Blood and Deputy Chief Medical Officer  Jo Brown Funding and Development Manager Hospitals Clare Thompson General Manager Non Clinical Support Services Michelle Webb Corporate Committee Administrator  (Other staff members who attend for a particular item are named at the start of the respective minute)
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**Apologies Members:** Nil.

**Apologies Staff:** Naida Glavish.

## Agenda

Please note that agenda times are estimates only

- 1.30pm    **1. Attendance and Apologies**
- 2. Register and Conflicts of Interest**  
            Does any member have an interest they have not previously disclosed?  
            Does any member have an interest that may give rise to a conflict of interest with a matter on the agenda?
- 1.35pm    **3. Confirmation of Minutes 07 December 2016**
- 4. Action Points**
- 1.40pm    **5. PERFORMANCE REPORTS**
- 5.1 Provider Arm Operational Performance – Executive Summary
- 5.2 Provider Arm Scorecard
- 5.3 Clinical Support Services Update
- 5.4 Women’s Health Directorate Update
- 5.5 Child Health Directorate Update
- 5.6 Perioperative Services Directorate Update
- 5.7 Cancer and Blood Directorate Update
- 5.8 Mental Health Directorate Update
- 5.9 Adult Medical Directorate Update
- 5.10 Community and Long Term Conditions Directorate Update
- 5.11 Surgical Services Directorate Update
- 5.12 Cardiovascular Directorate Update
- 5.13 Non-Clinical Support Services Update
- 5.14 Provider Arm Financial and Operational Performance Report
- 2.15pm    **6. INFORMATION REPORTS**
- 6.1 Patient Experience Report
- 2.25pm    **7. RESOLUTION TO EXCLUDE THE PUBLIC**

<b>Next Meeting:</b> Wednesday, 26 April 2017 at 1.30pm A+ Trust Room, Clinical Education Centre Level 5, Auckland City Hospital, Grafton
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## Attendance at Hospital Advisory Committee Meetings

Members	01 Feb. 17	15 Mar. 17	26 Apr. 17	07 Jun. 17	19 Jul. 17	30 Aug. 17	11 Oct. 17	22 Nov. 17
Judith Bassett (Chair)	c							
Joanne Agnew	c							
Michelle Aitken	c							
Doug Armstrong	c							
James Le Fevre (Deputy Chair)	c							
Lee Mathias	c							
Gwen Tepania-Palmer	c							
Key: x = absent, # = leave of absence, c = meeting cancelled								



## Conflicts of Interest Quick Reference Guide

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

An “interest” can include, but is not limited to:

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

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

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

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

### IMPORTANT

If in doubt – declare.

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

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

## Register of Interests – Hospital Advisory Committee

Member	Interest	Latest Disclosure
<b>Jo AGNEW</b>	Professional Teaching Fellow – School of Nursing, Auckland University Casual Staff Nurse – Auckland District Health Board Director/Shareholder 99% of GJ Agnew & Assoc. LTD Trustee - Agnew Family Trust Shareholder – Karma Management NZ Ltd (non-Director, minority shareholder)	17.01.2017
<b>Michelle ATKINSON</b>	Evaluation Officer – Counties Manukau District Health Board Director – Stripey Limited	17.01.2017
<b>Doug ARMSTRONG</b>	Shareholder - Fisher and Paykel Healthcare Shareholder - Ryman Healthcare Shareholder – Orion Healthcare (no personal beneficial interest as it is held through a Trust) Trustee – Woolf Fisher Trust Trustee- Sir Woolf Fisher Charitable Trust Daughter – Partner Russell McVeagh Lawyers Member – Trans-Tasman Occupations Tribunal	16.01.2017
<b>Judith BASSETT</b>	Shareholder - Fisher and Paykel Healthcare Shareholder - Westpac Banking Corporation Husband – Fletcher Building Husband - shareholder of Westpac Banking Corporation Granddaughter - shareholder of Westpac Corporation Daughter – Human Resources Manager at Auckland DHB	26.01.2017
<b>James LE FEVRE</b>	Board member – Waitemata DHB Emergency Medicine Specialist - Adult Emergency Department, Auckland DHB DHB Representative (Auckland and Waitemata DHBs) – Air Ambulance Codesign Procurement Governance Board Fellow - Australasian College for Emergency Medicine - FACEM Member - Association of Salaried Medical Specialists Shareholder - Pacific Edge Diagnostics Ltd Trustee - Three Harbours Health Foundation Wife - Medicolegal advisor, Medical Protection Society Wife – Employee Waitemata DHB Department of Anaesthesia and Perioperative Medicine	16.01.2017
<b>Lee MATHIAS</b>	Chair - Health Promotion Agency Chair - Unitec Acting Chair - Health Innovation Hub Director - Health Alliance Limited (ex officio Counties Manukau DHB) Director/shareholder - Pictor Limited Director - Lee Mathias Limited Director - John Seabrook Holdings Limited Trustee - Lee Mathias Family Trust Trustee - Awamoana Family Trust Trustee - Mathias Martin Family Trust Director – New Zealand Health Partnerships Member – New Zealand National Party	20.01.2017



<b>Gwen TEPANIA-PALMER</b>	Board Member - Manaia PHO Board Member - Health Quality and Safety Commission Board Member – Terenga Paraoa Ltd Northland Committee Member - Te Taitokerau Whanau Ora Committee Member - Lottery Northland Community Committee Chair - Ngati Hine Health Trust Life member – National Council of Maori Nurses Alumnus – Massey University	22.02.2017
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# Minutes

## Hospital Advisory Committee Meeting

### 07 December 2016

**Minutes of the Hospital Advisory Committee meeting held on Wednesday, 07 December 2016 in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton commencing at 2.35pm**

[Secretarial Note: The Chair, Judith Bassett opened the meeting at 2pm, adjourning it until 2.35pm to allow the completion of the full Board meeting.]

<p><b>Committee Members Present</b></p> <p>Judith Bassett (Chair) Jo Agnew Doug Armstrong Michelle Atkinson Zoe Brownlie Dr James Le Fevre Dr Lester Levy Dr Lee Mathias Robyn Northey Gwen Tepania-Palmer</p>	<p><b>Auckland DHB Executive Leadership Team Present</b></p> <table border="0"> <tr><td>Ailsa Claire</td><td>Chief Executive Officer</td></tr> <tr><td>Margaret Dotchin</td><td>Chief Nursing Officer</td></tr> <tr><td>Dr Debbie Holdsworth</td><td>Director of Funding – ADHB/WDHB</td></tr> <tr><td>Fiona Michel</td><td>Chief Human Resources Officer</td></tr> <tr><td>Dr Andrew Old</td><td>Chief of Strategy, Participation and Improvement</td></tr> <tr><td>Sue Waters</td><td>Chief Health Professions Officer</td></tr> <tr><td>Dr Margaret Wilsher</td><td>Chief Medical Officer</td></tr> </table> <p><b>Auckland DHB Senior Staff Present</b></p> <table border="0"> <tr><td>Dr Vanessa Beavis</td><td>Director Perioperative Services</td></tr> <tr><td>Dr John Beca</td><td>Director Surgical, Child Health</td></tr> <tr><td>Duncan Bliss</td><td>General Manager Surgical Services</td></tr> <tr><td>Jo Brown</td><td>Funding and Development Manager Hospitals</td></tr> <tr><td>Judith Catherwood</td><td>Director Long Term Conditions</td></tr> <tr><td>Ian Costello</td><td>Director of Clinical Support Services</td></tr> <tr><td>Dr Mark Edwards</td><td>Director Cardiovascular Services</td></tr> <tr><td>Dr Sue Fleming</td><td>Director Women’s Health</td></tr> <tr><td>Deirdre Maxwell</td><td>General Manager, Cancer and Blood</td></tr> <tr><td>Riki Nia Nia</td><td>General Manager Māori Health</td></tr> <tr><td>Auxilia Nyangoni</td><td>Deputy Chief Financial Officer</td></tr> <tr><td>Anna Schofield</td><td>Acting Director Mental Health and Addictions</td></tr> <tr><td>Dr Michael Shepherd</td><td>Director Medical, Children’s Health</td></tr> <tr><td>Dr Barry Snow</td><td>Director Adult Medical</td></tr> <tr><td>Marlene Skelton</td><td>Corporate Business Manager</td></tr> <tr><td>Suzanne Stephenson</td><td>Acting Director Communications</td></tr> </table> <p>(Other staff members who attend for a particular item are named at the start of the minute for that item)</p>	Ailsa Claire	Chief Executive Officer	Margaret Dotchin	Chief Nursing Officer	Dr Debbie Holdsworth	Director of Funding – ADHB/WDHB	Fiona Michel	Chief Human Resources Officer	Dr Andrew Old	Chief of Strategy, Participation and Improvement	Sue Waters	Chief Health Professions Officer	Dr Margaret Wilsher	Chief Medical Officer	Dr Vanessa Beavis	Director Perioperative Services	Dr John Beca	Director Surgical, Child Health	Duncan Bliss	General Manager Surgical Services	Jo Brown	Funding and Development Manager Hospitals	Judith Catherwood	Director Long Term Conditions	Ian Costello	Director of Clinical Support Services	Dr Mark Edwards	Director Cardiovascular Services	Dr Sue Fleming	Director Women’s Health	Deirdre Maxwell	General Manager, Cancer and Blood	Riki Nia Nia	General Manager Māori Health	Auxilia Nyangoni	Deputy Chief Financial Officer	Anna Schofield	Acting Director Mental Health and Addictions	Dr Michael Shepherd	Director Medical, Children’s Health	Dr Barry Snow	Director Adult Medical	Marlene Skelton	Corporate Business Manager	Suzanne Stephenson	Acting Director Communications
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**1. APOLOGIES**

That the apology of Sharon Shea be received.

That the apologies of senior executive team members Jo Gibbs, Director Provider Services and Linda Wakeling, Chief Intelligence and Informatics be received.

That the apologies of senior staff Dr Richard Sullivan, Director Cancer and Blood and Deputy Chief Medical Officer, Mr Wayne Jones Director Surgical Services and Clare Thompson, General Manager Non Clinical Support Services be received.

## 2. REGISTER AND CONFLICTS OF INTEREST

The following amendments to the interests register were advised:

Dr Lester Levy advised that he had resigned from his position as head of the New Zealand Leadership Institute, University of Auckland.

James Le Fevre added his membership of the Waitemata District Health Board and advised that he is a union member.

Robyn Northey – advised further interests pertaining to her husband:

- Chair of the Community Housing Foundation
- Member Waitemata Local Board

The following conflicts of interest relating to items on the open agenda were advised:

James Le Fevre advised that as a member of the Emergency Department he may have a conflict of interest with items on this agenda but that he would seek the Chairs advice at the time if he felt a conflict may exist.

## 3. CONFIRMATION OF MINUTES 26 October 2016 (Pages 8 to 18)

**Resolution:** Moved Gwen Tepania-Palmer / Seconded Robyn Northey

**That the minutes of the Hospital Advisory Committee meeting held 26 October 2016 be confirmed as a true and accurate record.**

**Carried**

## 4. ACTION POINTS (Page 19)

Rehabilitation Services for Young Children – John Beca, Director Surgical Child Health and Michael Shepherd, Director Medical Child Health provided a verbal report at the meeting as part of their directorate report which covered this issue.

New Cancer Drugs – Deirdre Maxwell, General Manager, Cancer and Blood provided a verbal report at the meeting as part of the directorate report which covered this issue.

## 5. PROVIDER ARM PERFORMANCE REPORT

[Secretarial Note: Items 5.0 and 5.1 were taken as one item]

Ailsa Claire, Chief Executive Officer spoke to the report on behalf of Jo Gibbs, Director Provider Services highlighting the following:

- The Faster Cancer Treatment 62 day target has been achieved
- The hospital had undergone a particularly busy period which had required a completely flexed up bed plan to manage.

## 5.1 Scorecard (Pages 24 to 26)

Matters covered in discussion of the report and in response to questions included:

- Lee Mathias asked how confident management were in bringing the budget back in line. Ailsa Claire advised that good progress had been made in bringing expenses down. However, there is a challenge with increased acute activity and a decrease in electives and therefore revenue needs to be managed.
- Alisa Claire advised that some of the targets in the scorecard reported to the Committee required review as the variable of just one or two patients can put a target in the red. There is a need to look at the current scorecard approach to address this and to provide meaningful information to Committee members.

**That the Provider Arm Performance Report be received.**

**Carried**

## 6. DIRECTORATE UPDATES

### 6.1 Clinical Support Services (Pages 27 to 34)

Ian Costello, Director of Clinical Support Services asked that the report be taken as read, highlighting as follows:

- The National Forensic Pathology Service contract has been signed with the Ministry of Justice.
- This contract included the funding for upgrading the CT Scanner to support a research project into reducing the number of invasive post-mortems through improved imaging.

Matters covered in discussion of the report and in response to questions included:

- It was requested that that future reports be more specific about numbers of staff undertaking Improvement Practitioner training.

### 6.2 Women's Health Directorate (Pages 35 to 45)

Dr Sue Fleming, Director Women's Health asked that the report be taken as read, highlighting as follows:

- There is pressure on the maternity service due to an overall shortage of midwives. Staff are working well and flexibly to manage and it is hoped that the midwifery intake in the new-year will alleviate the situation.
- The Ministry of Health has determined that there will be three gynaecology oncology service centres based in Auckland, Dunedin and Christchurch. This together with a

change in the pattern of endometrial cancer in women who are pre-menopausal and obese and with ovarian cancer at stage three has meant an increase in the flow of women in the upper North Island to Auckland DHB. These women are requiring more aggressive surgery. This has put increased pressure on resources and is posing a challenge to the elective surgery space.

Matters covered in discussion of the report and in response to questions included:

- Judith Bassett requested that the Committee be kept advised of what was occurring with the obstetrician clinic at Glen Innes and in particular the attendance rate as the high DNA rate was of concern.

### **6.3 Child Health Directorate (Pages 46 to 55)**

Dr John Beca, Director Surgical, Child Health and Dr Michael Shepherd, Director Medical, Children's Health asked that the report be taken as read, highlighting as follows:

- The community service re-design document had been released for consultation and closes next week. It features a focus on Whanau centred care within a virtual locality and what that will mean for staff. It has generally met with approval.
- The 5<sup>th</sup> floor closure due to building work has created some capacity issues which are impacting on acute flow and maintenance of the children's ED target..
- Attention was drawn to the clinical excellence score card and in particular that the data collection capacity is lagging which has affected the reported results.
- Collaboration with Waitemata DHB around the delivery of the full continuum of rehabilitation services continues. Auckland DHB will subcontract Waitemata DHB to provide residential rehabilitation and outpatient services. The contract with ACC had been agreed.
- The summer drop off in acuity has not yet been in evidence and it is hoped that the holiday period will provide some relief for the service.

Matters covered in discussion of the report and in response to questions included:

- Lee Mathias commented that she was pleased to hear about the virtual locality model and asked if Care Connect was being utilised and healthAlliance involved. Mike Shepherd advised that it was being looked at as a part of the primary and community programme Board.

### **6.4 Perioperative Services Directorate (Pages 56 to 63)**

Dr Vanessa Beavis, Director Perioperative Services asked that the report be taken as read, highlighting that:

- There were major issues relating to service in CSSD as detailed on page 60 of the agenda.
- 79 transplants had been completed year to date.

## 6.5 Cancer and Blood Directorate (Pages 64 to 70)

Deirdre Maxwell, General Manager, Cancer and Blood asked that the report be taken as read, highlighting as follows:

- A focus had been placed on the redesign project, in particular, day stay and clinics to ensure a better patient experience.
- The 62 day Faster Cancer Treatment (FCT) Target is currently sitting at 88.1%

Matters covered in discussion of the report and in response to questions included:

- Judith Bassett noted that there was a challenge with the Haematology service and was advised that there is a need to better understand what is occurring in both secondary and tertiary service provision in order to manage the demand. It is a 27 bed ward which had 37 patients admitted during the peak. Demand fluctuates making it difficult to forecast and manage the service.
- Advice was given that Pharmac was consulting on nine new drugs and there was a focus on two that dealt with metastatic breast cancer. As a result, from 1 January 2017, Auckland DHB would require more infusion time. While this move was of benefit to the patient it was going to be a challenge to the service in terms of funding.

## 6.6 Mental Health Directorate (Pages 71 to 82)

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

- Good progress had been made in the reducing assault work which has been incorporated into Project Haumarua, a wider change programme at Te Whetu Tarawera which aims to proactively engage and involve all staff. ICU has the greatest risk of assault and is the initial focus and pilot for the assault reduction aspect of this work. Components of the South London and Maudsley Trust (SLaM) model of assault reduction have been introduced.
- This is a busy time of year for the service and ongoing demand is being balanced with required recruitment.

Matters covered in discussion of the report and in response to questions included:

- Clarification that 'SMI' on page 71 of the agenda means Serious Mental Illness.
- Advice that, in relation to the ligature risk referred to on page 80 of the agenda, a ligature risk assessment would be referred to the Finance, Risk and Assurance Committee
- Anna agreed with Robyn Northey that waiting times do continue to be of concern and in particular, community waiting times.
- Judith Bassett asked if there were particular targets associated with "Right Interventions at the right time - Stepped Care key work training provided to staff

involved in the first step of the care pyramid” referred to on page 71 of the agenda. It was advised that there was now an appointment nurse and the pathway was well mapped. In terms of credentialing it was an interesting exercise that had required a staff culture shift. A Board is in place to manage this pathway and Anna was confident that it was being directed correctly.

Lester led a discussion with regard to how Board members should manage direct contact from members of the public and their concerns about personal health circumstances or service provided by Auckland DHB. It was pointed out that any advice given by a Board member could become part of the chain of care and this was to be avoided. Board members were to ensure that these members of the public were referred directly to the correct part of the organisation for information and to get assistance.

#### **6.7 Adult Medical Directorate (Pages 83 to 88)**

Dr Barry Snow, Director Adult Medical asked that the report be taken as read.

Matters covered in discussion of the report and in response to questions included:

- An explanation was given to a point made on page 87 of the agenda in relation to, “a greater focus on mental health attendance to AED is being made. This is as a result of a change in Police policy for dealing with mental health patients or “people with behaviours of concern”. These people are now being brought directly to the accident and emergency department. Staff have received additional training. There is also a need for the physical space within the accident and emergency department. While a room has been set aside it is not considered ideal.
- Lee Mathias was advised that while 24 hour support from mental health services staff was available in the emergency department it was on the basis of seven days a week until 11pm after which a Registrar is on call.
- Michelle Atkinson was advised that the room set aside for mental health patients within the accident and emergency department was not a seclusion room and not used as such.

#### **6.8 Community and Long Term Conditions Directorate (Pages 89 to 98)**

Judith Catherwood, Director Long Term Conditions asked that the report be taken as read

Matters covered in discussion of the report and in response to questions included:

- Judith Bassett commented that it was good to see a favourable financial position reported for the quarter.
- It was also noted that it was pleasing to see that a new programme of work had commenced with ACC in relation to care pathways within non-acute rehabilitation services for older adults and the implementation of a new case mix funding model. [as reported on page 95 of the agenda]

[Secretarial Note: Zoe Brownlie did not take part in this item declaring an interest in some parts of the information provided within the report and subsequent discussion.]



## 6.9 Surgical Services Directorate (Pages 99 to 109)

The Chair noted that an apology had been received from Wayne Jones and that this would have been the last meeting that Wayne would have attended prior to standing down in January 2017. The Chair expressed the Committee's thanks to Wayne Jones for his significant contributions to surgical services and the work of the Committee.

Duncan Bliss, General Manager Surgical Services asked that the report be taken as read, highlighting as follows:

- There had been a continued reduction in Surgical Length of Stay (LOS) across Acute Surgery. Active participation in discharge planning processes had reduced delayed discharges and in turn length of stay (LOS)
- At the end of October the Adult ESPI 2 position was non-compliant for Auckland DHB at 0.74%. This worsened position was due to an increase of 16% FSA's in Orthopaedics without the increased capacity to deliver it. The organisational position for ESPI 5 is reported as non-compliant for patients not receiving a date for surgery within 4 months at 2.68% (the target is <1.0%). This is predominantly due to the continuing Orthopaedic under-delivery of 109 cases by the end of October. This position was also impacted from the loss of over 200 OR hours across all surgical services through the RMO industrial action.
- Ophthalmology Services increased weekend activity throughout October in an attempt to increase cataract volumes that will continue for the rest of the year.

## 6.10 Cardiovascular Directorate (Pages 110 to 117)

Dr Mark Edwards, Director Cardiovascular Services asked that the report be taken as read.

Matters covered in discussion of the report and in response to questions included:

- Advice that there had been challenges in managing the waiting list. There had been sustained referrals, at least two to three per week more than in past years. Both Counties and Northland DHBs had contributed to this situation. There is unmet need with Northland DHB however, it is not yet understood what is occurring within Counties DHB. Production had also increased to deal with this situation.

## 6.11 Non-Clinical Support Services (Pages 118 to 125)

Ailsa Claire, Chief Executive Officer in the absence of Clare Thompson asked that the report be taken as read.

Matters covered in discussion of the report and in response to questions included:

- An explanation was provided in relation to the VRE outbreak mentioned on page 119 of the agenda. VRE is a resistant organism found in the blood. There has been no reported case since September and staff are maintaining a vigilant environmental watch to keep this organism out of the Hospital. There have been no deaths at Auckland DHB as a result of VRE.

**That the Directorate Update Reports for December 2016 be received.**

**Carried**

**7. PROVIDER ARM FINANCIAL PERFORMANCE (Pages 126 to 140)**

Ailsa Claire, Chief Executive Officer asked that the report be taken as read.

Matters covered in discussion of the report and in response to questions included:

- James Le Fevre asked for an explanation of “Outsourced Other” on paged 128. Ailsa Claire undertook to provide an answer detailing what this line item encompassed.

**That the Provider Arm Financial Performance Report for October 2016 be received.**

**Carried**

**8. PATIENT EXPERIENCE REPORT (Pages 141 to 148)**

Dr Andrew Old, Chief of Strategy, Participation and Improvement asked that the reports 8.1 and 8.2 be taken together and as read.

During September the focus of these reports was on Respect | Manaaki which is one of the Boards core values.

**8.1 Inpatient Experience (Pages 141 to 144)**

The rating has increased statistically by a significant five percentage points since 2011 from 79 percent to 84 percent today.

Overall, being treated with dignity and respect is one of the three dimensions Auckland DHB rates most highly on, with 85% rating performance at 8, 9 or 10 on a 10- point scale (second equal along with confidence).

One area patients do tell us we can improve is talking in front of them as if they weren't there. One in every five respondents say that staff sometimes or often do this so it's timely to reflect on the role of the patient and the family as partners in their care and to take opportunities to include them.

**8.2 Outpatient Experience (Pages 145 to 148)**

This report shows there is much to celebrate. One of the highest ratings across the entire survey relates to the respectful ways patients are treated. The percentage of patients who say they were treated with dignity and respect has continued to increase over the past year across many of the questions.

Overall, 88 percent of our patients rated our care as very good or excellent during the period July 1, 2015 to June 30, 2016.

Andrew Old advised that the Auckland DHB website and Intranet had been redesigned so that this information was easier to find by both public and staff. The information is used for research and planning of future work. A new report; "Report at a Glance" is soon to be made available for the public which will provide a high level overview of this information.

**Resolution:** Moved Jo Agnew / Seconded Robyn Northey

**That the patient experience reports for December 2016 be received.**

**Carried**

**9. RESOLUTION TO EXCLUDE THE PUBLIC** (Pages 149 to 152)

**Resolution:** Moved James Le Fevre / Seconded Lee Mathias

That in accordance with the provisions of Clauses 34 and 35, Schedule 4, of the New Zealand Public Health and Disability Act 2000 the public now be excluded from the meeting for consideration of the following items, for the reasons and grounds set out below:

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
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 26 October 2016	<p><b>Commercial Activities</b> To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]</p> <p><b>Obligation of Confidence</b> Information which is subject to an express obligation of confidence or which was supplied under compulsion is enclosed in this report [Official Information Act 1982 s9(2)(ba)]</p>	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	<p><b>Commercial Activities</b> To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]</p> <p><b>Obligation of Confidence</b> Information which is subject to an express obligation of confidence or</p>	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

	which was supplied under compulsion is enclosed in this report [Official Information Act 1982 s9(2)(b)]	[NZPH&D Act 2000]
5.1 Faster Cancer Treatment Report	<p><b>Prevent Prejudice to Commercial Activities</b> Information contained in this report related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]</p> <p><b>Free and Frank Opinion</b> This paper contains free and frank expression of opinions by management to board [Official Information Act 1982 s9(2)(b)]</p>	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.2 Security for Safety Programme Report	<p><b>Prejudice to Health and Safety</b> Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time [Official Information Act 1982 s9(2)(i)]</p> <p><b>Prevent Prejudice to Commercial Activities</b> Information contained in this report related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]</p> <p><b>Free and Frank Opinion</b> This paper contains free and frank expression of opinions by management to board [Official Information Act 1982 s9(2)(b)]</p>	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]
5.3 Food Services Report	<p><b>Prevent Prejudice to Commercial Activities</b> Information contained in this report related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]</p> <p><b>Free and Frank Opinion</b> This paper contains free and frank expression of opinions by management to board [Official</p>	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]

	Information Act 1982 s9(2)(b)	
5.4 Reablement Services Report	<p><b>Prevent Prejudice to Commercial Activities</b>            Information contained in this report related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]</p> <p><b>Free and Frank Opinion</b>            This paper contains free and frank expression of opinions by management to board [Official Information Act 1982 s9(2)(b)]</p>	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. Risk Register Report	<p><b>Prejudice to Health and Safety</b>            Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time [Official Information Act 1982 s9(2)(i)]</p> <p><b>Prevent Prejudice to Commercial Activities</b>            Information contained in this report related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]</p> <p><b>Free and Frank Opinion</b>            This paper contains free and frank expression of opinions by management to board [Official Information Act 1982 s9(2)(b)]</p>	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.1 Complaints	<p><b>Prevent Prejudice to Commercial Activities</b>            Information contained in this report related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]</p> <p><b>Free and Frank Opinion</b>            This paper contains free and frank expression of opinions by management to board [Official Information Act 1982 s9(2)(b)]</p>	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.2 Compliments	<p><b>Prevent Prejudice to Commercial Activities</b></p>	That the public conduct of the

	<p>Information contained in this report related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]</p> <p><b>Free and Frank Opinion</b> This paper contains free and frank expression of opinions by management to board [Official Information Act 1982 s9(2)(b)]</p>	<p>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&amp;D Act 2000]</p>
7.3 Incident Management	<p><b>Prevent Prejudice to Commercial Activities</b> Information contained in this report related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]</p> <p><b>Free and Frank Opinion</b> This paper contains free and frank expression of opinions by management to board [Official Information Act 1982 s9(2)(b)]</p>	<p>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&amp;D Act 2000]</p>
7.4 Policies and Procedures	<p><b>Prevent Prejudice to Commercial Activities</b> Information contained in this report related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]</p> <p><b>Free and Frank Opinion</b> This paper contains free and frank expression of opinions by management to board [Official Information Act 1982 s9(2)(b)]</p>	<p>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&amp;D Act 2000]</p>

**Carried**

The meeting closed at 4.20pm.

Signed as a true and correct record of the Hospital Advisory Committee meeting held on Wednesday, 07 December 2016

Chair: \_\_\_\_\_ Date: \_\_\_\_\_  
Judith Bassett

## Action Points from Previous Hospital Advisory Committee Meetings

As at Wednesday, 15 March 2017

Meeting and Item	Detail of Action	Designated to	Action by
26 October 2016 Item 6.11	<p><b>People Metrics for Directorate Reports</b></p> <p>That the Chief Human Resources Officer submit a report proposing alternative people metrics for consideration.</p> <p><i>Update: item to be discussed with the Human Resources Sub-committee prior to reporting to the Hospital Advisory Committee. Item deferred to 26 April HAC agenda.</i></p>	Fiona Michel	26 April 2017
16 Sep 2015 Item 8.1	<p><b>Auckland Integrated Cancer Centre</b></p> <p>That the Strategic Assessment for the Auckland Integrated Cancer Centre business case be provided to the HAC December meeting.</p> <p><i>Update: discussions are occurring across the northern region relating to the development of a programme business case. Progress report available February 2017.</i></p>	R Sullivan	1 February 2017 (February HAC meeting cancelled, item deferred. Preparation of business case delayed. Next steps under discussion at regional level).
11 May 2016 Item 8.2	<p><b>Patient Experience Survey Net Promoter Score</b></p> <p>That a presentation be made to the Board on the MOS Board system and how it operated.</p> <p><i>[This presentation will be tied to a demonstration showing how the automated scorecard works with MOS.]</i></p> <p><i>Update: Item to be transferred to the 5 April 2017 Board agenda</i></p>	L Wakeling	1 February 2017 (to be referred to the Board)





# Provider Arm Performance Report

## Recommendation

**That the Hospital Advisory Committee receives the Provider Arm Performance report for March 2017.**

Prepared by: Joanne Gibbs (Director Provider Services)

Endorsed by: Ailsa Claire (Chief Executive)

5.1

### 1. Board Strategic Alignment

Community, whanau and patient-centred model of care	Our Daily Hospital Functioning, Deteriorating Patients and Afterhours Inpatient Safety work programmes directly led to reviewing and enhancing patient safety practices and outcomes; the 24/7 Hospital Functioning consultation document outlines our proposed solution.
Emphasis/investment on both treatment and keeping people healthy	The FCT, ED and elective discharge targets focus on timely access to early interventions and effective treatments.
Service integration and/or consolidation	Our Using the Hospital Wisely work programme aims to reduce pressure on our hospital services through improvement to processes, pathways and use of services.
Intelligence and insight	We are developing a database to capture data for the identified measures for the Deteriorating Patients work programme.
Evidence informed decision making and practice	The 24/7 Hospital Functioning consultation document outlines proposed changes to make the hospital safer, strengthen clinical leadership and decision making, and improve the efficiency of bed management.
Outward focus and flexible service orientation	Our Outpatients Model of Care work programme aims to review our current model of care to ensure we provide a high quality outpatient service and experience that is patient centric.
Operational and financial sustainability	The Think and Do Tank has prioritised eight projects for implementation which focus on opportunities to maximise revenue, improve productivity and reduce waste.

### 1. Executive Summary

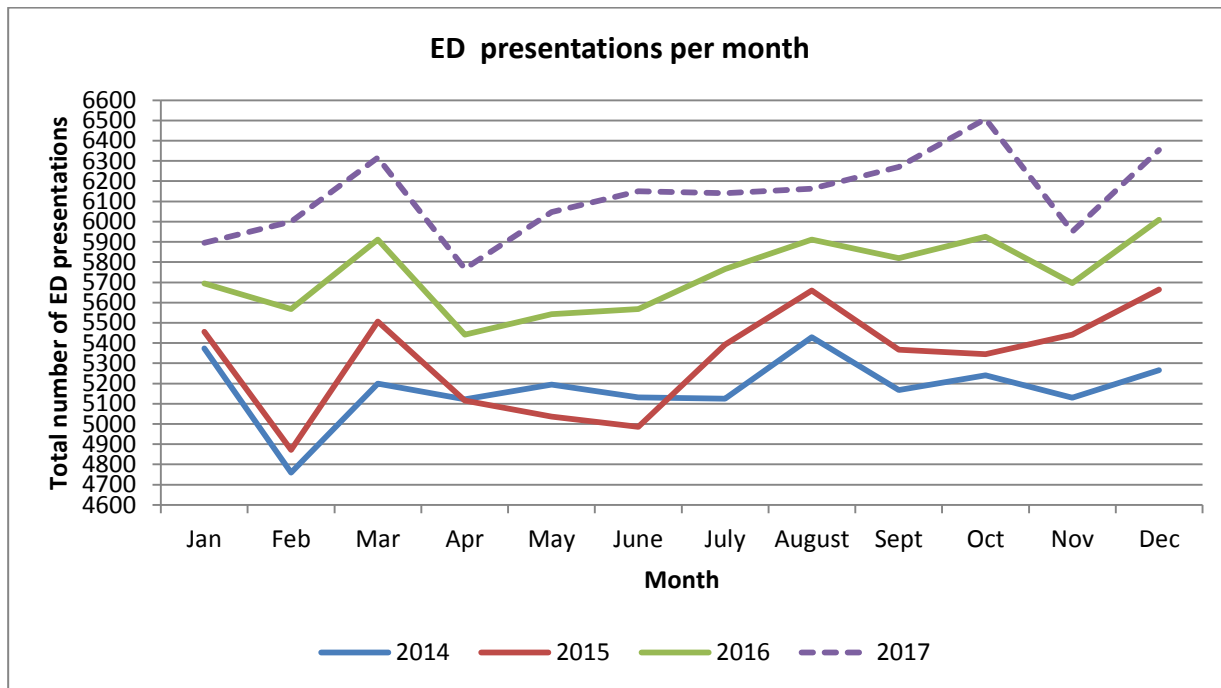
The Executive Team highlight the following performance themes for the March 2017 Hospital Advisory Committee meeting:

- The Adult Emergency Department (AED) experienced a significant increase in volume during the last quarter of 2016 compared to the same quarter in 2015. Currently Quarter 3 performance to date for the 6 hour target overall is 94.58% (Adult 93.54%, Child 96.99%).
- Elective discharge performance recovered during Quarter 2 to report 96.8% (exceeding the target of 95%). Achievement of the Quarter 3 result is heavily dependent on orthopaedic outsourcing for the remainder of the year.
- The Provider Group has made the decision to move to the new 24/7 Hospital Functioning Model of Care and Structure and the formal decision document has been released.

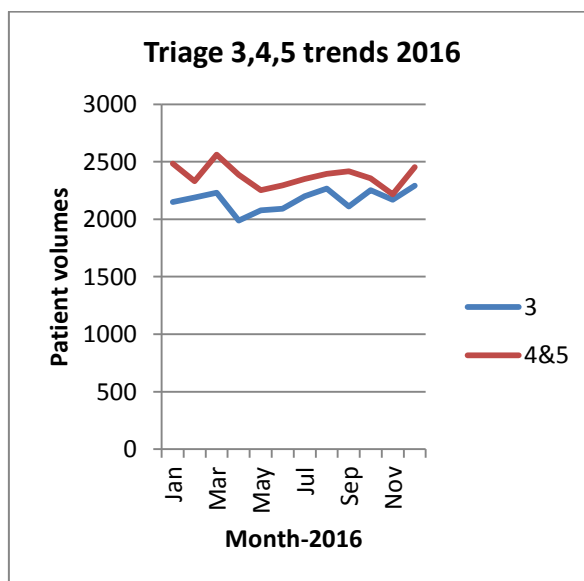
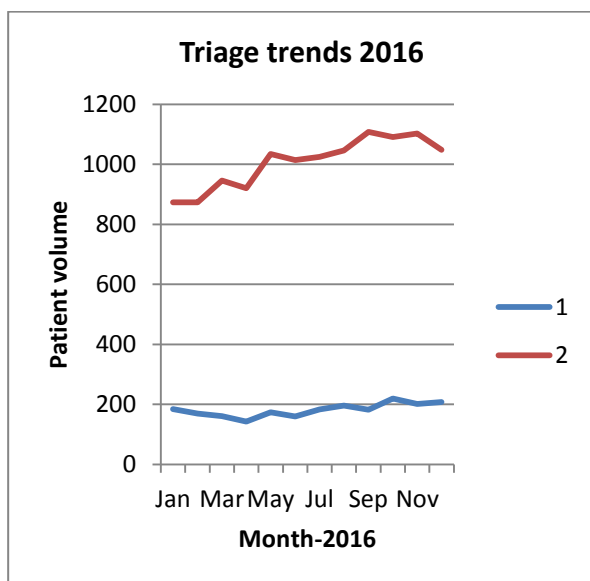
## 2. Progress/Achievements/Activity

### Acute demand

- Total volumes (predicted for 2017)



- The increase in volumes from the last quarter of 2015 to the last quarter of 2016 are focussed in the triage 1 and 2 categories (most critically ill patients)
  - Triage 1 = +16%
  - Triage 2 = +15%
  - Triage 3, 4, 5 = + 1.6%



- There are a number of actions which have been identified to respond to respond to this activity increase

## Elective discharge cumulative variance from target

- Elective discharge performance recovered during Quarter 2 to report 96.8% (exceeding the target of 95%)
- Achievement of the Quarter 3 result is heavily dependent on orthopaedic outsourcing for the remainder of the year.
- Achieving 98% by Quarter 3 is at high risk for this reason
- With the exception of orthopaedics, the specialties that were previously reported as being under specific monitoring are now on track with remedial actions delivering improvement to plan.

## Provider Services 2016/17 Business Plan

### 24/7 Hospital Functioning Model of Care and Structure

- The 24/7 Hospital Functioning Model of Care and Structure consultation document outlined proposed changes to the structure of the way the hospital functions from a daily operations and patient safety perspective. The Committee was briefed on the consultation by email in November and an update was provided at the December meeting.
- Submissions regarding the proposal were received from both internal and external stakeholders including individual employees, employee teams and the New Zealand Nurses Organisation. Support for the model of care proposed was evident in the feedback received.
- The feedback was grouped into themes and forwarded to the respective work programme Steering Group for consideration (Deteriorating Patients / Afterhours Inpatient Safety / Daily Hospital Functioning). Recommendations were made to the Provider Group for consideration.
- The Provider Group has made the decision to move to the new 24/7 Hospital Functioning Model of Care and Structure and the formal decision document has been released. The decision will ensure the Auckland City Hospital site continues to function with optimal safety and effectiveness, seven days a week, 24 hours a day, 365 days a year.
- The new model will enhance clinical leadership 24/7 to support staff and make care for our patients safer, increase the number and capability of clinical leaders in the afterhours team, introduce a 'Patient at Risk' model and streamline bed management.
- The decision has been discussed with all employees whose current roles will be affected and finding alternative positions for them within the new model of care is the aim.
- A Steering Group has been established to oversee the changes and ensure that the transition is as smooth as possible for all involved. The new model is set to be in place by winter 2017. Further updates will be provided to the Committee.

### Daily Hospital Functioning

- Escalation plan development progressing with plan now complete for Cardiovascular services and plans nearing completion for the Adult Hospital, General Surgery, Reablement services, Cancer and Blood, and AED.
- Workshop held with Business Intelligence team to identify ideal high level structure for status at a glance information including content identified during prioritisation exercise.

- New occupancy dashboard by Business Intelligence team presented to working group including forecast occupancy and link to escalation plans.
- Review drafted regarding pilot of Day of Surgery Admissions (DOSAs) patients through the transition lounge. Overall positive outcomes and recommendation to continue pilot process. Plans for improving discharge process through transition lounge being developed.
- Meeting held with architects to initiate design process for transition lounge stage two facility changes.
- Steering Group review of feedback received regarding the bed management process proposed in the 24/7 Hospital Functioning consultation. Recommendations drafted for consideration by the Provider Group.
- Development of 24/7 Hospital Functioning Model of Care and Structure decision document in conjunction with the Deteriorating Patients and Afterhours Inpatient Safety work programmes.

### **Deteriorating Patients**

- Auckland DHB has been selected as one of the five DHBs to trial the new national vital signs chart and Early Warning Score (EWS) as part of the HQSC Deteriorating Patients Programme. The pilot commenced on 20 February on Ward 65, Ward 76 and Te Whetu Tawera (adult acute mental health inpatient unit), and will run for three months. Learning from the pilot will improve the EWS and vital signs chart before it is rolled out across the country later this year.
- The Deteriorating Patients database has been successfully implemented on Concerto. The database will be used during the HQSC national vital signs and EWS trial.
- Feedback received regarding the PAR team proposed in the 24/7 Hospital Functioning consultation was reviewed by the Steering Group. Recommendations were drafted for consideration by the Provider Group. Development of 24/7 Hospital Functioning Model of Care and Structure decision document in conjunction with the Daily Hospital Functioning and Afterhours Inpatient Safety work programmes.
- As outlined in the 24/7 Hospital Functioning Model of Care and Structure decision document, there will be a PAR Governance Group established to oversee all aspects of the management of deteriorating patients. In the interim, the Deteriorating Patients Steering Group will provide governance of the PAR model.

### **Afterhours Inpatient Safety**

- The Starship Hospital Afterhours intranet page is now live. Developed by the Child Health Afterhours Inpatient Safety Child Health work stream, the page contains an at a glance guide for employees working afterhours in Starship Hospital. This includes on call contact numbers, frequently asked questions and links to clinical support resources. It is planned for this page to be replicated by the other Afterhours Inpatient Safety work streams (Adult, Women's Health and Mental Health).
- Feedback received regarding the Clinical Nurse Manager role proposed in the 24/7 Hospital Functioning consultation was reviewed by the Steering Group. Recommendations were drafted for consideration by the Provider Group. Development of 24/7 Hospital Functioning

Model of Care and Structure decision document in conjunction with the Daily Hospital Functioning and Deteriorating Patients work programmes.

- As outlined in the previous report, five priorities which impact on all areas of the hospital afterhours have been identified. A working group has been established to progress the out of hours theatre access project, with a business case currently being drafted. Staffing afterhours is being addressed in the interim through the 24/7 Hospital Functioning Model of Care and Structure. The remaining three priority projects (information for afterhours staff, future oversight of afterhours inpatient safety, and handover) which impact on all areas of the hospital will continue to be progressed by the Steering Group / work groups. Project Manager resource is being sourced to develop this work.

### Using the Hospital Wisely

- The Programme Board has prioritised the initial areas of focus to be discharge planning, clinical pathways, and palliative care. These sub-programmes have commenced with good progress to date and all are being supported by the Performance Improvement team.

#### *Discharge Planning Update*

- Five priority directorates in scope: Women's Health, Child Health, Adult Medical, Surgical Services, and Adult Community and Long Term Conditions
- A ward self-assessment against discharge planning best practice has been completed by over 50 staff across 20 wards to identify opportunity for local-led improvement
- Ten wards are piloting using new functionality on their electronic whiteboards to increase visibility, escalation, and tracking of discharge delays for our patients. This will also provide an opportunity to identify core reasons for delays and will inform further improvement.
- Four individuals have enrolled in Improvement Practitioner Training (Green Belt) and are leading ward level projects to improve discharge planning including earlier time of day of discharge, improved Estimated Discharge Date accuracy for elective ERAS patients, and increase transition lounge usage.

#### *Pathways Update*

- A Rapid Improvement Event was held in December with representatives from hospital and primary care teams with the aim to reduce hospitalisation and length of stay for patients with the primary diagnosis of cellulitis. Implementation of key improvements is underway with projected benefits of over 1,000 fewer bed days per year and improved patient experience.
- A framework to support clinical pathway development across the hospital is also being considered. A draft will be presented for agreement to the Provider Directors in March.

#### *Palliative Care Update*

- The third of three workshops will be held in March with over 30 stakeholders from across the system. The first two workshops identified barriers and solutions to delivering our aim. In the third workshop we will prioritise our actions, agree to leads and agree to key performance indicators.
  - A plan to address the barriers is in development.
  - A hospice-sponsored project commenced in February to increase the proportion of patients transferred to hospice within 24 hours of referral from Auckland City

Hospital. The project facilitator is enrolled in Improvement Practitioner Training to support this work.

- The Using the Hospital Wisely programme board will be overseeing two additional workstreams that originated in the Get on Track group. The first is increasing Day of Surgery Admissions (DOSAs) and the second is to realign adult bed allocation. The programme board is also continuing to review existing improvement work and identify new areas for improvement.

### **Outpatients Model of Care**

- A Project Manager is in place for the Interpreter project. Additional services have agreed to trial telephone interpreting and a clear plan is in place. Trial outcomes presented to provider Group in February, further roll out and transition to BAU agreed.
- A proposal has been written to work collaboratively with Waitmata and Counties Manukau DHBs on interpreting services and was presented to the Provider Collaboration Meeting in January. Discussions around collaboration model with Counties Manukau DHB and Waitemata DHB started.
- A review of booking and schedulers working hours has been undertaken. This was presented at the General Managers' meeting in December 2016; a consultation paper is currently being drafted and will be circulated to all Directors and General Managers for feedback.
- Data is being analysed in relation to clinic utilisation, volumes per speciality and clinic capacity to support the project.
- Access, booking and choice policy has been written and approved by the Provider Group. The policy will be rolled out across the organisation. Clear KPIs will also be implemented alongside this policy.
- A business case has been written to describe the various options for a more robust process for the management of letters across the organisation and this will be presented to the relevant committee within the next 4-6 weeks.
- The first Programme Board meeting took place in December 2016 and Project Managers are currently being recruited for the workstreams.
- Literature reviewed for new models of care and mapped against requirements and criteria. DHB capability analysis has commenced.
- Discussions around collaboration model with Counties Manukau DHB and Waitemata DHB started.

**Auckland DHB Provider Scorecard**  
for January 2017

	Measure	Actual	Target	Prev Period	Commentary
<b>Patient Safety</b>	% AED patients seen within triage time - triage category 2 (10 minutes) <span style="float: right;"><i>PR006</i></span>	77.46%	>=80%	74.26%	Improvement over last period. Hyperacute stroke pathway will speed assessment of stroke patients.
	% CED patients seen within triage time - triage category 2 (10 minutes) <span style="float: right;"><i>PR008</i></span>	93.86%	>=80%	89.68%	
	Number of reported adverse events causing harm (SAC 1&2) <span style="float: right;"><i>PR084</i></span>	1	<=12	5	
	Central line associated bacteraemia rate per 1,000 central line days <span style="float: right;"><i>PR087</i></span>	0	<=1	1.09	
	Healthcare-associated Staphylococcus aureus bacteraemia per 1,000 bed days <span style="float: right;"><i>PR088</i></span>	0.29	<=0.25	0.08	Increase in vascular access device-related infections - for review .
	Healthcare-associated bloodstream infections per 1,000 bed days - Adult <span style="float: right;"><i>PR089</i></span>	1.62	<=1.6	1.34	Increase in vascular access device-related infections contributing to increase overall HA-BSI rate.
	Healthcare-associated bloodstream infections per 1,000 bed days - Child <span style="float: right;"><i>PR090</i></span>	2.39	<=2.4	2.76	
	Falls with major harm per 1,000 bed days <span style="float: right;"><i>PR095</i></span>	0.07	<=0.09	0	
	Nosocomial pressure injury point prevalence (% of in-patients) <span style="float: right;"><i>PR097</i></span>	4.81%	<=6%	1.59%	
	Rate of hospital-onset healthcare-associated Clostridium difficile inpatients >=16 years of age per 10,000 bed days (ACH) (Quarterly) <span style="float: right;"><i>PR143</i></span>	3.04	<=4	1.56	
	Nosocomial pressure injury point prevalence - 12 month average (% of in-patients) <span style="float: right;"><i>PR185</i></span>	3.7%	<=6%	3.83%	
	% Hand hygiene compliance <span style="float: right;"><i>PR195</i></span>	81.55%	>=80%	84.79%	
	Unviewed/unsigned Histology/Cytology results > 90 days <span style="float: right;"><i>PR290</i></span>	105	0	95	Significant progress over several months. The IM team is working with services to cease the distribution of paper results. Regular reports sent to Directorate Directors for review and action. Quarterly review planned at Provider Group.

(MOH-01) % AED patients with ED stay < 6 hours	PR013	94.85%	>=95%	93.77%	
(MOH-01) % CED patients with ED stay < 6 hours	PR016	97.61%	>=95%	94.69%	
% Inpatients on Older Peoples Health waiting list for 2 calendar days or less	PR023	75.89%	>=80%	91.62%	The service was working to their summer bed plan in January based on previous expected levels of demand. Demand was higher than expected between end of December and the 2nd week in January which impacted on the waiting time into Reablement Services overall.
HT2 Elective discharges cumulative variance from target	PR035	0.97	>=1	0.95	Recovery plans are in place and performance is improving. Additional day-stay cases during industrial action have also boosted discharge numbers.
(ESPI-2) Patients waiting longer than 4 months for their FSA	PR038	1.04%	0%	0.31%	Industrial action on the back of the holiday period has prevented mitigation of the reduced capacity. Expect to return to orange again in March.
(ESPI-5) Patients given a commitment to treatment but not treated within 4 months	PR039	5.78%	0%	3.62%	ESPI 5 non-compliance is driven by Orthopaedics (for which we have MOH dispensation). The remainder of services have gone red for January due to industrial action on the back of the holiday period, and will recover to orange for February.
Cardiac bypass surgery waiting list	PR042	82	<=108	108	
% Accepted referrals for elective coronary angiography treated within 3 months	PR043	100%	>=90%	100%	
% Urgent diagnostic colonoscopy compliance	PR044	92.31%	>=85%	95.83%	
% Non-urgent diagnostic colonoscopy compliance	PR045	73.57%	>=70%	94.75%	
% Outpatients and community referred MRI completed < 6 weeks	PR046	48.14%	>=85%	66.83%	High no of MRT vacancies and a 6 month training period has resulted in decrease in performance. Outsourcing options are being explored.
% Outpatients and community referred CT completed < 6 weeks	PR047	91.77%	>=95%	97.52%	Stat holidays and vacancies reduced capacity in January.
Elective day of surgery admission (DOSA) rate	PR048	68.63%	>=68%	65.38%	
% Day Surgery Rate	PR052	66.64%	>=70%	53.47%	% Day increase largely down to targeted increase in daycase work during industrial action in January.
Inhouse Elective WIES through theatre - per day	PR053	R/U	>=99	136.39	
% DNA rate for outpatient appointments - All Ethnicities	PR056	9.93%	<=9%	10.28%	
% DNA rate for outpatient appointments - Maori	PR057	18.78%	<=9%	19.7%	HKW continues to "call to remind" as well as follow up after DNA for outpatient clinics. Cancer and Blood, Diabetes and Cardiac Clinics are still our priority.
% DNA rate for outpatient appointments - Pacific	PR058	19.64%	<=9%	20.77%	The rate sitting at 19.74% reduced from 20.77%. The call-backs to Cancer and Blood pacific patients is showing a good result at 11.19%.



% Chemotherapy patients (Med Onc and Haem) attending FSA within 4 weeks of referral	PR059	94.69%	100%	98.46%	Stat holidays and RMO strike reduced clinic capacity. In addition a number of FSA slots had to be used as on treatment slots.
% Radiation oncology patients attending FSA within 4 weeks of referral	PR064	85.25%	100%	94.41%	Stat holidays and RMO strike reduced clinic capacity. In addition there was significantly reduced clinic capacity 28-30/12 and 04-06/01 based on anticipated/historic referral volumes.
% Cancer patients receiving radiation/chemo therapy treatment within 4 weeks of DTT	PR070	99.36%	100%	100%	
Average LOS for WIES funded discharges (days)	PR074	1.97	<=3	2.48	
28 Day Readmission Rate - Total	PR078	R/U	<=6%	9.07%	
Mental Health - 28 Day Readmission Rate (KPI Discharges) to Te Whetu Tawera	PR119	R/U	<=10%	7.41%	
Mental Health Average LOS (KPI Discharges) - Te Whetu Tawera	PR120	28.4	<=21	19.3	Although above target & well above the extremely low December figure (19.3d), this is a marked improvement on recent months which saw Av LoS at more than 30 days.
% Very good and excellent ratings for overall inpatient experience	PR154	R/U	>=90%	84.08%	
Number of CBU Outliers - Adult	PR173	338	0	461	Improvement through January.
% Patients cared for in a mixed gender room at midday - Adult	PR175	14.03%	0%	13.62%	Further analysis required to assess if increase associated with Seasonal plan.
31/62 day target – % of non-surgical patients seen within the 62 day target	PR181	R/U	>=85%	92.63%	
31/62 day target – % of surgical patients seen within the 62 day target	PR182	R/U	>=85%	83.78%	
62 day target - % of patients treated within the 62 day target	PR184	R/U	>=85%	87.86%	

Improved Health Status	Breastfeeding rate on discharge excluding NICU admissions	PR099	R/U	>=75%	78.84%	Transitioning to new 1 July MoH reporting requirements that will replace relapse with wellness plans.	
	% Long-term clients with relapse prevention plans in last 12 months (6-Monthly)	PR125	*	89.45%	>=95%		91.41%
	% Hospitalised smokers offered advice and support to quit	PR129		95.45%	>=95%		95.68%

**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

**PR053**

Result unavailable until after the 10th day of the next month.

**PR078, PR119**

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

**PR099**

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

**PR154**

This measure is based on retrospective survey data, i.e. completed responses for patients discharged the previous month.

**PR181, PR182, PR184**

Results unavailable from NRA until after the 20th day of the next month.

**\*** = Quarterly or 6-Monthly Measure

**PR125 (6-Monthly)**

Actual result is for the period ending December 2015. Previous period result is for period ending June 2015.

**PR143 (Quarterly)**

Actual result is for the period ending December 2016. Previous period result is for period ending September 2016.

## Clinical Support Directorate

Speaker: Ian Costello, Director

### Service Overview

The Clinical Support Directorate is comprised of the following service delivery group; Hospital Daily Operations (including transit, resource, nursing bureau and reception), Patient Services Centre (Administration, Contact Centre and Interpreter services), Allied Health Services (including Physiotherapy, Occupational Therapy, Speech Language Therapy, Social Work), Radiology, Laboratory – including community Anatomical Pathology, Gynaecological Cytology, Clinical Engineering and Pharmacy.

The Clinical Support Services Directorate is led by:

Director:	Ian Costello
General Manager:	Kelly Teague
Director of Nursing:	Joyce Forsyth
Director of Allied Health:	Moses Benjamin
Director of Primary Care:	Dr Barnett Bond

### Directorate Priorities for 16/17

**In 2016/17 our Directorate will contribute to the delivery of the six Provider Arm work programmes. In addition to this we will also focus on the following Directorate priorities:**

1. Develop and implement a robust strategy for each service working in collaboration with other Directorates to deliver agreed priorities aligned to ADHB strategy.
2. Implement an appropriate leadership and organisational structure for each service to deliver on the agreed priorities.
3. Develop workforce, capacity and people plans for each of our services that support quality, efficiency and alignment with ADHB values in delivering the organisational priorities.
4. Embed a discipline of quality driven activity, financial responsibility and sustainability in each service area and across the Directorate through further utilisation of MOS and other enablers. To enhance visibility of this through improved reporting and analysis against agreed priorities with key stakeholders.
5. To identify and implement collaborative opportunities with the University of Auckland, AUT and other potential partners to deliver improvement in quality, outcomes, research and joint ventures.
6. Achieve Directorate financial savings target for 2016/17.

## Q3 Actions – 90 and 180 day plan

Priority	Action Plan
<b>1</b>	<ul style="list-style-type: none"> <li>Laboratory and Radiology strategy documents to be discussed at Provider Group Feb 2017</li> <li>Pharmacy and Medicines strategy- Phase 2 implementation underway</li> </ul>
<b>2</b>	<ul style="list-style-type: none"> <li>Leadership appointments, orientation and induction programme underway in Allied Health</li> <li>MOS system established and functional at Directorate level and at departmental level in the following areas: Pharmacy, Daily Operations, Radiology, Laboratories and Clinical Engineering</li> </ul>
<b>3</b>	<ul style="list-style-type: none"> <li>Workforce planning completed in Pathology. Model to be applied across specialities and professions in Laboratory</li> <li>Data and reports to support capacity planning in Radiology and Laboratories developed</li> <li>Four Clinical Support Staff members attending the next phase of the Improvement Practitioner (Green Belt) training commencing Feb 2017</li> <li>Four Clinical Support Staff members attending the Coaching Programme commencing in March 2017</li> <li>Four Senior Clinicians/Managers attending Leadership Development Course commencing in March 2017</li> </ul>
<b>4</b>	<ul style="list-style-type: none"> <li>Introduce regular integrated Clinical Governance and quality meetings at service level – Draft TOR established for Radiology and Laboratory</li> <li>Automation of Directorate Scorecard is underway</li> <li>Pharmacy and Clinical Engineering scorecards to be established</li> <li>Financial objectives set for each Department, monitoring and reporting process centralised at Directorate level</li> <li>Operational forecasting and planning - Production planning integrated with Daily Ops function – supports weekly Capacity and Demand forum and seasonal plan development</li> </ul>
<b>5</b>	<ul style="list-style-type: none"> <li>Collaboration Steering Groups agreed with University of Auckland for Pharmacy, Radiology and Laboratories</li> </ul>
<b>6</b>	<ul style="list-style-type: none"> <li>Savings plan developed and risk assessed</li> <li>Interpreter services pilot completed and report to Provider Group February 2017</li> </ul>

## Measures

Measures	Actual	Target (End 16/17)	Previous Period
Strategy and priorities agreed for each service	Consultations documents published	Labs and Radiology approved by April 17 Daily Ops Dec 16	Pharmacy implemented
Leadership structures implemented	Consultations documents published	Labs and Radiology implemented by Jun17 Daily Ops Mar 17	Pharmacy implemented
Succession plans in place for key roles	Key roles identified	Key roles have leadership development plan within department by Dec 16	n/a
Workforce, capacity and quality outcome measures developed for all services	Workforce and capacity data collection underway	Workforce, capacity plans: Pharmacy completed Pathology completed Labs completed Radiology Mar 17	n/a
Strategic plans agreed for collaborations with the University of Auckland	MoU's in development	Steering groups established for Pharmacy, Radiology, Labs	n/a
Breakeven to budget position and savings plan achieved	Savings plan developed.  Suite of business management and quality reports in development.	Breakeven  Detailed business management and quality reporting implemented	n/a

## **Key achievements in the month**

- Access, Booking and Choice policy for the management of outpatients has been finalised and agreed across Directorates
- The recruitment to the Clinical Lead roles for the Allied Health services (Physiotherapy, Occupational Therapy, Speech and Language, Social Work and Dietetics) has been completed. This will provide greater leadership in service delivery and development
- An Allied Health service excellence project has begun to define the core purpose and vision of each of the Allied Health services and alignment to directorate and organisational strategies
- Turnaround times for histology at APS Mount Wellington significantly improved
- Air conditioning for Greenlane outpatients installed
- Medicines Academic Practice Unit has been formed with the School of Pharmacy and School of Nursing to enhance research, education and development in the field of medicines management, medication safety and patient medication support. Three research grant bids have been successful
- Recruitment to Forensic Pathology and APS Mount Wellington SMO positions completed

## **Key issues and initiatives identified in coming months**

- Continue progress on implementation of an Integrated Daily Operations Centre
- Continue to improve the process for patients receiving their appointment letters
- Continue with implementation of the Interpreter improvement project
- Orderly Service to commence review of patient dispatching and management of patient transfers in February
- Radiology waiting list recovery plan and strategic plan for MRT workforce planning
- Consult on Pathology and Radiology strategies

## Scorecard

### Auckland DHB - Clinical Support Services HAC Scorecard for January 2017

	Measure	Actual	Target	Prev Period
Patient Safety	Medication Errors with major harm	0	0	0
	Number of reported adverse events causing harm (SAC 1&2)	0	0	0
Better Quality Care	Number of complaints received	3	No Target	1
	% Outpatients and community referred MRI completed < 6 weeks	48.14%	>=85%	66.83%
	% Outpatients and community referred CT completed < 6 weeks	91.77%	>=95%	97.52%
	% Outpatients and community referred US completed < 6 weeks	78.5%	>=95%	85.8%
Engaged Workforce	Excess annual leave dollars (\$M)	\$0.63	0	\$0.69
	% Staff with excess annual leave > 2 years	7.56%	0%	8.13%
	% Staff with excess annual leave and insufficient plan to clear excess by the end of financial year	R/U	0%	R/U
	Number of Pre-employment Screenings (PES) cleared after the start date	1	0	1
	Sick leave hours taken as a percentage of total hours worked	3.5%	<=3.4%	3.5%
	% Voluntary turnover (annually)	9.71%	<=10%	9.86%
	% Voluntary turnover <1 year tenure	4.86%	<=6%	4.11%

R/U Result unavailable

## Scorecard commentary

### Radiology

**Overall:** Performance against Ministry of Health (MoH) indicators across modalities has decreased significantly over the last 2 months due to a combination of sick leave, annual leave, parental leave and vacancies. An increase in acute referrals has also contributed to this as a result of higher than anticipated admissions requiring imaging diagnostics. Recruitment strategies and staff training combined with process improvement activity and short term outsourcing will have a positive impact on the waitlist over the coming months.

### MRI

Performance against the MRI target of 85% of referrals completed within six weeks has dropped considerably in January (48%) compared to performance over the last six months. This is mainly caused by short term capacity challenges arising over the holiday period and planned and unplanned MRT vacancies. The majority of vacancies have been filled, but it has proven difficult to recruit experienced MRTs in to these roles. The majority of new recruits are recent graduates who require a further six months post-graduate training to be able to perform MRIs. In addition, overseas appointees must undergo this training as previous experience is not recognised by the New Zealand regulator.

A number of challenges still remain with specialist investigations, especially congenital cardiac services, due to acute staffing issues. Directorates are working in collaboration to rectify this issue.

The number of adult patients waiting longer than 42 days increased to 262 patients at the end of January 2017. The number of paediatric patients waiting longer than 42 days has remained stable at three.

A recovery plan is in place involving short, medium and long term strategies. In the short term outsourcing to external providers will improve the position. These options are being finalised with the support of healthAlliance procurement and Planning and Funding.

Medium term we have recruited additional MRT graduates to provide succession planning and mitigate future occurrence of the recruitment gap.

Longer term, workforce planning strategies are being developed with the training institutions. Scoping the potential for a collaborative approach to training, support and utilisation of MRT staff across the three Auckland DHBs may also be of value

## **CT**

Performance against the MoH indicator of 95% of out-patients completed within six weeks has slightly deteriorated and is currently at 92% for January 2017. A reliable service model is in place and there is a high degree of confidence that performance against this target will improve and be maintained over the coming months as recruitment to vacant posts continues.

## **Ultrasound**

While this is an internal target (95%) we are mindful of the importance of patient access to service and safe waitlist management. Performance against this target has shown a slight deterioration to 78% of out-patients scanned within 6 weeks in January 2017. We continue to work on long term solutions to manage demand, for example, through direct communication with all GP referrers and providing clinical advice and guidance where required.

## **Complaints**

There were 3 complaints received in January 2017 compared to 6 in December 2016 and 11 in November 2016. All the complaints in January related to booking and scheduling information and how this was provided. We are reviewing options for customer service training for all booking, scheduling and Patient Contact Centre staff. The Directorate has recently introduced a complaints action plan database to ensure that actions are complete and that a 'lessons learnt' approach is adopted which will be shared across all departments.

## **Incidents**

There was 1 falls incident reported for January 2017 which occurred in Radiology. No harm was reported. The incident was reviewed and corrective actions have been put in place.

No SAC1 or SAC 2 incidents were reported in January 2017.

No moderate or major medication incidents were reported in January 2017.

Quality and Patient Safety leads have been identified in each service to form the Directorate Quality, Safety and Governance Committee. Quality markers are being developed through this group for all our services together with an annual Clinical Audit Programme that aligns to corporate and Directorate strategies.

- Clinical Engineering has further increased compliance against the Safety Maintenance programme and has now reached 98% compliance for over 17,000 medical devices.
- The pilot of telephone interpreting consultations continues within a number of clinics within the Long Term Conditions and Surgical Directorates. The aim is to reduce waiting times and



increase capacity in our interpreting services. Discussions on the potential for collaboration around Interpreting Services have begun with Counties MDHB and Waitemata DHB.

- The Directorate is developing a strategic approach to education, training and research across a range of professions. A key element is the development of a strategic partnership with Auckland University through the Academic Health Alliance. Steering Committees have been formed with the University to review opportunities for collaboration in Pharmacy, Pathology and Radiology.
- The Directorate Health and Safety Committee continues to have oversight of Health and Safety issues in the Directorate. Each department has developed a risk register which in turn escalates to the Directorate Register. A gap analysis has been undertaken across the directorate to determine the training requirements for Health and Safety Representatives.
- A monthly HR report has been developed for the Directorates Senior Leadership to review and take action with regards to improving excess annual leave, sick leave and voluntary turnover. A mandatory training database has been developed for the Directorate to ensure all staff have the relevant training to support safety and competency requirements within each of our services.
- Auckland DHB values workshops have been undertaken in several departments with a view to a roll out.
- The Engagement Survey results are being analysed for each service. Initial analysis has identified areas for improvement in a number of services around engagement, awareness of strategy, workload and culture. Feedback to staff and support for our service leadership teams will be important to address the findings and improve staff engagement.
- The Speak up Campaign has been launched across all of our services through presentations and workshops.
- This year will see significant service transformation and strategy development in many of our services which will require staff engagement for this to be successful. Support for senior managers across the directorate is being developed with the support of the Organisational Development department.

## Financial Results

STATEMENT OF FINANCIAL PERFORMANCE						
Clinical Support Services						Reporting Date <b>Jan-17</b>
(\$000s)	MONTH			YEAR TO DATE (7 months ending Jan-17)		
	Actual	Budget	Variance	Actual	Budget	Variance
<b>REVENUE</b>						
Government and Crown Agency	1,358	1,663	(306) U	10,491	11,601	(1,110) U
Funder to Provider Revenue	2,532	2,532	0 F	21,141	21,141	(0) U
Other Income	860	1,065	(205) U	8,406	8,169	237 F
<b>Total Revenue</b>	<b>4,749</b>	<b>5,260</b>	<b>(511) U</b>	<b>40,039</b>	<b>40,911</b>	<b>(873) U</b>
<b>EXPENDITURE</b>						
<b>Personnel</b>						
Personnel Costs	10,325	10,699	374 F	71,507	75,375	3,869 F
Outsourced Personnel	249	45	(204) U	2,832	315	(2,516) U
Outsourced Clinical Services	346	492	146 F	4,147	3,548	(600) U
Clinical Supplies	3,219	3,316	97 F	27,358	26,741	(617) U
Infrastructure & Non-Clinical Supplies	401	427	25 F	3,488	3,245	(243) U
<b>Total Expenditure</b>	<b>14,541</b>	<b>14,979</b>	<b>439 F</b>	<b>109,332</b>	<b>109,224</b>	<b>(107) U</b>
<b>Contribution</b>	<b>(9,792)</b>	<b>(9,719)</b>	<b>(73) U</b>	<b>(69,293)</b>	<b>(68,313)</b>	<b>(980) U</b>
Allocations	(6,704)	(6,881)	(177) U	(54,955)	(55,505)	(550) U
<b>NET RESULT</b>	<b>(3,088)</b>	<b>(2,838)</b>	<b>(250) U</b>	<b>(14,338)</b>	<b>(12,808)</b>	<b>(1,530) U</b>
<b>Paid FTE</b>						
	MONTH (FTE)			YEAR TO DATE (FTE) (7 months ending Jan-17)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	146.1	143.0	(3.1) U	140.7	143.0	2.3 F
Nursing	69.1	81.0	11.9 F	71.7	81.0	9.3 F
Allied Health	811.8	815.4	3.6 F	804.1	820.1	16.0 F
Support	71.4	70.6	(0.9) U	72.3	70.6	(1.7) U
Management/Administration	289.7	292.7	3.0 F	292.6	292.7	0.1 F
<b>Total excluding outsourced FTEs</b>	<b>1,388.2</b>	<b>1,402.6</b>	<b>14.5 F</b>	<b>1,381.4</b>	<b>1,407.4</b>	<b>26.0 F</b>
Total :Outsourced Services	7.6	1.1	(6.5) U	20.0	1.1	(18.9) U
<b>Total including outsourced FTEs</b>	<b>1,395.8</b>	<b>1,403.7</b>	<b>8.0 F</b>	<b>1,401.4</b>	<b>1,408.5</b>	<b>7.1 F</b>

### Comments on major financial variances

YTD result is \$1,530K U. The key drivers of this result are:

1. Revenue is below budget in Radiology due to planned additional revenue for Clot Retrieval not received \$1,079K, offset by on call roster not implemented \$444K and additional service billing so cost neutral for directorate. Other income is favourable due to a combination of increased Clinical Trial revenue in Pharmacy, and Laboratories, due to price per test and volumes being above budget.
2. Personnel costs including outsourced are \$1,353K F to budget due to vacancies and phasing of recruitment.
3. The main contributor to Outsourced Clinical Supplies is MRI scans in Radiology to meet Ministry of Health targets.

4. Clinical Supplies over budget by \$617K. \$270K due to savings from delivery of interpreter's service not being achieved in the first half of the FY. \$322 K U in Pharmacy due to increased trials but offset by revenue above.
5. Internal allocations are lower than budget reflecting organisational volumes being below contract.



## Women's Health Directorate

Speaker: Dr Sue Fleming, Director

5.4

### Service Overview

The Women's Health portfolio includes all Obstetrics and Gynaecology services in addition to the Genetics Services provided via the Northern Genetics Hub. The services in the Directorate are divided into six service groups:

- Primary Maternity Services
- Secondary Maternity Services
- Regional Maternity Services
- Secondary Gynaecological Services (including Fertility Services)
- Regional Maternity Services
- Genetics Services

#### **The Women's Health Directorate is led by:**

Director: Dr Sue Fleming

General Manager and Nursing Professional lead: Karin Drummond

Director of Midwifery: Melissa Brown

Director of Allied Health: Linda Haultain

Director of Primary Care: Dr Diana Good

### Directorate Priorities for 16/17 Q2 – 90 day plan update

#### **1. Demonstrably safer care**

##### *Afterhours care*

We continue to work on strengthening our afterhours care, which includes working with Adult Surgical Services to explore options for enhancing our capacity to provide timely access to operating theatres afterhours by moving resourced theatre capacity to level 8.

We are progressing a plan to strengthen Midwifery Care, including afterhours, in a way that aligns with the broader 24/7 Hospital Functioning model of care and structure. A formal consultation process will commence in April.

##### *Pregnancy and Parenting Programme*

The programme is successfully reaching Asian/Sub-Asian continent women with good uptake through the community classes. More challenging is reaching Maori, Pacific and young/teen parents. A variety of creative approaches are being used including: opportunistic education for patients who attend outpatient clinics or have inpatient admissions; home visits for the most vulnerable; and using more holistic approaches to providing education within local communities.

Ngati Whatua Orakei run three group courses and two waananga using a holistic approach to the education, encompassing elements of wairua (spiritual), tinana (physical), hinengaro (mental) and whanau (family) is unique, very culturally affirming and, overall, provides for a very empowering experience for all.

### *Wahine Ora*

The multiagency forum that plans and coordinates wrap around services for pregnant women experiencing complex social risk has been a primary area of focus over the previous twelve months. Achievements include: the development of a practice guideline for socially complex pregnant women who require an enhanced pathway; teaching our LMC workforce how to implement the pathway; publication of the model of early intervention services provided by Women's Health Social Work having successfully completed a quality audit; the establishment of the Māori midwifery team; reporting metrics drafted and work underway to strengthen our governance structure. While this work continues to be challenging, significant progress has been made. This is evident by a significant reduction in sentinel events, and no un-planned transitions into care having occurred this year.

### *Clinical Governance – Aspiring to Excellence programme*

Following a workshop with all our senior leaders, clinicians and consumers we have strengthened our Clinical excellence programme. We recognise that we need to strengthen our leadership for both operational and clinical quality and safety matters which we propose to address through our leadership development and excellence programme.

We continue to progress our work with our nominated formal consumer representative to ensure consumer representation on all our key Clinical Excellence Groups and the formation of a Women's Health Consumer Council.

### *Faster cancer treatment*

We have made consistent improvement in meeting targets over the past six months.

- Performance has increased from 68% in Q 2 to 85% as of mid-January.
- New patient administration templates and the establishment of a rapid access clinic has resulted in 78% of patients being seen for FSA within 14 days.
- 93% of patients are achieving the 31 day target for decision to treat to treatment.

## **2. An engaged, empowered and productive workforce**

We had an overall participation rate of 61% in the *Auckland DHB Employee Survey* with 58% of our SMO completing. We are working with our leaders to find ways to celebrate the positives from this survey and to develop plans to support our workforce where we have opportunities to do better.

Participation in Coaching Conversations and Leadership Development Programme continues.

Building Team Resilience workshops are now completed. Teams identified actions during the workshop, with follow through to come.

Our four weekly, *Aspiring to Excellence* multidisciplinary teaching programme continues to be a success. We plan to use this approach to support learning from quality and safety events.

### **3. Delivering of services in a manner that is sustainable, closest to home and maximises value**

#### *Postnatal discharge project*

We have demonstrated a reduction in post caesarean section length of stay following uncomplicated elective CS and have reached our target of 3 days.

#### *Reconfiguring our facilities*

After review of our level 9 and 10 facilities we have agreed that until a comprehensive review of the postnatal model of care is completed we need to retain our postnatal capacity on level 10.

#### *Pacific women's non-attendance (DNA) - Gynaecology Outpatient*

Our targeted efforts to reduce DNA rate for Pacific women continues. We plan to run a Pacific Engagement Programme in the first half of 2017 to increase our staffs' understanding of Pacific culture.

#### *Review of care pathways*

A new project is underway to streamline care for women undergoing an induction of labour. This will offer a more mobile, patient empowered approach to low risk women undergoing induction of labour. A new pathway for women with breech presentation who wish to increase their chances of a vaginal birth is in the final stages of design.

#### *Supporting Primary Birthing*

In 2016 we commenced a piece of work in collaboration with Birthcare to create a safe, caring birthing environment which is the preferred place of birth for low risk women and their midwives. This work, which is led by our SCD Primary Maternity Services, is progressing well.

### **4. Progress opportunities for regional collaboration ( Auckland DHB – WDHB Maternity Collaboration);**

The Womens Health Collaboration group have agreed priorities to enable high quality sustainable maternity services across the two DHBs. This will provide a roadmap for service improvement over the next 10 years. Ongoing oversight will be provided through the Pregnancy, Parenting and First Year of Life programme group, to ensure visibility and alignment with other initiatives being implemented in Auckland DHB and Waitemata DHB. Implementation of the initiatives will occur at a local DHB level and sit within each DHB's respective Maternity Quality and Safety programme (MQSP).

### **5. Ensure business models for services maximise funding and revenue opportunities**

#### *Develop sustainability model for gynaecology service*

We are challenged with the increasing Gynae-Oncology demand and the case mix complexity. In the short term we are working to maximise our theatre usage and utilisation and are recruiting additional workforce to help us meet our demand and faster cancer timeframes. We are developing a sustainable service plan that aligns with the National 3 centre model endorsed by the MOH.

*Plan to increase private revenue generation by Fertility Plus*

We have formally appointed a Business Development Manager who started in early January 2016; they will lead our redesign work within both Fertility and Genetic Services to enable growth in revenue. We are building our private volumes and have increased pricing for private patients effective 1 March 2017.

## Directorate Priorities for 16/17 Q3 and Q4

**We have refreshed our Directorate Priorities for the 3<sup>rd</sup> and 4<sup>th</sup> quarters of 16/17. We will strengthen our focus on the value of the care that we deliver. Many of our work streams will continue. Some new pieces of work are underway.**

1. Demonstrably safer care (*Deteriorating Patients, Afterhours Inpatient Safety, Faster Cancer Treatment*)
2. Strengthened leadership for both operational matters and clinical quality and safety (*Leadership development, New Excellence program*)
3. An engaged, empowered and productive workforce (*efficient rostering and scheduling, teaching and training, expanding scope of practice, living our values*)
4. Delivery of services in a manner that is sustainable, closest to home and maximises value (*Daily Hospital Functioning, Using the Hospital Wisely, Outpatient Redesign*)
5. Ensure business models for services maximise funding and revenue opportunities (*address funding shortfalls, public/private revenue opportunities*).

*Note: Italics shows alignment to Provider Arm work programmes and/or productivity and savings priorities.*

	Action plan for Q3 and Q4	Sponsor	Q1	Q2	Q3	Q4
1	Implementation of afterhours inpatient safety model	Sue Fleming				
1	Vulnerable women pathways agreed	Linda Haultain				
1	Markers of vulnerability determined	Linda Haultain				
2	Leadership training for all SCDs, MUMs and NUMs	Sue Fleming				
2	Embed Auckland DHB values	Louise Bull				
2	Strengthen employee engagement	Louise Bull				
3	Efficient rostering of medical staff	Sue Fleming				
3	Maternity workforce plan developed and implemented	Melissa Brown				
4	Pathways review for acute gynaecology patients	Sue Fleming				
4	Collaborative primary birthing project	Melissa Brown				
5	Sustainability plan for Genetics (5 yrs plan)	Sue Fleming				
5	Sustainable service delivery by Fertility Plus	Karin Drummond				
5	Develop sustainability model for gynae-oncology	Karin Drummond				



## Measures

Measures	Current	Target (End 16/17)
Average length of stay after elective CS	3.1	3
FCT targets met (62 day target)	87.5%	85%
Elective surgical targets met	91%	100%
% of category 2 caesarean section patients meeting 60 min. time target	80%	95%
Number of unplanned transitions to care	0	0
Nursing and midwifery FTE variance from budget	1.78 FTE	0 FTE
Breakeven revenue and expenditure position	\$879,000 U	Breakeven
Vacancies in midwifery workforce	22.5	10
Number of women having primary births at BirthCare/month	26	32

### Key achievements in the month

- We maintained near full service delivery over the January strike period whilst also allowing many staff to take leave over the festive period
- Our Business Development Manager commenced on 16 January
- We progressed Genetic services salary bargaining with agreement to align with the National Genetic services pay scales. This was signed off under a memorandum of understanding
- We have refreshed our Womens Health priorities for quarter 3 and 4, and our action plan

### Areas off track and remedial plans

- We continue to be challenged with our workforce measures. Work is underway to enable more effective rostering of our medical workforce. We are exploring electronic rostering systems that will enable us to better manage our SMO workforce and meet our operational needs.
- Despite an aggressive multi-pronged approach to recruitment we are carrying an increasing number of midwifery vacancies which places our maternity service at significant risk. Our Midwifery Director has developed a robust workforce strategy. We have 14 new graduates commencing in March 17. We are planning an open day to enable Auckland DHB nurses to explore the option in working within Women's Health, which will allow other services to offer roles to new graduate nurses.
- We face a critical shortage of Maternal Fetal Medicine Specialists (MFM). This is due to a mix of factors including delays with an academic appointment and two resignations. We have developed a robust plan which includes redefining the scope of work our MFM Specialists do for both for our Auckland DHB population and for other DHBs. We are actively recruiting and have identified two overseas MFM specialists who are appointable.

## **Key issues and initiatives identified in coming months**

- Progress consultation of Midwifery Workforce plan in line with the 24/7 Hospital Functioning decisions.
- Implementing price increase for private Fertility services
- As outlined above we have developed our action plans and measures for Q3 and Q4
- Develop a sustainable workforce plan for MFM team.

# Scorecard

## Auckland DHB - Women's Health HAC Scorecard for January 2017

	Measure	Actual	Target	Prev Period
Patient Safety	Medication Errors with major harm	0	0	0
	Number of falls with major harm	0	0	0
	Nosocomial pressure injury point prevalence (% of in-patients)	0%	<=6%	0%
	Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	0%	<=6%	0%
	Number of reported adverse events causing harm (SAC 1&2)	0	0	0
	Unviewed/unsigned Histology/Cytology results < 90 days	49	0	38
	Unviewed/unsigned Histology/Cytology results > 90 days	0	0	0
Better Quality Care	HT2 Elective discharges cumulative variance from target	0.9	>=1	0.88
	(ESPI-1) % Services acknowledging 90% of FSA referrals in 15 calendar days or less	R/U	100%	100%
	(ESPI-2) Patients waiting longer than 4 months for their FSA	0%	0%	0%
	(ESPI-5) Patients given a commitment to treatment but not treated within 4 months	0.6%	0%	0%
	% DNA rate for outpatient appointments - All Ethnicities	9.39%	<=9%	9.77%
	% DNA rate for outpatient appointments - Maori	27.48%	<=9%	23.95%
	% DNA rate for outpatient appointments - Pacific	21.34%	<=9%	22.4%
	Elective day of surgery admission (DOSA) rate	91.49%	>=68%	95.7%
	% Day Surgery Rate	41.03%	>=50%	31.13%
	Inhouse Elective WIES through theatre - per day	4.52	>=4.5	9.83
	Number of CBU Outliers - Adult	9	0	19
	% Very good and excellent ratings for overall inpatient experience	R/U	>=90%	75%
	% Very good and excellent ratings for overall outpatient experience	R/U	>=90%	77.4%
	Number of complaints received	6	No Target	3
	Number of patient discharges to Birthcare	312	TBC	298
	Average Length of Stay for WIES funded discharges (days) - Acute	1.66	<=2.1	1.87
Average Length of Stay for WIES funded discharges (days) - Elective	1.9	<=1.5	1.53	
Post Gynaecological Surgery 28 Day Acute Readmission Rate	R/U	No Target	4.64%	
Improved Health Status	% Hospitalised smokers offered advice and support to quit	92.75%	>=95%	93.1%
	Breastfeeding rate on discharge excluding NICU admissions	R/U	>=75%	78.84%
Engaged Workforce	Excess annual leave dollars (\$M)	\$0.31	0	\$0.35
	% Staff with excess annual leave > 1 year	26.95%	0%	27.9%
	% Staff with excess annual leave > 2 years	14.8%	0%	15.01%
	% Staff with excess annual leave and insufficient plan to clear excess by the end of financial year	R/U	0%	R/U
	Number of Employees who have taken greater than 80 hours sick leave in the past 12 months	127	60	129
	Number of Pre-employment Screenings (PES) cleared after the start date	0	0	1
	% Voluntary turnover (annually)	14.13%	<=10%	13.53%
	% Voluntary turnover <1 year tenure	7.55%	<=6%	3.92%

**Amber** Variance from target not significant enough to report as non-compliant. This includes percentages/rates within 1% of target, or volumes within 1 value from target. Not applicable for Engaged Workforce KRA.

**R/U** Result unavailable

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

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

**% Very good and excellent ratings for overall inpatient experience**

**% Very good and excellent ratings for overall outpatient experience**

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

**Post Gynaecological Surgery 28 Day Acute Readmission Rate**

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

**Breastfeeding rate on discharge excluding NICU admissions**

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

## Scorecard Commentary

- We have performed well in our patient safety metrics which is a reflection of our aspiring to excellence programme
- We are actively working to meet our elective discharge recovery plan. This includes additional theatre sessions and clinics to enable our Auckland DHB surgical waitlist to grow to meet the target. We continue to be challenged in meeting all our surgical demands within our current theatre capacity and are proactively reviewing our theatre utilisation to ensure we can optimise our lists.
- Our DNA rates for Maori have increased over the holiday period; however, we continue to make progress in reducing our Pacific DNAs.

## Financial Results

STATEMENT OF FINANCIAL PERFORMANCE						
<i>Womens Health Services</i>						Reporting Date <b>Jan-17</b>
(\$000s)	MONTH			YEAR TO DATE (7 months ending Jan-17)		
	Actual	Budget	Variance	Actual	Budget	Variance
<b>REVENUE</b>						
Government and Crown Agency	195	179	16 F	1,431	1,310	121 F
Funder to Provider Revenue	5,970	5,970	0 F	49,335	49,335	0 F
Other Income	151	250	(99) U	1,141	1,400	(260) U
<b>Total Revenue</b>	<b>6,316</b>	<b>6,399</b>	<b>(83) U</b>	<b>51,907</b>	<b>52,045</b>	<b>(139) U</b>
<b>EXPENDITURE</b>						
<b>Personnel</b>						
Personnel Costs	3,456	3,447	(9) U	23,894	23,300	(595) U
Outsourced Personnel	94	77	(17) U	322	540	218 F
Outsourced Clinical Services	49	38	(12) U	276	265	(11) U
Clinical Supplies	387	371	(16) U	3,117	3,028	(89) U
Infrastructure & Non-Clinical Supplies	70	78	9 F	561	547	(14) U
<b>Total Expenditure</b>	<b>4,056</b>	<b>4,011</b>	<b>(45) U</b>	<b>28,170</b>	<b>27,680</b>	<b>(489) U</b>
<b>Contribution</b>	<b>2,260</b>	<b>2,388</b>	<b>(128) U</b>	<b>23,737</b>	<b>24,365</b>	<b>(628) U</b>
Allocations	692	634	(58) U	5,381	5,130	(251) U
<b>NET RESULT</b>	<b>1,568</b>	<b>1,754</b>	<b>(186) U</b>	<b>18,356</b>	<b>19,235</b>	<b>(879) U</b>
<b>Paid FTE</b>						
	MONTH (FTE)			YEAR TO DATE (FTE) (7 months ending Jan-17)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	70.0	66.3	(3.7) U	72.4	66.3	(6.0) U
Midwives, Nursing	247.5	253.6	6.1 F	251.8	253.6	1.8 F
Allied Health	16.8	21.3	4.5 F	16.7	21.3	4.6 F
Support	0.0	0.0	0.0 F	0.0	0.0	0.0 F
Management/Administration	38.5	35.1	(3.4) U	39.4	35.3	(4.1) U
Other	0.0	0.0	0.0 F	0.0	0.0	0.0 F
<b>Total excluding outsourced FTEs</b>	<b>372.8</b>	<b>376.3</b>	<b>3.5 F</b>	<b>380.3</b>	<b>376.5</b>	<b>(3.8) U</b>
Total : Outsourced Services	3.6	2.6	(1.0) U	2.4	2.6	0.1 F
<b>Total including outsourced FTEs</b>	<b>376.3</b>	<b>378.9</b>	<b>2.5 F</b>	<b>382.7</b>	<b>379.1</b>	<b>(3.6) U</b>

## Comments on major financial variances (YTD)

The Directorate's result YTD shows a budget variance of \$879k U, mostly from lower private patient revenue, and higher personnel costs, higher Labs tests requested offset by a favourable reduction in doubtful debt provision

Overall YTD CWD volumes rose to 104% of contract and Specialist Neonates were steady at 80% for YTD (FY15/16: 70%).

The Gynaecology acute WIES continues to be high at 102%YTD of contract, and performance of their electives contract was 92% (of WIES contract value, but not discharge target).

### Revenue Allocation analysis YTD

The combined DRG and Non-DRG volumes equated to being \$997k F (last month \$171k F) of revenue *above* contract (not recognised in the Directorate result), a very large positive swing coming through in January for Maternity inpatient volumes.

### Jan.'17: Year-to-date- financial analysis:

- 1 Revenue \$139k U YTD.
  - a. **Non-Resident and Private patient** billing dropped further and is now \$180k U to budget. These revenues are unpredictable.
  - b. **Other income** is \$80k U and consists of donations of \$38k F from Starship Foundation to fund the purchase of Pepipods (see below), which offsets a Genetics budgeted income variance of \$128k U arising from a change in accounting policy for income received in advance.
  - c. **Government Revenue** is \$121k F due to ACC income, Colposcopy volume exceeding budget, and the new extension of the MFM contract which had been only budgeted to the known expiry date
- 2 Expenses

Expenditure variance is now \$741k U YTD; this variance is mostly the net result of:

  - a. **Personnel** \$595k U, mostly due to Medical payroll \$653k U:
    - i. Arising from 1FTE Senior Medical Officer (SMO) to handle the increase in IDF Gynaecology Oncology volumes, and 1.0 FTE SMO for a fellow position.
    - ii. House Officers FTEs 2.37 FTE U

Continued efforts in the Midwifery and Nursing workforce across a range of HR and operational strategies and initiatives, has sustained a drop in Bureau cost, which were down 19% YTD compared to January YTD last year.
  - b. **Outsourced personnel** \$218k F; as a result of a continued University vacancy, and this offsets some of the Medical payroll budget variance
  - c. **Clinical supplies** are \$89k U consisting of Pepipod purchases \$38k U (this is in regards to funding received in the Other Income, above) and a range of instrument and diagnostic cost over-runs that are tracking the volume increases of inpatients.
  - d. **Infrastructure and Non-Clinical** total of \$14k U.
  - e. **Internal Allocations** total \$251k U Mostly due to higher than budgeted Labs test requests \$188k U for Gynaecology, Maternity and Send-away tests for Genetics.



## Child Health Directorate

Speakers: Dr John Beca, Surgical Child Health Director and Dr Michael Shepherd, Medical Child Health Director.

### Service Overview

The Child Health Directorate is a dedicated paediatric healthcare service provider and major teaching centre. This Directorate provides family centred care to children and young people throughout New Zealand and the South Pacific. Care is provided for children up to their 15th birthday, with certain specialised services beyond this age range.

A comprehensive range of services is provided within the two Directorate portfolios:

#### Surgical Child Health

- Paediatric and Congenital Cardiac Services, Paediatric Surgery, Paediatric ORL, Paediatric Orthopaedics, Paediatric Intensive Care, Neonatal Intensive Care, Neurosurgery.

#### Medical Child Health

- General Paediatrics, Te Puaruruhau, Paediatric Haematology/Oncology, Paediatric Medical Specialties (Dermatology, Developmental, Endocrinology, Gastroenterology, Immunology, Infectious Diseases, Metabolic, Neurology, Chronic Pain, Palliative Care, Renal, Respiratory, Rheumatology), Children's ED, Consult Liaison, Safekids and Community Paediatric Services (including Child Health and Disability, Family Information Service, Family Options, Audiology, Paediatric Homecare and Rheumatic Fever Prevention).

#### The Child Health Directorate is led by

Director Surgical:	Dr John Beca
Director Medical:	Dr Mike Shepherd
General Manager:	Emma Maddren
Director of Nursing:	Sarah Little
Director of Allied Health:	Linda Haultain
Director of Primary Care:	Dr Barnett Bond

### Directorate Priorities for 16/17

**In 2016/17 our Directorate will contribute to the delivery of the six Provider Arm work programmes. In addition to this we will also focus on the following Directorate priorities:**

1. Further embedding Clinical Excellence programme
2. Financial sustainability and achieve Directorate financial savings target for 2016/17
3. Community services redesign
4. Aligning services to patient pathways
5. Hospital operations/inpatient safety
6. Meaningful involvement from our workforce in achieving our aim
7. Tertiary service / National role sustainability

## Q3 Actions – 90 day plan

Priority area	Action plan	Commentary
1.	Robust system of safety event reporting and review	<ul style="list-style-type: none"> <li>Safe care committee established and reviewing all events</li> <li>Safety measures developed as part of directorate and service-level dashboard.</li> <li>Implementation of the new Safety Management System (Datix) in conjunction with Quality Department.</li> </ul>
2.	Excellence programme development within all services	<ul style="list-style-type: none"> <li>Directorate wide measures/dashboard.</li> <li>Further progress in the development of service-level metric dashboards.</li> <li>Patient safety culture, service level results presented and implementation planned.</li> <li>Exploring options to capture families' perceptions of safety culture.</li> </ul>
3.	Ongoing effective financial management	<ul style="list-style-type: none"> <li>Dual emphasis on revenue (ACC, donations, tertiary services) and cost containment.</li> <li>Further financial mitigations were developed and presented to the oversight committee</li> <li>An extensive leave management programme is in place across Child Health with a \$100k reduction year to date.</li> <li>Emphasis on financial strategy across multiple years to ensure enduring change.</li> </ul>
4.	Community service re-design	<ul style="list-style-type: none"> <li>Decision document released December 2016.</li> <li>Implementation planned for March 2017.</li> </ul>
5.	Establish hospital allied health leadership and integration	<ul style="list-style-type: none"> <li>SCD Allied Health role has made immediate progress in a range of workforce, revenue and improvement areas.</li> </ul>
6.	Rehabilitation service and TBI pathway development	<ul style="list-style-type: none"> <li>ADHB awarded the contract for the full continuum of services with contract go-live 1 December 2016.</li> <li>Collaboration with Waitemata DHB around the delivery of the full continuum of rehabilitation services continues. ADHB will subcontract WDHB to provide residential rehab and outpatient services.</li> </ul>
7.	Implementation of deteriorating patients model; implementation of afterhours inpatient safety model	<ul style="list-style-type: none"> <li>Proposed PaR governance structure and escalation process finalised</li> <li>Phase 1 of organisational Deteriorating Patients database completed which will enable reporting of identified measures once system change implemented.</li> <li>24/7 Hospital Functioning Decision document released.</li> </ul>
8.	Surgical performance	<ul style="list-style-type: none"> <li>The core requirements for a surgical dashboard have been agreed.</li> <li>The immediate priority is to provide sub-specialty production planning data for paediatric spinal surgery, this was complete in December with further refinements expected in early 2017.</li> </ul>
9.	Acute flow	<ul style="list-style-type: none"> <li>Direct admission from CED for General Paediatric patients is now occurring 24/7</li> <li>Discharge planning focus continues <ul style="list-style-type: none"> <li>Project group identified</li> <li>Initial data analysis completed</li> <li>Priority wards agreed</li> </ul> </li> </ul>
10.	Leadership development programme	<ul style="list-style-type: none"> <li>All Child Health service-level leadership staff have now participated in or are scheduled to participate in the leadership programme. Excellent feedback has been</li> </ul>



Priority area	Action plan	Commentary
		received to date and participants have identified development goals.
11.	Improved programme of funding for research and training for all Starship Child Health staff	<ul style="list-style-type: none"> <li>The Starship Foundation research, training and education programme was launched in July with \$500k available for the initial round of proposals.</li> <li>Seven high quality research proposals approved for funding in 2017</li> </ul>
12.	Tertiary services stakeholder engagement	<ul style="list-style-type: none"> <li>A proposal to the Ministry of Health is expected to be delivered in early 2017.</li> </ul>

## Measures

Measures	Current	Target (End 2016/17)	2017/18
Quality and Safety metrics established across services	All services are developing metrics	Well defined metrics	Reporting and improving
Quality and safety culture (AHRQ)	Measured, priority areas identified	Improved	Improved
Meet budget	Not met, contingencies in place	Budget met	Budget met
Achieve planned savings target	Nearly achieved	Achieved	Achieved
Community redesign programme	Consultation complete, redesign changes communicated.	Consultation completed, implementation commenced	Sustainable funding model aligned to service design
Operational structure that follows patient pathways	Includes Allied Health	Includes all	Includes all
Rehabilitation service model	Service commenced December 2016	Implemented	Pathway operational
Acute Flow metric	95%	95%	95%
Surgical performance and pathways	Metrics in development	Balanced safety, performance, efficiency	Improving performance
Defined safety metrics – Code Pink, urgent PICU transfer from ward	Developing in conjunction with wider organization Patient at Risk model	Defined and improving	Improved
Leaders completed leadership training	10/25	20/25	All
Staff satisfaction	Engagement survey complete	Measured	Improved
Tertiary services	Report complete	Consultation complete and outcome agreed	Implementation of agreed national approach

## Key achievements in the month

- Decision document published announcing the outcome of the Community Services Redesign. The new structure will be implemented in May 2017 with appointment to leadership roles and transition to the virtual locality model.
- Work progressed on the significant facilities projects within Starship including the patient lift replacement programme, level 5 refurbishment, outpatient refurbishment and cath lab HVAC installation.
- Auckland DHB was awarded the ACC contract for the provision of Specialist Paediatric and Adolescent Rehabilitation (SPAR) Services. This National continuum of services, provided in collaboration with Waitemata DHB, commenced on 1 December 2016.

## Areas off track and remedial plans

- Appointment to the Lead Clinician Clinical Excellence role – a suitable candidate has been identified who is likely to commence mid-2017.
- Financial performance – unfavourable result YTD, continued focus on optimising revenue and cost containment.
- Significant risks emerging from the refurbishment of levels 3 and 5 in Starship. Twice weekly risk mitigation meetings are occurring to ensure effective project delivery and to maintain clinical safety and minimise disruption to services.

## Key issues and initiatives identified in coming months

- Starship level 5, outpatients and cath lab projects will continue until May 2017.
- Starship lift replacement programme will continue until September 2017.
- Community Redesign Project – implementation will occur from May 2017.
- Continued development of the service-level clinical excellence groups and finalisation of the service-level outcome measures.
- Tertiary services proposal to the Ministry of Health timeline and strategy to be agreed.

## Starship Clinical Excellence Programme

The following scorecard is the latest iteration of the directorate wide Clinical Excellence programme measures.

Child Health is developing these measures and the corresponding targets and internationally relevant benchmarks. Over the next few months we will refine these measures and their use to either monitor clinical quality or assist with improvement. It represents a balanced view of quality for the directorate.

We plan to highlight different services' clinical outcomes each month, in this months example the key clinical effectiveness indicators for the Paediatric Intensive Care Unit (PICU) and Nursing are presented.

<b>Safety</b>					
	Frequency	Actual	Target	Benchmark	Previous
Confirmed central line associated bacteraemia rate per 1,000 central line days	Monthly	0	<=1		0
Probable central line associated bacteraemia rate per 1,000 central line days	Monthly	R/U	lower		R/U
% Hand hygiene compliance	Monthly	87.7%	100%	>=80%	88.1%
Medication Fluid Errors reported rate per 1,000 bed days	Monthly	6.2	higher	6.6	7.1
Medication Fluid Errors requiring intervention	Monthly	R/U	lower		R/U
Ward Code Blue Calls	Monthly	3	lower		0
Unexpected PICU admissions	Monthly	R/U	lower		R/U
% PEWS compliance	Monthly	88.8%	95%		97.5%
Nosocomial pressure injury point prevalence – 12 month average (% of in-patients)	Monthly	3.0%	<=6%		3.1%
Good Catches	Monthly	3	higher		3
		<b>PICU</b>	<b>SCH Best</b>	<b>Starship Average</b>	
Safety Culture - PICU		69	72	58	
<b>Timeliness</b>					
	Frequency	Actual	Target	Benchmark	Previous
(ESPI-2) Patients waiting longer than 4 months for their FSA	Monthly	0.16%	0%		0.16%
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Total	Monthly	9	0		8
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Maori	Monthly	2	0		1
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Pacific	Monthly	3	0		2
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Asian	Monthly	4	0		3
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Deprivation Scale Q5	Monthly	3	0		2
(ESPI-5) Patients given a commitment to treatment but not treated within 4 months	Monthly	5.4%	0%		3.0%
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Total	Monthly	42	0		24
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Maori	Monthly	2	0		1
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Pacific	Monthly	0	0		1
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Asian	Monthly	2	0		0
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Deprivation Scale Q5	Monthly	12	0		7
(MOH-01) % CED patients with ED stay < 6 hours	Monthly	95%	>=95%		94%
Median time on acute theatre list	Monthly	4.1	lower		3.9
<b>Efficiency</b>					
	Frequency	Actual	Target	Benchmark	Previous
% Adjusted Theatre Utilisation	Monthly	76.6%	>=80%	75%	75.8%
Occupancy	Monthly	92%	>=95%		R/U
Pathway Use	Monthly	R/U	higher		R/U
Laboratory cost per bed day	Monthly	R/U	lower		R/U

Radiology cost per bed day	Monthly	R/U	lower		R/U
% of patients discharged on a date other than their estimated discharge date	Monthly	33.9%	lower		35.8%
% Day Surgery Rate	Monthly	72%	>=55%	47%	62%
Antibiotic cost per bed day	Monthly	R/U	lower		R/U
PICU Exit Blocks	Monthly	16	0		3
<b>Effectiveness</b>					
	<b>Frequency</b>	<b>Actual</b>	<b>Target</b>	<b>Benchmark</b>	<b>Previous</b>
28 Day Readmission Rate – Total	Monthly	R/U	<=6%		8.3%
28 Day Readmission Rate – Maori	Monthly	R/U	<=6%		6.5%
28 Day Readmission Rate – Pacific	Monthly	R/U	<=6%		7.6%
28 Day Readmission Rate – Asian	Monthly	R/U	<=6%		7.8%
28 Day Readmission Rate – Deprivation Scale Q5	Monthly	R/U	<=6%		5.0%
<b>Service Outcome and Benchmarking Measures - PICU</b>					
	<b>Year</b>	<b>PICU</b>	<b>Target</b>	<b>Benchmark ANZICS</b>	
SMR (Standardised mortality ratio)	2015	1.18		1.0	
Efficiency index (risk adjusted LOS)	2015	0.86		1.0	
Failed extubations (rate/100 intubations)	2015	3.3		3.5	
Readmissions <72hrs post discharge from ICU (rate/100 discharges)	2015	3.3		3.3	
After hours discharges from PICU 1800-0600 (rate/100 discharges)	2015	1		7	
	<b>Frequency</b>	<b>2015-16</b>	<b>Target</b>	<b>Benchmark</b>	<b>2014-15</b>
Inability to admit to PICU (patients/year)	Annual	46			63
Inability to discharge from PICU (patients/year)	Annual	65			62
	<b>Frequency</b>	<b>Actual</b>	<b>Target</b>	<b>Benchmark</b>	<b>Previous</b>
Confirmed central line associated bacteraemia rate per 1,000 central line days	Monthly	0	<=1		0
Number of days since confirmed central line associated bacteraemia	Monthly	98	higher		67
% Hand hygiene compliance	Monthly	91.9%	100%	>=80%	93.33%
<b>Patient Centred</b>					
	<b>Frequency</b>	<b>Actual</b>	<b>Target</b>	<b>Benchmark</b>	<b>Previous</b>
% Very good and excellent ratings for overall inpatient experience	Monthly	R/U	>=90%		86%
% Very good and excellent ratings for overall outpatient experience	Monthly	R/U	>=90%		80%
Nursing Family Feedback	Monthly	88%	>=90%		95%
% Was Not Brought (WNB) rate for outpatient appointments – All Ethnicities	Monthly	11%	<=9%	10.5%	12%
% Was Not Brought (WNB) rate for outpatient appointments – Maori	Monthly	18%	<=9%	10.5%	19%
% Was Not Brought (WNB) rate for outpatient appointments – Pacific	Monthly	22%	<=9%	10.5%	21%
% Was Not Brought (WNB) rate for outpatient appointments – Asian	Monthly	7%	<=9%	10.5%	8%

% Was Not Brought (WNB) rate for outpatient appointments – Deprivation Scale Q5	Monthly	17%	<=9%	10.5%	17%
Number of compliments received	Monthly	0	higher		18
Number of complaints received	Monthly	3	lower		7

## Safety

Metric	Frequency	Actual	Target	Benchmark	Previous
Central line associated bacteraemia rate per 1,000 central line days	Monthly	0	<=1		0
Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	Monthly	3.4%	<=6%		3.0%
Medication Fluid Errors requiring intervention	Monthly	R/U	Lower		R/U
Medication Fluid Errors reported rate per 1,000 bed days	Monthly	6.1	Higher	6.6	6.2
Good Catches	Monthly	4	Higher		9
Unexpected PICU admissions	Monthly	7	Lower		R/U
Ward Code Blue Calls	Monthly	0	Lower		3
% PEWS Compliance	Monthly	94.3%	>=95%		88.8%
% Hand hygiene compliance	Monthly	84.1%	100%	>=80%	87.7%

## Safety - Nursing

Number of reported pressure injuries – grade 3 or 4	Monthly	0	0		0
Glamorgan pressure injury risk assessment compliance	Monthly	89%	>=90%		87%
Pressure injury bundle of care compliance	Monthly	81%	>=90%		70%
Number of reported medication errors	Monthly	20	Higher		19
% Hand hygiene compliance		87%	100%	>=80%	91%

## Timeliness

Metric	Frequency	Actual	Target	Benchmark	Previous
(MOH-01) % CED patients with ED stay < 6 hours	Monthly	98%	>=95%		95%
Median acute time to theatre (decimal hours) - Starship	Monthly	2.6	Lower		4.6
(ESPI-2) Patients waiting longer than 4 months for their FSA	Monthly	0.55%	0%		0.16%
(ESPI-5) Patients given a commitment to treatment but not treated within 4 months	Monthly	5.8%	0%		4.7%
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Maori	Monthly	10	0		6
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Pacific	Monthly	8	0		8
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Asian	Monthly	4	0		5
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Deprivation Scale Q5	Monthly	16	0		11
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Total	Monthly	46	0		41
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Total	Monthly	12	0		9
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Maori	Monthly	4	0		2
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Asian	Monthly	1	0		4

(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Deprivation Scale Q5	Monthly	2	0		3
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Pacific	Monthly	3	0		3

## Efficiency

Metric	Frequency	Actual	Target	Benchmark	Previous
% Day Surgery Rate	Monthly	68%	>=55%	47%	64%
% Adjusted Session Theatre Utilisation	Monthly	75.3%	>=80%	77%	76.7%
Occupancy	Monthly	86%	>=95%		93%
Pathway Use	Monthly	R/U	Higher		R/U
Laboratory cost per bed day	Monthly	\$74.65	Lower		\$72.87
Radiology cost per bed day	Monthly	\$94.77	Lower		\$87.86
% of patients discharged on a date other than their estimated discharge date	Monthly	30.0%	Lower		28.2%
Antibiotic cost per bed day	Monthly	\$14.89	Lower		\$24.14
PICU Exit Blocks	Monthly	0	0		16

## Effectiveness

Metric	Frequency	Actual	Target	Benchmark	Previous
28 Day Readmission Rate - Total	Monthly	R/U	<=10%		8.4%
28 Day Readmission Rate - Maori	Monthly	R/U	<=6%		6.7%
28 Day Readmission Rate - Pacific	Monthly	R/U	<=6%		8.2%
28 Day Readmission Rate - Asian	Monthly	R/U	<=6%		8.4%
28 Day Readmission Rate - Deprivation Scale Q5	Monthly	R/U	<=6%		6.0%

## Patient Centred

Metric	Frequency	Actual	Target	Benchmark	Previous
% Was Not Brought (WNB) rate for outpatient appointments - All Ethnicities	Monthly	11%	<=9%	10.5%	12%
% Was Not Brought (WNB) rate for outpatient appointments - Maori	Monthly	15%	<=9%	10.5%	19%
% Was Not Brought (WNB) rate for outpatient appointments - Asian	Monthly	10%	<=9%	10.5%	8%
% Was Not Brought (WNB) rate for outpatient appointments - Pacific	Monthly	24%	<=9%	10.5%	25%
% Was Not Brought (WNB) rate for outpatient appointments - Deprivation Scale Q5	Monthly	17%	<=9%	10.5%	19%
Number of complaints received	Monthly	2			0
% Very good and excellent ratings for overall inpatient experience	Monthly	R/U	>=90%		82%
% Very good and excellent ratings for overall outpatient experience	Monthly	R/U	>=90%		87%
Number of compliments received	Monthly	58	Higher		0
Child Health Nursing Family Feedback	Monthly	97%	>=90%		97%

# Scorecard

## Auckland DHB - Child Health HAC Scorecard for January 2017

5.5

	Measure	Actual	Target	Prev Period
Patient Safety	Central line associated bacteraemia rate per 1,000 central line days	0	<=1	0
	Medication Errors with major harm	0	0	0
	Number of falls with major harm	0	0	0
	Nosocomial pressure injury point prevalence (% of in-patients)	11.1%	<=6%	0%
	Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	3.4%	<=6%	3%
	Number of reported adverse events causing harm (SAC 1&2)	0	0	0
	Unviewed/unsigned Histology/Cytology results > 90 days	1	0	1
Better Quality Care	HT2 Elective discharges cumulative variance from target	0.94	>=1	0.89
	(MOH-01) % CED patients with ED stay < 6 hours	97.61%	>=95%	94.69%
	(ESPI-1) % Services acknowledging 90% of FSA referrals in 15 calendar days or less	R/U	100%	80%
	(ESPI-2) Patients waiting longer than 4 months for their FSA	0.55%	0%	0.16%
	(ESPI-5) Patients given a commitment to treatment but not treated within 4 months	5.8%	0%	4.74%
	% DNA rate for outpatient appointments - All Ethnicities	11.37%	<=9%	12.25%
	% DNA rate for outpatient appointments - Maori	15.36%	<=9%	19.22%
	% DNA rate for outpatient appointments - Pacific	23.97%	<=9%	24.85%
	Elective day of surgery admission (DOSA) rate	68.24%	TBC	55.15%
	% Day Surgery Rate	67.64%	>=52%	63.84%
	Inhouse Elective WIES through theatre - per day	15.41	TBC	26.93
	% Very good and excellent ratings for overall inpatient experience	R/U	>=90%	82.4%
	% Very good and excellent ratings for overall outpatient experience	R/U	>=90%	87.2%
	Number of complaints received	2	No Target	0
	28 Day Readmission Rate - Total	R/U	<=10%	8.36%
	% Adjusted Session Theatre Utilisation	75.29%	>=85%	76.73%
	Average Length of Stay for WIES funded discharges (days) - Acute	2.43	<=4.2	3.25
Average Length of Stay for WIES funded discharges (days) - Elective	0.68	<=1.5	1.51	
Engaged Workforce	Excess annual leave dollars (\$M)	\$0.44	0	\$0.55
	% Staff with excess annual leave > 1 year	28.01%	0%	29.8%
	% Staff with excess annual leave > 2 years	8.95%	0%	11.2%
	% Staff with excess annual leave and insufficient plan to clear excess by the end of financial year	R/U	0%	R/U
	Number of Pre-employment Screenings (PES) cleared after the start date	0	0	0
	Sick leave hours taken as a percentage of total hours worked	4.2%	<=3.4%	4.2%
	% Voluntary turnover (annually)	11.88%	<=10%	11.96%
	% Voluntary turnover <1 year tenure	12.31%	<=6%	11.45%

**Amber** Variance from target not significant enough to report as non-compliant. This includes percentages/rates within 1% of target, or volumes within 1 value from target. Not applicable for Engaged Workforce KRA.

**R/U** Result unavailable

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

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

**% Very good and excellent ratings for overall inpatient experience**

**% Very good and excellent ratings for overall outpatient experience**

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

**28 Day Readmission Rate - Total**

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

## Scorecard Commentary

### Elective discharges

The Child Health Directorate is at 91% of the target for Auckland DHB discharges at the end of January 2017 (improved from 88% at end of December 88%). Recovery plans in place for improved results in 2017 with emphasis on ORL, orthopaedics and paediatric surgery. Whilst demand is limiting performance in the short term to some extent, recovery plan includes extra clinics to maintain clinic volumes and stimulate surgical demand, insourced and if required, outsourced lists.

### Elective performance

Elective surgery performance continues to be actively managed to maintain 120 day compliance and elective discharges.

ESPI -1 (acknowledgement of referral) – although January are not yet validated results for this measure it is understood there were 10 ESPI breaches in January.

ESPI-2 (Time to FSA) 0.66% Non-compliant, 5 Paed Surgery, 8 Paed Ortho, 2 Paed ENT in total 15 cases breached, all other paediatric services were 100% ESPI-2 compliant at the end of January.

ESPI-5 – (Time to surgery) 6% non-compliant, 45 cases breached (27 Paed Ortho, 17 Paed Surgery, 1 Paed Cardiac) contributing factors include spinal surgery capacity constraints, acute demand. Mitigations include re-allocated theatre sessions and insourced lists.

### DNA rates

The Child Health Directorate has prioritised work on DNAs (also referred to as was not brought, WNB) for the past 12 months. Recent data demonstrates a reduction in DNA/WND overall.

- An overall reduction from 12.25% to 11.37% signals some progress in this area. A significant reduction for Māori, from 19.22% to 15.36% is a positive indicator that progress is being made. Unfortunately Pacific rates continue to cause significant concern with only a slight reduction during the January period, 24.85% to 23.97%.
- Plans are currently underway for a Pacific Health Navigator who has recently qualified as a social worker, to join the Starship social work team for 2,000 hours of supervised social work practice. The intention is to focus her activity on assisting us to address the Pacific WNB rate.
- The WNB policy is in final draft and is being tested with a specific group of children, many of whom are Samoan or Tongan. These children are failing to attend Ponseti (clubfoot) clinic.
- Negotiations have begun with both WDHb and CMDHB in an effort to engage them in providing the social and cultural resources that may be able to assist us to address the barriers associated with children 'crossing DHB borders' who fail to attend their appointments
- The child health community redesign process continues to maintain a strong focus on reducing health inequalities, and addressing issues associated with barriers to access. This forms part of the integrated approach to access to child health services.

### Excess annual leave usage

Excess annual leave management is continuing and the financial benefits of this work are now being realised with reductions in the latter part of 2016 and a significant reduction in the January period.

In summary the key activity is:



- Enhanced and more granular reporting at directorate, service, team and individual level, both annual leave and time in lieu.
- Dual emphasis on reducing excess leave and annual consumption of the leave entitlement of each employee.
- Monthly review of each service's leave performance with the Director, General Manager and Finance Manager.
- Targeted leave reduction plans with all employees whose leave exceeds two years.

### Staff turnover (annual)

Staff turnover consistently performs just above the organisational target, and fluctuates minimally month on month. Service-level analysis of the turnover data has revealed a small number of wards / services where turnover is of concern. This is being addressed within services / wards and will be strengthened through information gained in the recently completed staff survey and in the leadership development of all Child Health service-level leadership staff.

### Financial Results

<b>STATEMENT OF FINANCIAL PERFORMANCE</b>						
<i>Child Health Services</i>						
				Reporting Date <span style="border: 1px solid black; padding: 2px;">Jan-17</span>		
(\$000s)	MONTH			YEAR TO DATE (7 months ending Jan-17)		
	Actual	Budget	Variance	Actual	Budget	Variance
<b>REVENUE</b>						
Government and Crown Agency	762	805	(43) U	6,107	5,635	471 F
Funder to Provider Revenue	15,230	15,622	(391) U	124,161	126,497	(2,335) U
Other Income	1,049	1,165	(115) U	6,950	8,154	(1,205) U
<b>Total Revenue</b>	<b>17,042</b>	<b>17,592</b>	<b>(550) U</b>	<b>137,218</b>	<b>140,286</b>	<b>(3,069) U</b>
<b>EXPENDITURE</b>						
<b>Personnel</b>						
Personnel Costs	10,472	10,580	108 F	73,691	73,258	(433) U
Outsourced Personnel	124	122	(2) U	965	857	(108) U
Outsourced Clinical Services	284	238	(46) U	1,714	1,669	(45) U
Clinical Supplies	1,440	1,613	173 F	13,502	13,095	(407) U
Infrastructure & Non-Clinical Supplies	262	297	36 F	2,317	1,895	(422) U
<b>Total Expenditure</b>	<b>12,582</b>	<b>12,850</b>	<b>268 F</b>	<b>92,190</b>	<b>90,774</b>	<b>(1,415) U</b>
<b>Contribution</b>	<b>4,459</b>	<b>4,741</b>	<b>(282) U</b>	<b>45,028</b>	<b>49,512</b>	<b>(4,484) U</b>
Allocations	588	794	206 F	6,214	6,666	452 F
<b>NET RESULT</b>	<b>3,872</b>	<b>3,947</b>	<b>(75) U</b>	<b>38,814</b>	<b>42,846</b>	<b>(4,032) U</b>
<b>Paid FTE</b>						
	MONTH (FTE)			YEAR TO DATE (FTE) (7 months ending Jan-17)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	242.4	225.3	(17.2) U	231.3	225.3	(6.0) U
Nursing	613.3	641.6	28.3 F	638.3	642.1	3.8 F
Allied Health	179.4	183.1	3.7 F	173.8	178.4	4.6 F
Support	0.3	0.3	0.0 F	0.3	0.3	0.0 F
Management/Administration	85.3	64.2	(21.1) U	82.3	64.2	(18.1) U
<b>Total excluding outsourced FTEs</b>	<b>1,120.9</b>	<b>1,114.6</b>	<b>(6.3) U</b>	<b>1,126.0</b>	<b>1,110.3</b>	<b>(15.6) U</b>
Total :Outsourced Services	6.1	3.9	(2.2) U	7.7	3.9	(3.8) U
<b>Total including outsourced FTEs</b>	<b>1,127.0</b>	<b>1,118.5</b>	<b>(8.5) U</b>	<b>1,133.7</b>	<b>1,114.2</b>	<b>(19.4) U</b>

## Comments on major financial variances

The Child Health Directorate was \$ 75k U for the month of January and is now \$4.032M U year to date, including \$1.8M of wash-up risk on core volumes.

Year to Date revenue is \$3.069M unfavourable and driven primarily by wash-up risk on core WIES and non-WIES revenue (\$1.8M), and donation revenue (\$1.760M). Whilst year to date total expenditure (including allocations) is at \$0.963M U (101.0% of budget levels) this was compared to inpatient activity at 98% of budget volumes.

Total inpatient WIES for the month was 4% lower than 15/16 and 12 % lower than contracted volume.

Year to date WIES is now 3 % above last year although 2% below budget.

Factors impacting on the January year to date performance are as follows:

1. Revenue \$3.069M U:

- a. PVS base contract revenue \$1.8M U. Primarily relates to elective inpatient under-delivery across most specialities. Most services, however, continue to improve elective delivery. Since October total year to date elective WIES budget achievement has improved from 91% to 97%.
- b. Donation revenue is \$1.760M U. Donation receipts will be skewed toward the second half of the year due to the phasing of major projects through summer. Whilst we are comfortable with this phasing, significant delays in the build to date meant December and January donations were lower than expected and there is a risk project delays may push some donation revenue into 17/18.
- c. ACC \$0.361M F. The ACC Rehab service commenced in December generating new revenue of \$116k in both December and January (although there is approximately \$62k of related expenditure in each month). ACC revenue is now tracking at 117% of budget although there was a \$48k U result in January as the accrual was slightly understated.

2. Expenditure \$0.963M U:

- a. Overall year to date expenditure is 101.0% of budget, compared to inpatient volumes at 98% of contract. Clinical supply costs were 89% of budget in January – in line with volumes (\$407k unfavourable year to date, 103%). Year to date cost per cwd is approximately 106% of budget. Medical clinical supply costs are \$402k U due to very high haematology/oncology volumes. In Surgery, NICU (\$151k U); PICU (\$232k U), due to record occupancy levels; and orthopaedic implant costs (\$120k U), due to budget short-fall, are the other major drivers of expenditure.
- b. Employee costs are \$433k U from the budget year to date. The primary driver of this increased expenditure is additional RMO positions to budget (10.2FTE, \$356k U year to date). Other year to date employee costs are reasonable overall – but would need to drop further to achieve budget FTE and cost levels, given assumed saving initiative levels.

3. FTE 19.4 FTE U:

The year to date result is 19.4 U. This budget includes a savings target of 21.7fte. RMO staff are 10.2 FTE U which is the major reason the directorate is not closer to the target. Whilst nursing FTE are at budget they would need to be at lower levels to achieve overall FTE targets. However the nursing FTE result for January is 28.3 FTE F, reflecting a much lower occupancy level in January.

Key strategies currently employed to mitigate the 16/17 budget deficit include the following:

1. On-going focus on revenue streams – management of elective volumes, ACC, donations and non-residents. The new ACC Rehab Service contract has now been executed, which commenced on 1 December. The on-going risk is donation revenue and wash-up risk.
2. Leave management project to progressively reduce excess leave balances. This is reviewed regularly at monthly meetings and we have seen a drop of approximately \$450k (3.5%) in the year to date balance, primarily from a significant drop in January.
3. Monitoring of clinical activity to ensure bed closures that are consistent with both clinical requirements and budgeted expenditure across the full financial year. However there were significant bed pressures over the past three months through general wards, PICU and NICU.
4. Implementation of Directorate savings initiatives in addition to participation in Provider level projects.
5. Tight management of vacancy and recruitment processes.



## Perioperative Directorate

Speaker: Dr Vanessa Beavis, Director

5.6

### Service Overview

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

### The Perioperative Directorate is led by

Director: Dr Vanessa Beavis

General Manager: Duncan Bliss

Nurse Director: Anna MacGregor

Director of Allied Health: Kristine Nicol

### Directorate Priorities for 16/17

**In 2016/17 our Directorate will contribute to the delivery of the six Provider Arm work programmes. In addition to this we will also focus on the following Directorate priorities:**

1. Single Instrument tracking implementation.
2. Financial position tracking to budget.
3. Oracle Consignment module utilised and ready to upgrade to enable tunnel project.
4. All day operating lists fully resourced and utilised.
5. Support the delivery of the PVS and ESPI compliance.
6. A workforce that is fully engaged, recruited to establishment in line with demand and fully trained.

## Q3 Actions – 90 day plan

### 1. Single Instrument tracking implementation.

Activity	Progress
Implementation of single instrument tracking	Completion date for the single instrument tracking project has been extended – timeline yet to be confirmed due to IT and significant operational impacts. Further work is in progress regarding the suitability of the system. It is likely that an upgrade to the existing system will be preferred. There is high level contingency work underway by hA at present to provide some critical stabilisation of the current system.

### 2. Financial position tracking to budget.

Activity	Progress
Review of material management stock levels	This will be the next phase of the oracle consignment stock implementation. Small working groups are working on multiple projects in the interim. This will be supported by the RFID process when implemented.
Ordering and usage of loan equipment	This will form part of the end to end stock management project commencing in early 2017  The Production Management Committee commenced in November which is establishing a process for new stock items to be assessed before being available to order.  The top 20 consumable spends for both cost and volume have been reviewed by the project team to ensure products have been reviewed within the last year.
Late notice cancellations – work with specialities to understand the financial impact	Weekly scrum meetings have allowed recycling of sessions to avoid preventable losses.

**3. Oracle Consignment module utilised and ready to upgrade to enable tunnel project.**

Activity	Progress
NOS – National Oracle Project	Project plan being pulled together, data cleansing in progress. At present there is no further progress as we wait for national input Auckland DHB roll out currently scheduled for tranche 2

**4. All day operating lists fully resourced and utilised.**

Activity	Progress
Convert half day operating lists to full day	Phase 1 complete. There is now focus on the sessions at GSU OR sessions to increase full day operating.  The OR allocation committee is meeting in February 2017 to review 16/17 allocations and establish 17/18 requirements based on the PVS proposal.

**5. Support the delivery of the PVS and ESPI compliance.**

Pre- admission capacity and pathway review	Patients booked for elective surgery require an anaesthetic assessment (as well as other possible interventions) prior to surgery being confirmed. The current model has variable work flows that limit the ability to offer economies of scale, and causes frustration for services and staff day to day through the layout and management of this stage of the elective pathway. In addition, the current model will not cope with elective volume demand for the 17/18 financial year and beyond.  The project group has been formed and work has commenced with the assistance of the performance improvement team.
SCRUM process	Continue to reallocate sessions through the SCRUM process to reduce the number of sessions unfilled by service/late notice.  Session utilisation is currently running at 94% YTD (97% for December) against the internal target of 95%

**6. A workforce that is fully engaged, recruited to establishment in line with demand and fully trained.**

Review of current Models of Care across ORs	<p>Nurse Director working with all OR managers to identify the current state and ensure that the skill mix is correct to deliver a safe service.</p> <p>17/18 OR requirements will inform the Models of Care across the DHB with predicted significant increases in acute operating.</p>
Transfer of Ophthalmology ORs to Perioperative from the service	<p>Review of staffing model and support underway. A new charge nurse has been appointed and a new senior role introduced (clinical co-ordinator) dedicated to support ophthalmology. Furthermore, an additional clinical coach role has been introduced to support the service as they move to consistent OR standards of practice.</p> <p>A review of the employee engagement survey results will be completed in March to establish the themes that form the people strategy for Directorate. The review will also look for trends and further opportunities that may have arisen since the transfer of Ophthalmology OR's to Perioperative Services.</p>

**Measures**

Measures	Actual - January	Current	Target (End of 17/18)
Single instrument tracking in place		TDoc	Nexus or TDoc upgrade
Increase in access/capacity to ORs – reduce the number of half day lists and flex sessions.		Recruiting to the identified reallocation of sessions to accommodate full day lists	All level 4/8/9 to be full day lists
Reduction in waiting times for Anaesthesia assessment clinic, including Paediatrics		Project manager recruited - Feedback from a number of Anaesthetists and Preassessment Clinic Staff on what the guiding principles should be	Establish new guiding principles for on-going improvement in preadmission clinics
Reduction in the number of preventable session losses	34.6%	34.6%	65%



## Key achievements in the month

- Capex for Level 8 Operating Room towers has been accepted and purchased December. There are now 3 new towers – one of which is 3D.
- New Charge Technician appointed for Level 9 Operating Rooms.
- Staff member from Greenlane Surgical Unit – PACU was nominated for the Local Heroes award
- Improved planning for OR schedule over Christmas allowing for increased annual leave approval for staff and greater focus on the sessions planned to run.
- A Greenlane Surgical Unit Technician received an award at the Allied Health Awards for being voted the ‘anaesthetic technician that staff would like to be in the OR if they themselves (or their family) were having surgery.
- A contract review process is underway with CSSD contracts to external customers which is improving the compliance with Auckland DHB policy and is delivering some financial benefits.
- 2 Graduate nurses commenced the New to OR programme on 23 January

## Areas off track and remedial plans

- The single instrument tracking project is under review and delayed. Some additional legal requirements have been identified as being necessary. Health alliance and our legal team are working on this at Stabilisation of the TDoc platform is required urgently to mitigate the critical clinical risk of an unstable system.

## Key issues and initiatives identified in coming months

- Financial concerns, especially with regards to the impact of transplants (a cost review is underway around the cost of transplant consumables linked to transplants to ensure that are costs are accurately accounted for).
- On-going work on identifying the road blocks to implementing single instrument tracking.
- The recognised increase in use of OR minutes but under delivery of elective plan means there will be a potential issue around services requesting increased insourcing at evenings and weekends which will increase pressure on the OR staff to work above their contracted hours.
- Quality initiatives including in hospital assessment of patients on the acute pathway, to prevent avoidable morbidity and mortality
- Aligning the OR plan for 17/18 with the increased PVS volumes for the next financial year with anticipated growth in activity around 6% which cannot be accommodated in the current OR schedule.

## Scorecard

### Auckland DHB - Perioperative Services HAC Scorecard for January 2017

	Measure	Actual	Target	Prev Period
<b>Patient Safety</b>	Number of reported adverse events causing harm (SAC 1&2)	0	0	0
	% Acute index operation within acuity guidelines	75.93%	>=90%	74.03%
	Wrong site surgery	0	0	0
	% Elective prophylactic antibiotic administered <= 60 mins from procedure start	80.69%	>=90%	82.19%
<b>Better Quality Care</b>	Number of complaints received	0	<=3	0
	% Unplanned overnight admission	4.28%	<=3%	4.21%
	% Cases with unintended ICU / DCCM stay	0.30%	<=3%	0.07%
	% 30 day mortality rate for surgical events	2.02%	<=2%	1.96%
	% CSSD incidents	2.51%	<=2%	2.86%
<b>Improved</b>	% Elective sessions planned vs actual	91.3%	>=97%	97%
	% Adjusted theatre utilisation - All suites (except CIU)	83.4%	>=85%	84.68%
	% Late starting sessions	5.84%	<=5%	5.88%
<b>Engaged</b>	Excess annual leave dollars (\$M)	\$0.33	0	\$0.35
	% of Staff with excess annual leave > 1 year < 2 years	27.17%	<=30%	28.1%
	% Staff with excess annual leave > 2 years	9.67%	0%	10.37%
	Sick leave hours taken as a percentage of total hours worked	4.6%	<=3.9%	4.6%
	% Voluntary turnover (annually)	10.9%	<=10%	11.55%
	% Voluntary turnover <1 year tenure	4.71%	<=6%	4.44%

**Amber**

Variance from target not significant enough to report as non-compliant. This includes percentages/rates within 1% of target, or volumes within 1 value from target. Not applicable for Engaged Workforce KRA.

- There were no complaints received for Perioperative services for January 2017.
- No SAC 1 and SAC 2 incidents were reported in the three months from 1 November 2016 to 31 January 2017.
- Recommendations from previous RCAs have been implemented. The final set of recommendations from a previous RCA occurring in another directorate are being implemented.
- Formal auditing of the surgical safety check list has recommended this quarter, with good rates of engagement (and compliance).
- There were three medication incidents reported for January 2017, without harm. Each department holds a monthly quality meeting where all incidents are reviewed and investigated. This is monitored by a Directorate quality meeting where any recurring trends are reviewed and action plans agreed as necessary.
- Unplanned overnight admissions in January were 4.28% against a target of 3%, which is attributed to the acute load and case mix.
- There has been an improvement in the index case acuity targets. This is attributed to reduced elective orthopaedic sessions, which has meant reallocation of that time to acutes.

**Excess Annual Leave**

This has been a focus for January. Individuals identified with high annual leave and Time in Lieu balances have been asked for a plan to reduce the balance which will be agreed.

The OR summer plan signed off in November 2016 has allowed for better planning and allowed more OR staff to take annual leave over the summer period.

**Elective sessions planned vs actual**

January planned vs actual elective session usage was 91.3%, this is attributed to the high annual leave through January and the impact of industrial action where elective sessions were reduced over 4 days. As part of the summer plan review at the Surgical Board it has been agreed that we will extend the OR scheduling until after the January public holidays in future years.

**Late Starts**

Late start information is being provided to the relevant department managers to investigate and identify any trends that can be addressed. It is part of the MOS board directorate focus areas. There is ongoing attention to this issue, the causes of which are multifactorial.

**Engaged Workforce**

- DATIX training and plan to be rolled out in February 2017.
- VCA plan of action rolled out to all staff as of December 2016. Process needs to be completed by July 2018.
- Great teamwork across the team nurses, working and supporting the Ophthalmology and non- Ophthalmology teams.
- Analysis underway of the employee engagement survey results that will form part of the Directorate people strategy in the future.

## Financial Results Summary Net Result

### STATEMENT OF FINANCIAL PERFORMANCE

Perioperative Services

Reporting Date **Jan-17**

(\$000s)	MONTH			YEAR TO DATE (7 months ending Jan-17)		
	Actual	Budget	Variance	Actual	Budget	Variance
<b>REVENUE</b>						
Government and Crown Agency	189	191	(1) U	1,324	1,334	(9) U
Funder to Provider Revenue	3	3	0 F	18	18	0 F
Other Income	22	16	6 F	127	114	13 F
<b>Total Revenue</b>	<b>214</b>	<b>209</b>	<b>5 F</b>	<b>1,469</b>	<b>1,465</b>	<b>4 F</b>
<b>EXPENDITURE</b>						
<b>Personnel</b>						
Personnel Costs	7,858	7,618	(241) U	53,998	52,916	(1,082) U
Outsourced Personnel	50	43	(7) U	439	300	(139) U
Outsourced Clinical Services	0	0	0 F	0	0	0 F
Clinical Supplies	2,985	3,054	69 F	25,110	24,515	(594) U
Infrastructure & Non-Clinical Supplies	122	156	34 F	1,188	1,094	(94) U
<b>Total Expenditure</b>	<b>11,015</b>	<b>10,870</b>	<b>(145) U</b>	<b>80,735</b>	<b>78,826</b>	<b>(1,909) U</b>
<b>Contribution</b>	<b>(10,800)</b>	<b>(10,661)</b>	<b>(139) U</b>	<b>(79,266)</b>	<b>(77,361)</b>	<b>(1,905) U</b>
Allocations	26	22	(4) U	192	190	(3) U
<b>NET RESULT</b>	<b>(10,826)</b>	<b>(10,682)</b>	<b>(144) U</b>	<b>(79,459)</b>	<b>(77,551)</b>	<b>(1,908) U</b>
<b>Paid FTE</b>						
	MONTH (FTE)			YEAR TO DATE (FTE) (7 months ending Jan-17)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	168.0	168.8	0.8 F	165.0	168.8	3.8 F
Nursing	419.8	448.6	28.8 F	426.4	448.6	22.2 F
Allied Health	98.6	110.1	11.5 F	99.6	110.1	10.5 F
Support	106.8	115.3	8.5 F	109.2	115.3	6.2 F
Management/Administration	22.9	14.1	(8.7) U	23.1	14.1	(8.9) U
<b>Total excluding outsourced FTEs</b>	<b>816.2</b>	<b>857.0</b>	<b>40.8 F</b>	<b>823.2</b>	<b>857.0</b>	<b>33.8 F</b>
Total :Outsourced Services	2.7	0.0	(2.7) U	2.8	0.0	(2.8) U
<b>Total including outsourced FTEs</b>	<b>818.8</b>	<b>857.0</b>	<b>38.1 F</b>	<b>826.1</b>	<b>857.0</b>	<b>30.9 F</b>

### Comments on major financial variances

#### Month

The net result for January is an unfavourable variance of \$144k or 1.3% against budget, while volumes worked of 298,399 minutes (3,482 cases) compared to budgeted 294,764 minutes (3,329 cases), show a slight increase in minutes of 1.2% (but a greater increase in cases of 4.6% due to more smaller cases carried out this month).

The additional volumes and industrial action contributed to the unfavourable personnel cost variance of \$241k while clinical supply costs are slightly favourable due to the simpler case mix and ongoing focus on consumable usage control (reflected in a clinical supply actual cost per minute ratio of \$8.56 against budget of \$8.91).

**Year to date**

To date **personnel costs** are \$1,082k U (including a YTD target saving of \$1,145k) and is impacted by:

- Increasing volumes in minutes of 3.2% (primarily Cardiac, Women's and Starship). Transplants have also increased incrementally from month to month resulting in 116 cases at Jan YTD compared to 100 this time last year, an increase of 16%.

The **clinical supplies** variance of \$594k U or 3.1% (including a YTD target savings of \$281k) is due to:

- Asset disposal and depreciation costs over budget of \$408k U.
- Increasing volumes (3.2% above budget) and case complexity (average minutes per case is 1.2% above budget).
- The clinical supply cost per operating minute (excluding depreciation and asset disposal costs) has trended down from a high of \$9.43 in July to \$8.56 in January and YTD is \$8.64 against a YTD budget of \$8.83 per operating minute.

**Business Improvement Savings**

Total savings are \$406k YTD.



## Cancer and Blood Directorate

Speaker: Dr Richard Sullivan, Director

5.7

### Service Overview

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

#### The Cancer and Blood Directorate is led by:

Director:	Dr Richard Sullivan
General Manager:	Deirdre Maxwell
Director of Nursing:	Brenda Clune
Finance Manager:	Dheven Covenden
Human Resource Manager:	Andrew Arnold
Director of Allied Health:	Carolyn Simmons Carlsson

### Directorate Priorities for 16/17

**In 2016/17 our Directorate will contribute to the delivery of the six Provider Arm work programmes. In addition to this we will also focus on the following Directorate priorities:**

1. Tumour stream service delivery
2. Faster Cancer Treatment (FCT)
3. Haematology Service Model of Care
4. Supportive Care Service initiative
5. Northern Region Integrated Cancer Service (NRICS) development
6. Staff engagement in support of achieving these priorities
7. Achieve Directorate financial savings target for 2016/17

### Q3 Actions – 90 day plan

#### 1. Developing and implementing a tumour stream approach within Cancer and Blood Directorate

Our alignment project is underway, with project briefs drawn up, leads appointed and teams being formed to progress. Projects cover daystay and infusions, clinics and utilisation, acutes (starting with a radiation therapy rapid access clinic), and the haematology model of care. The focus of our work is directorate-wide in the main. Our projects will address all aspects of alignment, including mapping and readjusting clinic days/times to co-locate tumour streams to the greatest extent practicable.

The patient experience will be improved where appointments can be scheduled across medical and radiation oncology together when appropriate for the patient. The decant of SMO staff from Building 7 to Building 8 has been substantially completed, resulting in co-location of SMOs in the office environment as we move away from sub-specialty clustering.

## **2. Meeting the 62 day Faster Cancer Treatment (FCT) Target within Cancer and Blood**

This work continues, with increased linking of demand with capacity (using production planning methodologies). When SMO vacancies occur, we are now able to determine which sub-specialties we need to recruit to, to meet the needs of the tumour stream demand. The FCT Lead Tumour Stream Coordinator continues to work closely with our Service Clinical Directors, their teams and the scheduling lead to improve Cancer and Blood response times consistent with FCT and demand pressures.

## **3. Development and implementation of Haematology Model of Care**

As mentioned above, we will pick up BMT outpatient delivery modelling work previously started by the Performance Improvement manager. We are monitoring our BMT waitlist on a weekly basis, to keep track of patient numbers and to ensure we do not breach Ministry guidelines re waiting time. We will also work with Haematology daystay to determine how this can be integrated with Medical Oncology chemotherapy daystay provision. This is timely in that a change in charge nursing staff has presented this opportunity. In terms of the wider model of care work across the Haematology Service, we anticipate that there will be challenges in the evolving Model of Care to accommodate increasing demand consistent with the national profile.

## **4. Supportive Care Services**

The service continues to establish itself across the cancer care pathway. Referrals slightly slowed in December however the complexity of the referrals made to the services continues to be high. We have developed regular case discussion meetings with kaiatawhai and aim to do the same with the Pacific Health team. The service continues to work in collaboration with the other Northern Region DHB's, the Cancer Society and Leukaemia Blood Cancer NZ. Work with these groups focuses on referral pathways to and from the Regional Cancer and Blood Service, case review and journal club sessions, and shared patient resources. A recent psychology resignation will require recruitment, to continue to provide service within the small team setting.

## **5. Northern Region Integrated Cancer Service development, including local delivery of chemotherapy**

Pilot Adjuvant Herceptin delivery at Counties Manukau DHB: Our Auckland DHB service is working closely with Counties staff to support the establishment of this pilot. This service has now commenced and sees approximately 10 herceptin patients per week provided with chemotherapy service at Middlemore Hospital. Cancer and Blood staff continue to provide nursing oversight/training, and chemotherapy is provided through the Auckland DHB Service.

### ***Breast and Bowel Cancer - Chemotherapy Local Delivery:***

This regional work is underway consistent with Cancer Board oversight. The patient cohort includes adjuvant and metastatic breast and bowel cancer patients, but excludes complex cases and patients requiring concurrent radiation therapy. Auckland DHB is developing a first cut of a financial impact analysis – this aims to show the likely cost differential between status quo provision at Auckland



DHB, compared with a local model at Counties Manukau and Waitemata DHBs. To support this we have demand and capacity work underway, as well as medical and nursing models of care development, and transition planning and phasing. Issues relate to the wider service model of care and the lack of clinical engagement across the region in support of this work.

Auckland DHB senior leadership are considering the potential impacts of this work, and the demand/capacity pressures that will determine which options are supported.

**6. Employee Engagement Initiatives**

Cancer and Blood participation in the Auckland DHB employee survey was broadly consistent with the DHB-wide results, with an overall 77% engagement score. The survey has provided us with fresh information on which to act to support and improve employee engagement. Work has commenced on preparing for Service and Directorate wide action plans related to the survey results.

**7. Breakeven revenue and expenditure position**

We are working with our Service Clinical Directors and wider teams to ensure savings plans are produced and delivered, to meet with \$1.3M savings target required. Please refer Financial Results section.

**Measures**

Measures	Current	Target (End 2016/17)	2017/18
3 additional tumour streams implemented within Cancer and Blood (Gastro-intestinal, Breast, G-U)	1	3	N/A
62 day FCT target	87.8%	July 2016 85%	June 2017 90%
Development /implementation of Haematology Model of Care	10% (baseline work)	July 50% implementation	100% implementation year end 2017/18
Supportive Care Services - % urgent referrals contacted within 48hrs from across all DHB cancer services	100%	July 100%	July 100%
Northern Region Integrated Cancer Service - Local delivery of chemotherapy (CMDHB) – Auckland DHB meets regional project timeframes	100%	July 2017/18 commencement	100%
Employee engagement initiatives underway	1	3	tba
Breakeven revenue and expenditure position		Breakeven	

**Key achievements in the month**

- Cancer and Blood Alignment Project** – Work is underway to realign the Cancer and Blood Service preparatory to any moves into potential other builds. The short/medium term advantages pertain to better patient experience (tumour streaming and co-located clinics etc.) and more efficient use of staff and other resources. Now that the majority of our staff are housed in Building 8, we are already seeing the benefits of closer working relationships across teams.

- **Welcome Video** – We are working with Omnicron (video production company) and have developed a script. We are sourcing staff and patients who are willing to participate. The Chief Advisor Tikanga for Auckland and Waitemata DHBs and her team are assisting us with this work.

## Areas off track and remedial plans

- **Achieving Financial Savings** – We have developed financial savings plans, and although these are in place they are proving challenging to deliver against.
- **Northern Region Integrated Cancer Service Development** – While governance arrangements have been established through the CEO/CMO forum, progress remains complex and slow. Current regional work focuses on the explicit creation of research-enabled clinical care in conjunction with the University of Auckland Academic Health Alliance.

## Key issues and initiatives identified in coming months

- **Linear Accelerator Replacement** - Our Radiation Oncology Service is preparing for the planned replacement of one of our six linear accelerators in the coming months, on completion of a healthAlliance-led procurement process. We have prepared a paper for the Board's consideration around potential options as part of a longer term procurement process, including leasing and other arrangements. This will be presented to Finance Risk and Assurance Committee in March 2017.
- **Phase 1 Trials Unit Establishment** - The Auckland DHB Cancer and Blood Research Department has been operating for over 20 years, aiming to future-proof the health of the community by enabling cutting-edge research via the conduct of high quality cancer-related clinical trials. The Department currently manages a substantial suite of Phase II and III trials, currently totalling 140 trials. This year the scope has been expanded to include Phase I trials (early phase). This early phase work includes three active trials, two in setup and five in an engagement process. This work is supervised by a designated Phase I Senior Medical Officer, with specific Standard Operating Procedures. Current activity is focused on the establishment of a formal Phase 1 Trials Unit. A unit of this type requires carefully constructed specialist infrastructure and a governance framework to safely deliver this work. Such a unit needs to be designed and managed to the highest possible standards expected of accredited Phase 1 units internationally. We are working to establish a formal Phase 1 Governance Group under the Academic Health Alliance umbrella, consistent with Auckland DHB research requirements.
- **Internet/Intranet Project** – We are working with the Communications Team as an early adopter of the new internet/intranet upgrades. We are forming a project group to determine our Directorate requirements, with a view to utilising the full functionality available.

# Scorecard

## Auckland DHB - Cancer & Blood Services HAC Scorecard for January 2017

5.7

	Measure	Actual	Target	Prev Period
Patient Safety	Medication Errors with major harm	0	0	0
	Number of falls with major harm	0	0	0
	Nosocomial pressure injury point prevalence (% of in-patients)	0%	<=6%	0%
	Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	4.7%	<=6%	4.8%
	Number of reported adverse events causing harm (SAC 1&2)	0	0	1
	Unviewed/unsigned Histology/Cytology results < 90 days	2	0	1
	Unviewed/unsigned Histology/Cytology results > 90 days	0	0	0
Better Quality Care	(ESPI-1) % Services acknowledging 90% of FSA referrals in 15 calendar days or less	R/U	100%	100%
	% DNA rate for outpatient appointments - All Ethnicities	5.55%	<=9%	5.06%
	% DNA rate for outpatient appointments - Maori	11.91%	<=9%	11.64%
	% DNA rate for outpatient appointments - Pacific	11.19%	<=9%	11.26%
	Number of CBU Outliers - Adult	47	0	58
	% Very good and excellent ratings for overall inpatient experience	R/U	>=90%	72.7%
	% Very good and excellent ratings for overall outpatient experience	R/U	>=90%	93.9%
	Number of complaints received	4	No Target	2
	28 Day Readmission Rate - Total	R/U	TBC	23.76%
	Average Length of Stay for WIES funded discharges (days) - Acute	3.72	TBC	4.07
	% Cancer patients receiving radiation/chemo therapy treatment within 4 weeks of DTT	99.36%	100%	100%
	% Chemotherapy patients (Med Onc and Haem) attending FSA within 4 weeks of referral	94.69%	100%	98.46%
	% Radiation oncology patients attending FSA within 4 weeks of referral	85.25%	100%	94.41%
	% Patients from Referral to FSA within 7 days	23.14%	TBC	27.48%
	31/62 day target – % of non-surgical patients seen within the 62 day target	R/U	>=85%	92.71%
31/62 day target – % of surgical patients seen within the 62 day target	R/U	>=85%	83.78%	
62 day target - % of patients treated within the 62 day target	R/U	>=85%	87.92%	
Improved Health Status	% Hospitalised smokers offered advice and support to quit	82.61%	>=95%	100%
	BMT Autologous Waitlist - Patients currently waiting > 6 weeks	0	0	3
Engaged Workforce	Excess annual leave dollars (\$M)	\$0.12	0	\$0.14
	% Staff with excess annual leave > 1 year	29.06%	0%	29.2%
	% Staff with excess annual leave > 2 years	7.85%	0%	10.43%
	% Staff with excess annual leave and insufficient plan to clear excess by the end of financial year	R/U	0%	R/U
	% Staff with leave planned for the current 12 months	15.61%	100%	15.61%
	% Leave taken to date for the current 12 months	58.19%	100%	58.19%
	Number of Pre-employment Screenings (PES) cleared after the start date	0	0	0
	Sick leave hours taken as a percentage of total hours worked	3.3%	<=3.4%	3.3%
	% Voluntary turnover (annually)	11.81%	<=10%	13.04%
	% Voluntary turnover <1 year tenure	2.63%	<=6%	4.76%

**Amber** Variance from target not significant enough to report as non-compliant. This includes percentages/rates within 1% of target, or volumes within 1 value from target. Not applicable for Engaged Workforce KRA.

**R/U** Result unavailable

**(ESPI-1) % Services acknowledging 90% of FSA referrals in 15 calendar days or less**  
Result unavailable until after the 16th of the next month.

**% Very good and excellent ratings for overall inpatient experience**  
**% Very good and excellent ratings for overall outpatient experience**

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

**28 Day Readmission Rate - Total**

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

**31/62 day target – % of non-surgical patients seen within the 62 day target**

**31/62 day target – % of surgical patients seen within the 62 day target**

**62 day target - % of patients treated within the 62 day target**

Results unavailable from NRA until after the 20th day of the next month.

## Scorecard Commentary

- No falls with harm occurred in this period, and there were no Grade III or IV pressure injuries.
- We continue to roll out production planning methodologies to provide quicker access to all aspects of our services, with radiation oncology work underway.
- Our services have experienced continued high numbers of admissions, with a need to outlie although this need appears to be reducing.

## Financial Results

STATEMENT OF FINANCIAL PERFORMANCE						
<i>Cancer &amp; Blood Services</i>						Reporting Date <span style="border: 1px solid black; padding: 2px;">Jan-17</span>
(\$000s)	MONTH			YEAR TO DATE (7 months ending Jan-17)		
	Actual	Budget	Variance	Actual	Budget	Variance
<b>REVENUE</b>						
Government and Crown Agency	751	1,200	(449) U	6,694	8,403	(1,709) U
Funder to Provider Revenue	7,900	6,900	1,000 F	56,510	55,510	1,000 F
Other Income	101	28	73 F	545	197	348 F
<b>Total Revenue</b>	<b>8,752</b>	<b>8,128</b>	<b>624 F</b>	<b>63,748</b>	<b>64,109</b>	<b>(361) U</b>
<b>EXPENDITURE</b>						
<b>Personnel</b>						
Personnel Costs	3,035	2,974	(61) U	21,164	20,657	(507) U
Outsourced Personnel	4	76	72 F	239	534	295 F
Outsourced Clinical Services	152	236	84 F	1,555	1,650	95 F
Clinical Supplies	3,718	3,048	(669) U	25,087	24,880	(207) U
Infrastructure & Non-Clinical Supplies	91	74	(17) U	787	518	(270) U
<b>Total Expenditure</b>	<b>6,999</b>	<b>6,408</b>	<b>(592) U</b>	<b>48,833</b>	<b>48,240</b>	<b>(594) U</b>
<b>Contribution</b>	<b>1,752</b>	<b>1,720</b>	<b>32 F</b>	<b>14,915</b>	<b>15,870</b>	<b>(955) U</b>
Allocations	589	535	(54) U	4,280	4,242	(38) U
<b>NET RESULT</b>	<b>1,164</b>	<b>1,186</b>	<b>(22) U</b>	<b>10,635</b>	<b>11,628</b>	<b>(993) U</b>
<b>Paid FTE</b>						
	MONTH (FTE)			YEAR TO DATE (FTE) (7 months ending Jan-17)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	64.6	63.5	(1.1) U	64.9	63.5	(1.4) U
Nursing	142.6	145.2	2.7 F	145.7	145.2	(0.5) U
Allied Health	86.9	95.0	8.1 F	84.5	95.0	10.5 F
Support	2.3	1.0	(1.3) U	1.7	1.0	(0.7) U
Management/Administration	25.4	22.1	(3.4) U	25.2	20.6	(4.6) U
<b>Total excluding outsourced FTEs</b>	<b>321.8</b>	<b>326.8</b>	<b>5.0 F</b>	<b>321.9</b>	<b>325.3</b>	<b>3.3 F</b>
Total Outsourced Services	2.1	1.3	(0.8) U	2.0	1.3	(0.6) U
<b>Total including outsourced FTEs</b>	<b>323.9</b>	<b>328.1</b>	<b>4.2 F</b>	<b>323.9</b>	<b>326.6</b>	<b>2.7 F</b>

## Financial Commentary

The result for the year to date January is an unfavourable variance of \$993k. This is primarily driven by Haematology blood products (volumes and complexity) and Oncology IDF PCT costs (Herceptin and new high cost drugs).

**Volumes:** Overall volumes are 100.5 % of contract (0.5 % over contract - this equates to \$ 283k over contract).

**Total Revenue \$361k** - unfavourable mainly due to:

- Haemophilia blood product reimbursement \$1,664k U – (demand driven and offset by lower blood product costs).
- Provision for wash-up on Auckland DHB PCT costs \$1,000k F.
- Non Residents Income \$121k F.

**Total Expenditure- \$632k** unfavourable mainly due to

- **Personnel Including Outsourced Personnel – \$212k U** – mainly unfavourable SMO costs in Radiation Oncology and Haematology (due to paid extended sick leave) offset by vacancies in Allied health. The key driver of the unfavourable variance was savings target not fully achieved \$431k U.
- **Clinical Supplies \$207k F** – made up of:
  - **Haemophilia \$1,468k F** – mainly Haemophilia Blood product costs demand driven (offset by decreased revenue).
  - **Oncology \$888k** - primarily due to Pharmaceuticals (mainly high cost demand driven drugs – Herceptin and Melanoma drugs combined with unbudgeted new high cost drug Pertuzumab). This was offset by the provision for PCT wash-up revenue on IDFs \$1,000k F.
  - **Haematology \$800k U** – mainly due to blood products costs \$563k U and Pharmaceuticals \$233k U (volume driven combined with high cost BMT patients). Currently Haematology is over the YTD PVS contract by 3.3 % equating to \$486k over contract.
- **Infrastructure and Non Clinical Supplies - \$270k U**

This is primarily due to unachieved opex savings target.

**FTE** – 2.7 FTE favourable



## Mental Health and Addictions Directorate

Speaker: Anna Schofield, Director

### Service Overview

This Directorate provides specialist community and inpatient mental health services to Auckland residents. The Directorate also provides sub-regional (adult inpatient rehabilitation and community psychotherapy), regional (youth forensics and mother and baby inpatient services) and supra-regional (child and youth acute inpatient and eating disorders) services.

### The Mental Health and Addictions Directorate is led by

Director:	Anna Schofield
Director of Nursing:	Tracy Silva Garay
Director of Allied Health:	Mike Butcher
Director of Primary Care:	Kristin Good
General Manager:	Alison Hudgell

### Directorate Priorities for 16/17

**In 2016/17 our Directorate will contribute to the delivery of the six Provider Arm work programmes. In addition to this we will also focus on the following Directorate priorities:**

1. An integrated approach to care: An implementation plan to align services with the five locality boundaries. Tamaki 'integrated care' recommendations implemented. The physical move of the Community Mental Health team from St Lukes in September 2017 will be part of this plan.
2. Right facilities in the right place: A Facilities Plan will be developed to ensure facilities (leased or DHB owned) are fit for purpose, align with integrated models of care and locality approach and are informed by the Clinical Services Plan (CSP). New facilities will be identified to replace the existing facilities with leases due to expire in the next 18 months.
3. Safe acute environment (Te Whetu co-design): Systematic approach to implementing an assault reduction / increased safety programme. Te Whetu Tawera (TWT)/Community Mental Health Service (CMHS) integration in care planning, MDT and staff development to manage acute flow / transitions.
4. Right interventions at the right time: Stepped Care key work training provided to staff involved in the first step of the care pyramid. Credentialing framework confirmed for Steps 2 and 3.
5. Supporting Parents Healthy Children (SPHC): Implementation Plan in place that encompasses the Essential Elements of the SPHC framework. Regional dataset for SPHC data collection confirmed.
6. Equally well: Strengthened governance and relationships across mental health, NGO and PHO services for integrated care planning to improve the physical health of people with Severe Mental Illness (SMI). Develop template GP discharge summaries for service users highlighting physical health risks.
7. Achieve Directorate financial savings target for 2016/17.

## Q3 Actions

#	Action Plan	Owner
1	Develop Integrated Approach to Care implementation plan to align services with five locality boundaries	AS/AH
2	Facilities Plan developed, aligned with the CSP and priority services moved as leases expire	AH
3a	Complete and evaluate the TWT/CMHS escalation plan and collaborative MDT implementation.	AS
3b	Adoption and implementation of best evidence assault reduction activities	MB
4a	Specialist Stepped Care keyworker training and credentialing implemented with web resources	MB
4b	Shared care plan implementation	AS
5	SPHC implementation plan and regional data set developed	MB
6a	Cross primary, secondary, NGO governance group established, TOR and implementation plan developed	KG
6b	Template for GP discharge summaries for service users highlighting physical risks	KG
7	Balance clinical need, risk and safety with fiscal responsibility	AS/AH

### 1 Implementation Plan to Align Services with Locality Boundaries

The Mental Health Directorate is an integral part of the Primary and Community Programme Board and continues to engage in working on options for aligning mental health service provision and support across the 5 geographical locality areas.

### 2 Facilities Plan

A Mental Health Directorate wide Facilities Plan is in development and will incorporate a health and safety assessment for each of our facilities. There is a constant focus on alignment with the clinical services plan (including future need and potential co-location of services) and on prioritising services, including an alternative to the facility currently housing St Lukes Community Mental Health Team and the Assertive Community Outreach Service.

Of note is:

- The potential to relocate St Lukes Community Mental Health Team and the ACOS service, along with other mental health services, in a leased building in Dominion Road is no longer an option for Auckland DHB. This is very disappointing given that we had entered into a scoping exercise in good faith and on the understanding the facility would be available to Auckland DHB. The search for a suitable facility, including Auckland DHB and commercial facilities, continues.



- Agreement has been reached to move ACOS to the Rehab Plus building at Point Chevalier meaning high and complex needs service will be co-located on one site. This will reduce some of the health and safety risks associated with ACOS service users at the St Lukes site.
- The residential eating disorder service requires a suitable facility to be sourced, ideally one that enables co-location with the day programme and outpatient service. With a lease extension until February 2018, proposed options have been scoped and included in a report circulated at the Capital and Asset Management Planning Committee and for further discussion with the executive leadership team.

### **3(a) Te Whetu Tawera (TWT)/Community Mental Health Service (CMHS) Escalation Plan**

The purpose of the escalation plan is to improve flow and access across the acute mental health service delivery continuum. Ideally, acute inpatient units should run at an average occupancy of 85% in order to manage acute demand in a timely manner. Te Whetu Tawera frequently operates at 95-98% occupancy which, in turn, can impact on the Community Acute Service's ability to admit people in a timely way. It can also impact on wait times in the Auckland City Hospital Emergency Department.

The Te Whetu Tawera Occupancy Escalation Plan was developed, tested and implemented during 2016. It covers TWT, the four adult Community Mental Health services, two clinical cultural services and the Assertive Community Outreach Service. Since implementation the plan has twice been reviewed and amended accordingly.

The Escalation Plan is functioning well and is proving to be a more effective way of managing the response to high demand and occupancy when TWT is full. It is now embedded and operating business as usual. The plan is supported by the use of Real Presence secure videoconference technology across the community and inpatient teams.

### **3 (b) Adoption and Implementation of Best Evidence Assault Reduction Activities**

During 2015 there was a high level of assaults occurring in Te Whetu Tawera compared to previous years. In early 2016 reducing assault work was commenced in response. This initial programme of work has now been incorporated into Project Haumarua, a wider change programme at TWT focusing on improving safety, patient flow and staff wellbeing. The project aims to proactively engage and involve all staff.

Te Tumanako (ICU), where there is the greatest risk of assault, has been the initial focus and pilot for assault reduction with components of the South London and Maudsley Trust (SLaM) model of assault reduction introduced. The Dynamic Appraisal of Situational Aggression (DASA) has been re-implemented within Te Tumanako and through the open wards, with training and support from leadership. This, along with Intentional Rounding, is now embedded during the working week. The use of the nursing handover tool ISoBAR in Te Tumanako and the open wards is to be refreshed.

Results of these interventions appear to be flowing through with reduced levels of assault in Te Tumanako. A significant reduction in the overall number of assaults over the last six months

suggests a sustained change. It can however be expected that the rates will vary at times according to acuity, service user complexity and individual service user profile.

Other initiatives being undertaken as part of Project Haumarū and likely to have a positive long term effect include:

- Development of a Compact (or Agreement) with service users. This is a component of the SLaM model noted above that establishes a baseline for how both service users and staff wish to be treated at Te Whetu Tawera. Each service user will be given a copy on admission and can personalise it to express their goals whilst in Te Whetu Tawera. It is being developed in consultation with both staff and service users.
- Establishment of a Whare Tautoko which is a small room dedicated in particular, but not exclusively, as a space for use by Māori service users and their whānau within Te Tumanako.
- The employment of a Recreation Assistant to work alongside other staff such as occupational therapists, to provide service users in Te Tumanako with a broad daily programme of activities.

#### **4 (a) Specialist Stepped Care**

Stepped Care is a system of delivering and monitoring treatments so that the least intrusive treatment is delivered to meet service user's presenting need within adult community mental health services. It involves matching people's needs to the level of intensity of the intervention and only 'stepping up' to intensive or specialist services as clinically required. This approach aims to support self-care as an important aspect of managing demand across primary, community and specialist care settings. Stepped care work uses robust tools to routinely collect outcomes data to support people's journey into, through and out of services.

Progress to date includes the development of additional resources available on the Intranet; refinement of the credentialing process for specialised interventions and the appointment of a Nurse Educator to support workforce development and enable implementation of a range of clinical programmes related to Stepped Care. Training sessions for CMHCs will be rolled out between February and June.

#### **4 (b) Shared Care Plan**

A shared care plan is an electronically stored plan which details goals agreed by the service user and health professionals, along with actions and activities to support the achievement of these goals. One of the key benefits of the shared care plan is the ability for services outside of mental health (such as Emergency Department) to view portions of the plan to support patient led care and smooth the continuum of care through shared communication.

The implementation of collaborative shared care plans across adult Community Mental Health services commenced in 2016. All adult CMHCs, Fraser McDonald Unit and the Mental Health Services for Older People (MHSOP) Community Team have now received training and begun to use the tool. The adult acute inpatient unit TWT has commenced using the tool in 2017 as a component of discharge planning and there will be a monthly review of uptake.

## 5 Supporting Parents Healthy Children (SPHC)

The Government led SPHC programme aims to support parents to do the best for their children by providing guidelines and assistance to all mental health and addiction services to work in a family-focused way. The aim to ensure the wellbeing of children is everyone's responsibility and not just infant child and adolescent services. SPHC also supports the children of parents to improve outcomes for children and youth as set out in Rising to the Challenge (Ministry of Health, 2012).

The SPHC guidelines includes voices of parents and young people talking about their experiences of services and provides evidence based practice to support both parents and their children.

An important component to implementing SPHC is workforce development and the Ministry of Health has commissioned the mental health and addiction workforce centres to provide this support to mental health service providers in DHBs and NGOs.

In Auckland, regional data collection to identify service users who are parents or caregivers and their children began in November 2016. Training in SPHC will be offered to all Directorate staff, along with a brief introduction to SPHC for CMHCs in the first half of 2017.

### 6(a) Cross Primary, Secondary, NGO Governance Group

#### **Equally Well Governance Group:**

In New Zealand and overseas, people with mental health and addiction problems tend to have worse physical health and a shorter life expectancy than their counterparts in the general population. Diabetes, cardiovascular disease, metabolic syndrome, cancer and oral health issues are more prevalent for this population group.

Equally Well is about working together for change with the common goal of reducing physical health disparities for those who experience mental health and addiction problems. This group has representation from the DHB, PHOs and NGOs. There is consensus that this initiative will provide an opportunity to work differently and collaboratively to improve patient outcomes; and support for exploring the use of the Health Improvement Profile in an integrated fashion across primary and secondary care.

The Governance Group has been provided with information on initiatives currently underway in other parts of the country and has subsequently agreed to focus on establishing baseline data, determining elements to be included in the physical check, GP education, funding extended GP consultations and creation of contributory measures for inclusion in the Amenable Mortality System Level Measure.

#### **Community Mental Health Service Primary/Secondary Integration Strategic Group:**

Primary/secondary integration has been identified in Rising to the Challenge (Ministry of Health, 2012) as a means to provide seamless, effective services across the continuum for people experiencing mental health and addiction issues. Specialist mental health services have committed to addressing infrastructural barriers to enhancing coordination and integration between primary and specialist services.

The Community Mental Health Service Primary/Secondary Integration Strategic Group has been recently reconfigured and is working collaboratively on a work plan to address the gap in access to appropriate care within the community for patients whose needs are currently unmet in either primary or secondary care. The Strategic Group has confirmed the PREDICT tool is a key enabler for this initiative, especially given its effective and widespread use in primary care currently. The metro DHBs have signed off on PREDICT.

The CMHS primary/secondary integration initiative is provided in addition to the Tamaki Mental Health and Wellbeing Project being led by the Service Improvement Team.

#### **6(b) Template for GP Discharge Summaries for Service Users**

Adult community mental health services (CMHCs) have developed a discharge summary template to enable information to be shared electronically between specialist services and General Practitioners in a consistent format.

Since July 2016 electronic discharge summaries have been provided to GPs for 40% of discharges, and the Directorate aims to increase this to 90% by 2018. CMHCs are using the local KPI forum to track progress and share learnings to support the achievement of this goal.

Our acute adult inpatient unit Te Whetu Tawera is in the early stages of exploring the possibility of generating discharge summaries for GPs through the electronic clinical record software, HCC.

#### **7 Balance Clinical Need, Risk and Safety with Fiscal Responsibility**

With significant Mental Health funding being FTE based, we continue to address skill mix, including clinical and non-clinical staff. We are working with our clinical and management teams to ensure staff are working to their strengths, and working collaboratively within across services, to manage and lead clinical and operational components of mental health services. We have made a minor skill mix adjustment in Te Whetu Tawera to enable the recruitment of Mental Health Assistants to the permanent staff teams, thus decreasing our reliance on casual staff.

We are concerned however about the increased difficulty mental health services are facing in recruiting staff into our services. Anecdotally, we are aware of applicants who express interest in or are offered roles but subsequently do not progress with the recruitment process due to the current cost and availability of housing. This applies to international recruiting as well as from other regions in NZ. We continue to think of creative ways to access overseas staff, including offering fixed term contracts that enable more senior staff from overseas to take sabbaticals from existing roles for 18 months with the view to support for growing our own staff, along with increasing our internships from nursing and allied health.

## Measures

5.8

Measures	Current	Target (End 2016/17)	2017/18
Integrated Approach to Care Plan, aligned with localities approach signed off	Development stage. With Primary /Community Programme Board	Plan signed off	Staged implementation
Facilities Plan, aligned with CSP signed off	EDS residential has been scoped. Alternative ACOS facility identified	St Lukes relocated by Q4 Residential EDS options confirmed and implementation plan	Work through facilities by priority
Escalation Plan implemented in 2 services and evaluated	Implementation complete	Evaluation completed, plan refined and roll out underway	Roll out to other services
Shared Care Plan in place for adult CMHS clients	Development stage	80% of CMHS users have a Shared Care plan	90% target
Assault reduction best practice plan developed and rolled out	Implementation ongoing	Reduction in assaults for staff and patients	Maintenance of assault reduction
Stepped Care keyworkers trained in all modules Credentialing completed for relevant staff doing Step 2 & 3 Training resources on-line	Implementation in progress	80% keyworkers in CMHS trained in all modules 80% of staff credentialed for Steps 2 & 3 100% of training resources available online	95% of keyworkers trained in all modules
SPHC implementation plan developed and regional data set agreed	Data set agreed. Training underway	Plan signed off >80% of new service users screened for parental/care giving status	90% of all service users screened
Equally Well governance group established and plan developed	Governance group established, plan in development	Implementation Plan signed off 80% of GPs have discharge summaries that include physical risks for service users	Staged implementation
Breakeven revenue and expenditure position	Ongoing with regular monitoring and review	Breakeven	

## **Key achievements in the month**

### **Te Whetu Tawera (TWT)**

The TWT leadership team have implemented Project Haumaru which aims to improve patient safety, staff well-being and safety and patient flow. This builds on and incorporates the co-design work undertaken in Te Whetu Tawera. The environmental upgrade and improvements are complete with some minor finishing touches in some areas. It is hoped the remaining funding will support the Fale Alofa (Pacific space). This focused activity is led by the Service Clinical Director supported by a project manager, with input from the Performance Improvement team as appropriate. This activity is regularly reviewed.

With all service development and improvement work in Te Whetu Tawera now sitting under the 'umbrella' of Project Haumaru, staff across all disciplines and consumer representatives are actively engaged in this Project with the intention of increasing ownership and buy-in by staff. They are represented on the Steering Group and a range of sub committees including assault reduction, co-design, discharge planning, co-morbidities, staff wellbeing, outcomes and the development of a Compact. There is also a renewed focus in 2017 on seclusion and restraint reduction complemented through work underway in the national KPI forum.

## **Areas off track and remedial plans**

### **Supra- Regional Eating Disorder Service**

Auckland DHB has acknowledged the Midland DHBs notice of intention to withdraw from all but the adult residential component of the supra-regional eating disorder programme. Alternative options and financial and clinical impacts were developed by the provider, funder and NRA, and the recommended model endorsed by the Board.

Work has been initiated to identify a suitable location for the EDS residential service and a feasibility project has scoped options.

### **Youth Transition Programme**

The leased property housing the youth transition programme has been modified with assistance from the landlord and a number of corrective actions undertaken to meet health and safety standards. Since completion of these actions the property now meets standards so alternative premises are no longer required.

### **Ligature Risk at Te Whetu Tawera**

Several of the identified ligature risks within TWT have been mitigated in the currently allocated funding. This includes an agreed new prototype for taps in ensuites that will be available to TWT in 6 month time and does not require the walls to be opened. Whilst this is a longer wait than anticipated, it does reduce the disruption to wards. However due to the structure of the building, more detailed work revealed that costs associated with mitigating ligature risks posed by some windows would be significantly greater than budgeted for. This is because the structure of the current facility means replacement of windows would be cost prohibitive. The other option, of sealing windows and installing an HVAC system, would also require a significant investment. These options have been discussed by the DHB Leadership Team and will be presented at the Capital Asset Management and Planning Committee meeting.

## **St Lukes CMHC and Acute Community Outreach Service (CMHC) Facility**

As noted earlier, there are current challenges with sourcing an alternative facility for the St Lukes CMHC including our inability to secure a preferred facility to date. We continue to look for alternative options, including the use of the Point Chevalier campus.

## **Key issues and initiatives identified in coming months**

### **Facilities**

We will continue to proactively work on our Facilities Plan and to source fit for purpose facilities in the community or DHB facilities where existing leases are ending.

### **Localities**

Mental Health is represented on the Primary and Community Programme Board which is progressing the work of localities across Auckland DHB.

### **CFU**

Occupancy remains high over the past 6 months, with the usual pattern of lower occupancy in December. An escalation plan to manage access to the 18 acute beds is being developed in consultation with the supra regional stakeholders.

Implementation of recommendations from the review of the CFU model of care with supra-regional DHBs continues and pathways work is underway.

There is a project underway for analysing AWOL's and implementing an action plan for any new reduction and/or elimination strategies. The service is also building stronger relationships with the Auckland Police.

In addition a concerted effort has been made to work collaboratively with our Child Youth and Family colleagues at the regional and national level and the Ministry of Health to facilitate the best outcomes for children and young people with care and protection and mental health issues that access the Child Youth and Family Unit. Workshops were held in October and December, with a further one planned in March 2017.

### **Mental Health Emergency Department**

Increasing pressures for the Emergency Department (ED) and Mental Health services has highlighted a need to improve the flow and experience for Mental Health patients through ED services. This has led to collaboration between senior clinicians and management from both departments to develop an action plan to move towards enhanced models of care. The agreed principles underpinning this plan are the 'Right Care' in the 'Right Time' by the 'Right People' in the 'Right Environment'. The implementation of the action plan is a focus for the year ahead.

### **Community Pharmacy Technician Pilot**

The directorate will be piloting the use of a pharmacy technician to enable the pharmacists to work at the top of their scope and support service improvement work across the five inpatient units and have pharmacist resource available to the community teams. This will also assist in the transition of the regional eating disorder service from community pharmacy to utilising Auckland DHB pharmacy services.

## Roll Out of Safe Practice and Effective Communication Programme (SPEC)

The roll out of the SPEC programme has begun with a group of clinicians from our three acute inpatient units participating in the Train the Trainer programme for SPEC in February. Planning for roll out of the training is well underway and will commence in early April for a 12 week period for all staff working in acute inpatient areas.

## Scorecard

### Auckland DHB - Mental Health HAC Scorecard for January 2017

	Measure	Actual	Target	Prev Period
Patient Safety	Medication Errors with major harm	0	0	0
	Number of falls with major harm	0	0	0
	Nosocomial pressure injury point prevalence (% of in-patients)	0%	<=6%	0%
	Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	0%	<=6%	0%
	Number of reported adverse events causing harm (SAC 1&2) - excludes suicides	0	0	0
	Seclusion. All inpatient services - episodes of seclusion	2	<=7	6
	Restraint. All services - incidents of restraint	52	<=86	103
	Mental Health Provider Arm Services: SAC1&2 (Inpatient & Non-Inpatient Suicides)	0		1
Better Quality Care	7 day Follow Up post discharge	93%	>=95%	96%
	Mental Health - 28 Day Readmission Rate (KPI Discharges) to Te Whetu Tawera	R/U	<=10%	7.41%
	Mental Health Average LOS (KPI Discharges) - Te Whetu Tawera	28.4	<=21	19.3
	Mental Health Average LOS (All Discharges) - Child & Family Unit	15.2	<=15	9
	Mental Health Average LOS (All Discharges) - Fraser McDonald Unit	29.2	<=35	30.7
	Waiting Times. Provider arm only: 0-19Y - 3W Target	70.9%	>=80%	74.4%
	Waiting Times. Provider arm only: 0-19Y - 8W Target	88.44%	>=95%	89.8%
	Waiting Times. Provider arm only: 20-64Y - 3W Target	88.3%	>=80%	89.1%
	Waiting Times. Provider arm only: 20-64Y - 8W Target	94.5%	>=95%	94.7%
	Waiting Times. Provider arm only: 65Y+ - 3W Target	66.7%	>=80%	70.1%
Waiting Times. Provider arm only: 65Y+ - 8W Target	88.5%	>=95%	88.8%	
Improved Health Status	% Hospitalised smokers offered advice and support to quit	100%	>=95%	96.08%
	Mental Health access rate - Maori 0-19Y	5.97%	>=5.5%	6.15%
	Mental Health access rate - Maori 20-64Y	9.64%	>=12%	9.93%
	Mental Health access rate - Maori 65Y+	4%	>=4.25%	4.1%
	Mental Health access rate - Total 0-19Y	3.2%	>=3%	3.31%
	Mental Health access rate - Total 20-64Y	3.51%	>=4%	3.64%
	Mental Health access rate - Total 65Y+	3.01%	>=4%	3.11%
Engaged Workforce	Excess annual leave dollars (\$M)	\$0.1	0	\$0.12
	% Staff with excess annual leave > 1 year	23.2%	0%	25.3%
	% Staff with excess annual leave > 2 years	4.44%	0%	5.11%
	% Staff with excess annual leave and insufficient plan to clear excess by the end of financial year	R/U	0%	R/U
	Number of Pre-employment Screenings (PES) cleared after the start date	0	0	0
	Sick leave hours taken as a percentage of total hours worked	4.4%	<=3.4%	4.4%
	% Voluntary turnover (annually)	12.53%	<=10%	11.87%
	% Voluntary turnover <1 year tenure	8.6%	<=6%	9.09%

**Amber** Variance from target not significant enough to report as non-compliant. This includes percentages/rates within 1% of target, or volumes within 1 value from target. Not applicable for Engaged Workforce KRA.

**R/U** Result unavailable

#### Mental Health - 28 Day Readmission Rate (KPI Discharges) to Te Whetu Tawera

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



## Scorecard commentary

### Average LOS: Te Whetu Tawera

While the 28.4 days average LoS is above target, it is a jump from the extremely low December figure of 19.3 days and is a marked improvement on recent months with Av LoS at more than 30 days. The median LoS for January is 22.5 days indicating half of all discharges are very close to the 21 day target. Importantly there is a less skewed distribution of length of stays with far fewer very long stays. LoS is regularly monitored and the services is measuring and reporting on barriers to discharge with a view to formulating strategies to address key issues.

### Follow Up Rates

The percentage of discharges in January from Te Whetu Tawera seen by community services within 7 days of discharge is just under target, with three service users not seen in the target timeframe and two of these were seen one day outside the 7 days.

### Waiting Times

The data used by MoH for these latest waiting times calculations is based on incomplete data for Auckland DHB as there have been issues, which are now resolved, in providing up-to-date data.

Three data/reporting factors continue to impact on the rolling 12 month results. They are the introduction of the Starship consult liaison service into MoH reporting, the transfer of Huntington's clients from Liaison Psychiatry into a dedicated service and the management of memory clinic clients within MHSOP.

Changes to memory clinic referrals and measures put in place to improve waiting times for MHSOP are proving effective. However, given that the data is for the previous 12 months, this will take several more months to demonstrate significant improvement.

Waiting times remain a challenge for the older adult Community Team (MHSOP) and for our Child and Adolescent services. Both services have experienced growth in demand and associated activity in the first half of 16/17FY compared to the same period in 15/16FY. This increase in demand and waiting times is occurring for CAMHS services nationally.

### Access (DHB-wide)

'Access' is a count of mental health service contacts with, or about, Auckland DHB residents in any DHB or NGO services during a 12 month period. This count is calculated as a percentage of the projected population.

Access rates for Auckland DHB includes activity within Auckland DHB Provider Arm MH services and the NGO sector, as well as provider arm services contracted by Auckland DHB for delivery via Waitemata DHB (e.g. Community Alcohol and Drug services and Forensic services).

While access rates for the Maori 20-64y group remains a challenge, Auckland DHB does have the highest access target for this group in the country. It should be noted that, across the adult continuum, Auckland DHB provider arm delivers approximately 36% of the access for this group with NGOs, community alcohol and drug services (CADS) and other DHB services delivering the balance. It is challenging to understand the relative performance of different parts of this continuum from this broad access data provided by the MoH.

## **Leave Management**

Mental Health and Addictions continues to actively manage leave. The cost of excess annual leave at the end of January 2017 was \$0.02 lower than the previous period and \$0.01 favourable on the same time last year. STIL leave balances are also trending consistently lower compared to last year due to the Directorate's ongoing focus on leave planning.

Staff turnover appears to have increased slightly in January having trended downwards for the first two quarters. It is too early to know whether this is anything more than a seasonal occurrence.

Attracting mental health nurses continues to be challenging. One of the ways of addressing this is through the recruitment of new nursing graduates commencing. Appointments have been made to senior Medical and Nursing roles within the Directorate recently with the successful applicants having started, or expected to commence, employment between February and April/May.

## **Staff survey and team action planning**

67% of the Directorate participated in the staff survey and work is underway to debrief teams within the Directorate on their individual team's results and to support them to develop their engagement action plans.

## Financial Results

<b>STATEMENT OF FINANCIAL PERFORMANCE</b>						
<i>Mental Health &amp; Addictions</i>						Reporting Date <b>Jan-17</b>
(\$000s)	MONTH			YEAR TO DATE (7 months ending Jan-17)		
	Actual	Budget	Variance	Actual	Budget	Variance
<b>REVENUE</b>						
Government and Crown Agency	53	61	(9) U	505	453	52 F
Funder to Provider Revenue	8,882	8,882	0 F	62,176	62,176	0 F
Other Income	39	54	(15) U	392	376	16 F
<b>Total Revenue</b>	<b>8,974</b>	<b>8,997</b>	<b>(23) U</b>	<b>63,074</b>	<b>63,005</b>	<b>69 F</b>
<b>EXPENDITURE</b>						
<b>Personnel</b>						
Personnel Costs	6,378	6,331	(47) U	43,781	44,708	927 F
Outsourced Personnel	154	56	(98) U	1,082	390	(692) U
Outsourced Clinical Services	57	134	77 F	477	938	461 F
Clinical Supplies	61	66	6 F	615	543	(73) U
Infrastructure & Non-Clinical Supplies	290	360	70 F	2,522	2,496	(25) U
<b>Total Expenditure</b>	<b>6,940</b>	<b>6,947</b>	<b>7 F</b>	<b>48,477</b>	<b>49,075</b>	<b>598 F</b>
<b>Contribution</b>	<b>2,034</b>	<b>2,050</b>	<b>(16) U</b>	<b>14,596</b>	<b>13,930</b>	<b>667 F</b>
Allocations	1,750	1,797	47 F	12,342	12,627	285 F
<b>NET RESULT</b>	<b>284</b>	<b>253</b>	<b>31 F</b>	<b>2,254</b>	<b>1,303</b>	<b>951 F</b>
<b>Paid FTE</b>						
	MONTH (FTE)			YEAR TO DATE (FTE) (7 months ending Jan-17)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	96.2	97.3	1.1 F	93.0	97.3	4.3 F
Nursing	306.6	322.6	16.0 F	301.6	323.0	21.4 F
Allied Health	275.4	273.0	(2.3) U	270.3	273.0	2.8 F
Support	6.3	8.0	1.7 F	6.9	8.0	1.0 F
Management/Administration	57.8	54.5	(3.3) U	58.8	50.7	(8.1) U
<b>Total excluding outsourced FTEs</b>	<b>742.3</b>	<b>755.4</b>	<b>13.2 F</b>	<b>730.6</b>	<b>752.1</b>	<b>21.4 F</b>
Total : Outsourced Services	19.3	6.0	(13.3) U	17.5	6.0	(11.5) U
<b>Total including outsourced FTEs</b>	<b>761.5</b>	<b>761.4</b>	<b>(0.1) U</b>	<b>748.1</b>	<b>758.1</b>	<b>10.0 F</b>

### Comments on Major Financial Variances

The result for the month is a surplus of \$284k against a budgeted surplus of \$253k, leaving a favourable variance of \$31k.

The key driver for the small favourable result in the month is savings in non-personnel costs due to low activity over the holiday period which has offset the high cost of backfilling vacancies.

The key drivers of the favourable YTD results are:

- FTE vacancies offset by high overtime and high outsourced/backfill costs.
- Outsourced Clinical Services mainly due to low Flexi-funding and the funded GP visits which are rolling out.

### **Actions**

- There is wider focused work commencing on reducing overtime and excessive annual leave across the Directorate.
- There is on-going review of relevant HR expenditure including Authority to Recruits (ATR), and overtime. This year we are phasing the increase in FTE through vacancy management in order to meet Funder expectations by the end of the financial year and to be clinically safe.
- The on-going strategy to recruit new graduate nurses and interns will contribute in the long term to a lower skill mix and reduction in the premium paid on backfill.
- The service is actively monitoring and reviewing non-clinical spending. Various controls and mitigations are being explored.

### **Volumes**

We are now measuring volumes for internal purposes. Overall we are under-delivering against contract by around \$1M, primarily due to vacancies in funded FTE positions. There is no wash up on Mental Health volumes and the net under-delivery is not recognised in the results.

### **Savings**

Overall we are meeting our savings target for the year to date to January. This is achieved mainly through vacancy and annual leave management. We are forecasting to continuously achieve savings targets to the year-end through on-going active management of recruitment and other personnel costs.

### **Forecast**

The directorate is currently forecasting to be \$606k favourable to budget. There is on-going pressure in the balance of the year, especially with the additional costs of backfill to enable the implementation of the required National Safe Practice and Effective Communication (SPEC) Training Programme in the 3 acute units.

## Adult Medical Directorate

Speaker: Dr Barry Snow, Director

5.9

### Service Overview

The Adult Medical Directorate is responsible for the provision of emergency care, medical services and sub specialties for the adult population. Services comprise: Adult Emergency Department (AED), Assessment and Planning Unit (APU), Department of Critical Care Medicine (DCCM), General Medicine, Infectious Diseases, Gastroenterology, Respiratory, Neurology and Renal.

#### The Adult Medical Directorate is led by:

Director:	Dr Barry Snow
General Manager:	Dee Hackett
Director of Nursing:	Brenda Clune
Director of Allied Health:	Carolyn Simmons Carlsson
Director of Primary Care:	Dr Jim Kriechbaum

### Directorate Priorities for 16/17

**In 2016/17 our Directorate will contribute to the delivery of the six Provider Arm work programmes. In addition to this we will also focus on the following Directorate priorities:**

1. Developing the service/speciality leadership team to support the delivery of service transformation, performance management, living the values and financial management.
2. Meeting the organisational targets across all specialities.
3. Investing and developing our facilities and infrastructure to ensure they are fit for purpose and meet health and safety requirements.
4. Planning and implementation of service developments. Focus on at least one service development per speciality that improves the patient experience.
5. Overall reduction in the number of falls with serious harm, Grade 3 and 4 Pressure Injuries (PIs) and full compliance of 80% for hand hygiene across the Directorate.
6. Identify areas of waste that can be eliminated to save costs and improve quality and efficiency of care. Achieve directorate financial savings target for 2016/17.

### Q3 Actions – 90 day plan

- Weekly team and monthly directorate meetings are working well. MOS meetings are undertaken weekly with the Senior Leadership Team. Each service developing and delivering MOS.
- Monthly meetings with each service reviewing priority plans, finance information, HR information and newly developed service scorecards with each service.
- Capacity and demand work started for Neurology to assess growth and capacity to deliver services differently.
- Continuing with monthly steering group to progress renal business case. Strategic discussions for future spoke delivery have started with Tāmaki Regeneration Company. Business case to be submitted following further discussions with Tāmaki Regeneration Company.
- Preliminary design for CDU submitted and accepted by Board. Currently submitting building consent and construction will begin in May 2017. Working group established to manage developments of CDU and use of APU.
- Quality forum delivered. New scorecards for all services developed that include quality items. Scorecards reviewed with services on a monthly basis.

### Measures

Measures	Current	Target (End 2016/17)	2017/18
ED target, ESPI, FCT and FSA and FUs	Fully met	Fully met	
Business case submissions	Level 2		Renal BCs
L2 CDU build completed			Completion
Reduction in number of falls with serious harm	50% reduction from current	75% reduction from current	
Reduction in the number of PIs grade 3 and 4 hospital acquired	50% reduction from current	100% reduction from current	
Hand hygiene	80%	95%	
Breakeven revenue and expenditure position		Breakeven	

## Key achievements in the month

- Good performance in AED during quarter two in spite of a steady increase in attendance and unprecedented attendance in December over the holiday period.
- Colonoscopy target still being maintained.
- Have begun the delivery of the contract with Waitemata for Colonoscopy. Monitoring weekly with staff from Waitemata and currently working well. Will continue with weekly conferencing until we have established procedures and pathways.
- CDU design progressing and construction to start in 2017 and a working group established to manage the build and developments within APU. Workshop arranged for March 2017.
- Renal spoke concept design complete and design group established in preparation for concept design. Full engagement with Tāmaki Regeneration Company.
- Continued improvement in hand hygiene across directorate.
- Delivered the strategic business case for delivering a Regional Hyperacute Stroke Service submitted to the Executive Leadership Team for review.
- Rapid Improvement event for management of cellulitis held in December.

## Areas off track and remedial plans

- Slight issue with neurology and respiratory ESPI2. Currently working with services to rectify. Also seeking clarification of FSA status when patients are referred from the same speciality for a specialist opinion.
- DNA rates still an issue but remaining consistent. Will be looking at models of care for 17/18 to review DNAs. Higher percentage within FUs.
- High number of CBU outliers due to high number of admissions within January 2017.
- Mixed gender rooms are predominantly occurring in two wards. These areas have a continued focus on adjusting this at the end of each shift.

## Key issues and initiatives identified in coming months

- Progressing development of community dialysis provision and working collaboratively with Tāmaki Regeneration Company for future provision of capacity.
- Monthly priority plan and service performance meetings continuing with good engagement. Planning day for booked for March 2017 to develop plans for each service for 17/18.
- Continuing with Neurology and Respiratory capacity and demand planning.
- Full service review for the respiratory sleep services.
- Greater focus on mental health attendance to AED. A nursing education programme is being developed. A meeting was held and an action plan for implementation has been developed.
- Implementation of recommendations from the rapid improvement event in care of cellulitis.
- Development of business case to seek funding for regionally agreed Hyperacute service for stroke and a clot retrieval pathway. Proposal submitted to the Executive Leadership Team in February 2017. To be presented to the Regional Group with a funding paper outlining funding streams.
- Continuing to deliver extra colonoscopy capacity for Waitemata.

# Scorecard

## Auckland DHB - Adult Medical Services HAC Scorecard for January 2017

	Measure	Actual	Target	Prev Period
Patient Safety	Central line associated bacteraemia rate per 1,000 central line days	0	<=1	3.85
	Medication Errors with major harm	0	0	0
	Nosocomial pressure injury point prevalence (% of in-patients)	2.1%	<=6%	2.7%
	Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	5.8%	<=6%	6.1%
	Number of falls with major harm	0	0	0
	Number of reported adverse events causing harm (SAC 1&2)	0	0	2
	Unviewed/unsigned Histology/Cytology results < 90 days	22	0	24
	Unviewed/unsigned Histology/Cytology results > 90 days	1	0	4
Better Quality Care	(MOH-01) % AED patients with ED stay < 6 hours	94.85%	>=95%	93.77%
	(ESPI-1) % Services acknowledging 90% of FSA referrals in 15 calendar days or less	R/U	100%	100%
	(ESPI-2) Patients waiting longer than 4 months for their FSA	0.38%	0%	0%
	% DNA rate for outpatient appointments - All Ethnicities	12.05%	<=9%	12.26%
	% DNA rate for outpatient appointments - Maori	25.2%	<=9%	22.36%
	% DNA rate for outpatient appointments - Pacific	22.34%	<=9%	23.51%
	Number of CBU Outliers - Adult	87	0	101
	% Patients cared for in a mixed gender room at midday - Adult	25.8%	0%	27.13%
	% Patients cared for in a mixed gender room at midday - Adult (excluding APU)	10.5%	TBC	10.32%
	% Very good and excellent ratings for overall inpatient experience	R/U	>=90%	87.9%
	Number of complaints received	12	No Target	6
	28 Day Readmission Rate - Total	R/U	<=10%	11.23%
	% Urgent diagnostic colonoscopy compliance	92.31%	>=85%	95.83%
	% Non-urgent diagnostic colonoscopy compliance	73.57%	>=70%	94.75%
	% Surveillance diagnostic colonoscopy compliance	78.93%	>=70%	80.65%
	Average Length of Stay for WIES funded discharges (days) - Acute	1.83	TBC	2.05
Improved Health Status	% Hospitalised smokers offered advice and support to quit	94.21%	>=95%	94.52%
Engaged Workforce	Excess annual leave dollars (\$M)	\$0.56	0	\$0.62
	% Staff with excess annual leave > 1 year	31.64%	0%	32.5%
	% Staff with excess annual leave > 2 years	10.8%	0%	12.05%
	% Staff with excess annual leave and insufficient plan to clear excess by the end of financial year	R/U	0%	R/U
	% Staff with leave planned for the current 12 months	10%	100%	10%
	% Leave taken to date for the current 12 months	59.55%	100%	59.55%
	Number of Pre-employment Screenings (PES) cleared after the start date	0	0	0
	Sick leave hours taken as a percentage of total hours worked	3%	<=3.4%	3.9%
	% Voluntary turnover (annually)	11.33%	<=10%	11.07%
	% Voluntary turnover <1 year tenure	5.43%	<=6%	4.44%

**Amber** Variance from target not significant enough to report as non-compliant. This includes percentages/rates within 1% of target, or volumes within 1 value from target. Not applicable for Engaged Workforce KRA.

**R/U** Result unavailable

**(ESPI-1) % Services acknowledging 90% of FSA referrals in 15 calendar days or less**  
Result unavailable until after the 16th of the next month.

**% Very good and excellent ratings for overall inpatient experience**

This measure is based on retrospective survey data, i.e. completed responses for patients discharged or treated the previous month.

**28 Day Readmission Rate - Total**

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



## Scorecard Commentary

- Good performance across all patient safety metrics for January.
- AED performance met even though extremely busy with high attendance.
- Slight issue with neurology and respiratory ESPI2. Currently working with services to rectify. Also seeking clarification of FSA status when patients are referred from the same speciality for a specialist opinion.
- DNA rates still an issue but remaining consistent. Will be looking at models of care for 17/18 to review DNAs. Higher percentage within FUs.
- High number of CBU outliers due to high number of admissions within January 2017.
- Mixed gender rooms are predominantly occurring in two wards. These areas have a continued focus on adjusting this at the end of each shift.
- Number of complaints received increased but volumes much higher so slight percentage increase. All services responding within timeframes. Patients being contacted and in certain cases meetings have been arranged to address specific issues.
- Maintaining the colonoscopy target across all measures.
- Reduction in the % of staff with excess annual leave over 2 years. This is covered within the monthly service review meetings and has had a focus for 2016/17.
- Good result for staff sick leave (3%) as December and January were very busy with the increased volumes through AED and General Medicine. Also monitoring sickness very closely within monthly review meetings.

## Financial Results

STATEMENT OF FINANCIAL PERFORMANCE						
<i>Adult Medical Services</i>						Reporting Date <b>Jan-17</b>
(\$000s)	MONTH			YEAR TO DATE (7 months ending Jan-17)		
	Actual	Budget	Variance	Actual	Budget	Variance
<b>REVENUE</b>						
Government and Crown Agency	256	269	(12) U	2,187	1,917	271 F
Funder to Provider Revenue	12,379	12,379	0 F	92,031	92,031	0 F
Other Income	356	406	(50) U	2,997	2,845	152 F
<b>Total Revenue</b>	<b>12,991</b>	<b>13,054</b>	<b>(63) U</b>	<b>97,216</b>	<b>96,793</b>	<b>422 F</b>
<b>EXPENDITURE</b>						
<b>Personnel</b>						
Personnel Costs	8,846	8,367	(479) U	57,759	57,577	(183) U
Outsourced Personnel	108	94	(14) U	644	681	37 F
Outsourced Clinical Services	31	50	19 F	319	345	26 F
Clinical Supplies	1,642	1,468	(175) U	12,809	11,941	(868) U
Infrastructure & Non-Clinical Supplies	106	84	(22) U	1,112	752	(359) U
<b>Total Expenditure</b>	<b>10,733</b>	<b>10,063</b>	<b>(670) U</b>	<b>72,643</b>	<b>71,295</b>	<b>(1,347) U</b>
<b>Contribution</b>	<b>2,258</b>	<b>2,991</b>	<b>(732) U</b>	<b>24,573</b>	<b>25,498</b>	<b>(925) U</b>
Allocations	1,847	1,777	(70) U	14,623	14,187	(436) U
<b>NET RESULT</b>	<b>411</b>	<b>1,214</b>	<b>(803) U</b>	<b>9,950</b>	<b>11,311</b>	<b>(1,361) U</b>
<b>Paid FTE</b>						
	MONTH (FTE)			YEAR TO DATE (FTE) (7 months ending Jan-17)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	203.5	192.3	(11.1) U	201.1	192.3	(8.7) U
Nursing	551.6	544.5	(7.1) U	550.3	539.4	(10.8) U
Allied Health	44.0	51.8	7.7 F	45.0	51.8	6.7 F
Support	6.6	6.0	(0.6) U	6.0	6.0	(0.0) U
Management/Administration	55.3	41.0	(14.2) U	53.9	41.5	(12.4) U
<b>Total excluding outsourced FTEs</b>	<b>860.9</b>	<b>835.6</b>	<b>(25.3) U</b>	<b>856.3</b>	<b>831.0</b>	<b>(25.3) U</b>
Total : Outsourced Services	13.3	5.0	(8.3) U	5.1	5.0	(0.1) U
<b>Total including outsourced FTEs</b>	<b>874.3</b>	<b>840.6</b>	<b>(33.7) U</b>	<b>861.3</b>	<b>836.0</b>	<b>(25.4) U</b>

## Financial Commentary

The result for the year to date January 2017 is an unfavourable variance of \$1,361k.

**Volumes:** Overall volumes are 98.6 % of contract. This equates to \$ 1,248k under contract (Variance not recognised in the Adult Medical Provider result).

### Total Revenue - \$ 422k favourable

- primarily due to additional colonoscopy revenue for achieving the 15/16 target \$233k F and Nurse endoscopy training revenue \$95k F.

### Total Expenditure - \$ 1,783k unfavourable due to:

#### Personnel Costs - \$ 183k unfavourable

This is mainly unachieved savings target made up of personnel cost target saving of \$630k offset by favourable variances in Allied Health \$412k F. The savings initiatives comprises the management of overtime spend, patient attenders, allowances, sick leave, staff mix and annual leave.

**Clinical Supplies - \$ 868k Unfavourable** – driven by

- Treatment disposables \$543k due to blood product costs (mainly ED high cost patients and increased volume) and renal fluids unfavourable
- Instruments and Equipment \$164k U – mainly unplanned repairs to scopes and bariatric equipment
- Pharmaceuticals \$125k U mainly Gastroenterology (increases in IBD patient using high cost Biological infusions (infliximab).

**Infrastructure and Non-Clinical supplies - \$ 359k unfavourable**

This is primarily due to unachieved opex savings target.

**Internal Allocation - \$ 436k unfavourable**

This is mainly due to radiology \$309k U (mainly ED and Neurology clot retrieval) and nutrition \$166k U (budget understated).

**FTE**

The unfavourable Medical FTE variance for the month is overstated due to the transfer of annual leave for RMOs transferring between DHBs - this will correct next month. The underlying unfavourable FTE variance is due to increased nursing FTE in AED due to volumes and complexity, combined with unachieved FTE savings target.



# Community and Long Term Conditions Directorate

Speaker: Judith Catherwood, Director

5.10

## Service Overview

The Community and Long Term Conditions Directorate is responsible for the provision of care of Older People's Health Services, Adult Rehabilitation Services, Palliative Care Services, Community Based Nursing, Community Rehabilitation, Community Allied Health Services, and Long Term Condition and Ambulatory Services for the adult population. The services in the Directorate have been restructured under the clinician leadership model into six service groups:

- Reablement (in patient adult assessment, treatment and rehabilitation services)
- Sexual Health Services
- Community Services (Chronic Pain, Locality Community Teams and Mobility Solutions)
- Diabetes Services
- Ambulatory Services (Endocrinology, Dermatology, Immunology and Rheumatology)
- Palliative Care Services

### The Community and Long Term Conditions Directorate is led by

Director:	Judith Catherwood
General Manager:	Alex Pimm
Director of Nursing:	Jane Lees
Director of Allied Health:	Anna McRae
Director of Primary Care:	Jim Kriechbaum
Medical Director:	Dr Lalit Kalra

## Directorate Priorities for 16/17

**In 2016/17 our Directorate will contribute to the delivery of the six Provider Arm work programmes. In addition to this we will also focus on the following Directorate priorities:**

1. Embedding clinical governance culture across the Directorate to support all decision making.
2. Leadership and workforce development programme.
3. Outpatient improvement programme.
4. Improvement in health outcomes through new models of care.
5. Achieve Directorate financial savings target for 2016/17.

## **Q3 Actions – 90 day plan**

### **1. Extend and develop clinician leaders and managers through leadership and management programmes**

A programme of facilitated team development based on Board mandatories, values and strategic direction has commenced. Service Leadership Team events to support this are in progress across the Directorate. Two members of our new clinician leadership team have completed their leadership development programme. Nine members of staff have commenced the programme in various cohorts in 2017. Leadership and management support and training for our new leaders and level four team members has been identified as a priority for this year and will be supported.

### **2. Implement plan for advancement in roles for nurses, allied health and support staff**

Workforce planning for nursing and allied health role development continues to progress. New assistant roles across Community Services are being developed to support our clinical teams. The new service developments in progress, including rapid response, intermediate care, early supported discharge and stroke services provide opportunities to enhance nursing and allied health roles. An advanced clinician role and nurse specialist role in Reablement Services have been recruited to. Nursing roles in Sexual Health, Diabetes, Dermatology and Rheumatology services are also currently being reviewed to support service requirements.

### **3. Complete the implementation of the Directorate outpatient improvement programme**

DNA action plan continues to be implemented with our initial focus on Diabetes Services. Our DNA rates have declined over the last six months. There is still significant progress to be made, with plans in place. Cancellation rates are also being monitored as late cancellations will have an impact on service delivery and outcomes.

The process to reduce rescheduling rates by applying a six week booking rule is in place in a number of outpatient clinics. Our rescheduling rates continue to slowly reduce and the trajectory is on target to meet our goal. At present we do not have data to indicate how many appointments are rescheduled due to patient choice versus service requirements. This change mirrors the six week booking rule for leave and ensures we aim only reschedule a patient's appointment if it is patient initiated or urgent due to specific patient care requirements. Baseline assessment to ensure accurate measurement of virtual contacts is progressing in all services. Our services are increasing the use of virtual contacts in all services.

Implementation of business rules into Older People's Health outpatient services and Community Services has been completed to ensure accurate activity and waiting times reporting. Reporting processes have been completed with Business Intelligence.

### **4. Implement the stroke plan and work towards a comprehensive adult stroke unit**

The integrated all age stroke rehabilitation unit opened in July 2016. Early Supported Discharge Services (ESD) also commenced simultaneously. A plan for the hyper acute stroke pathway has been completed for regional approval. The quarterly data on admissions to a rehabilitation service within 7 days of acute stroke presentation was stable at 43.1% in the last quarter. In our most recent data for December 2016 82% of Auckland DHB patients were transferred within the 7 day target, an improvement on the previous month.

We expect our quarterly data to reflect continuous improvement each quarter. Plans to create the comprehensive adult stroke unit are progressing and will continue through 2017 as it will require a full business case to be developed.

## **5. Extend the locality model of care to other services**

The locality model continues to develop with Community Services and Diabetes. A plan to achieve this in full by end of 2016/17 is in place. Geriatric Medicine are in the process of finalising a plan and work is now in progress to ensure gerontology support is in place in all localities.

A programme of work to support integration of the locality model across the four main directorates engaged in community service delivery is in progress across the provider arm.

The Adult Palliative Care Strategy continues to be implemented. The Auckland DHB Board received a report on progress in February 2017. Plans for integrating the specialist service across Auckland DHB are close to being finalised and the Auckland DHB Board has been asked to support an Agreement for a joint leadership role between ourselves and Mercy Hospice. Two rapid improvement events to improve care for those at end of life have been held in November 2016. An Action Plan from these events is in development and will be finalised in March 2017.

A consultation to resize the Sexual Health and Sexual Assault Services has been completed. The Directorate received significant feedback on the consultation. The MoH has been briefed given the significance of the change proposed. A decision document has been released to the Unions and workforce. A transition period to implement the new workforce model will take place over the course of 2017.

## **6. Implement the frailty pathway**

The first stage of the frailty pathway was implemented successfully on 29 August 2016. Further work is progressing to develop care pathways across the hospital and extend this to older adults living in their own homes and in aged care facilities over time. The aim of the pathway is to standardise the care bundle provided to all frail patients presenting to the ED and ensure rapid access to the most appropriate services and a comprehensive geriatric assessment early in the care pathway, with the aim of reducing the LOS for frail patients in hospital or supporting care in patient's own homes to reduce any unnecessary admissions. Rapid Response services and end of life care are also very important parts of this pathway in community settings. It is positive to note that in 2016, Auckland DHB had its lowest rate of bed days occupied by over 85 year olds, with a 5000 less bed days (12% reduction) occupied from a peak in 2011.

## **7. Implement step up/step down intermediate care models**

Rapid Response Services continue to be delivered and are now accessible from ED, hospital services, general practice, aged care facilities, St John and Homecare Medical referral sources. We continue to promote services and are working on a new community central referral model to enhance navigation to services.

An approach to utilise the interim care contract for a wider group of patients has been agreed. We have also completed work with Orthopaedics to enhance allied health and gerontology nursing input to these patients during their care period in aged care. This will allow us to improve rehabilitation outcomes and reduce LOS on the interim care programme.

This strategy is an essential part of the future care delivery model for Reablement Services. It will also ensure we can deliver earlier rehabilitation and greater flow at a reduced cost. The new pathways were implemented during November 2016 and evaluation is ongoing.

### Develop long term conditions strategy across the organisation

This strategy will be developed later in 2016/17 as per business planning cycle.

## Measures

Measures	Current	Target (end 16/17)	Previous Period
Did not attend (DNA) rate	12.44%	<9%	12.44%
Rescheduling rate	57.69%	<40%	50.21%
Proportion of activity undertaken as virtual or non-face-to-face activity	1%	5%	1%
Patient waiting times – outpatients, community and inpatients	Outpatients – max.4 mths Inpatients – 75.9% within 2 days Community – 86.6% within 6 weeks	Outpatients – max 3 months; Inpatients – max 2 days; Community – max. 6 weeks	Outpatients – max.4 mths Inpatients – 76% within 2 days Community – 92% within 6 weeks
Admissions to age-related residential care	Average 101/month	5% reduction per quarter Q2 Target: 86	Average 103.5/month
Proportion of HCAs and TAs as percentage of total workforce	11.4%	15%	11.4%
Percentage of stroke patients transferred to rehabilitation services within seven days of admission (MOH definition, quarterly reporting)	43.1%	80%	45%
Percentage of patients transferred to hospice within 24 hours of being clinically ready to transfer	70%	85%	33%
Breakeven revenue and expenditure position	Favourable	Breakeven	Favourable

## Key achievements in the month

- The Diabetes Services have finalised a plan to deliver extra support to community and primary care services in the delivery of diabetes care across the care continuum. This will be rolled out over the course of 2017. An evaluation of the Auckland PHO/Specialist Service diabetes project has commenced. Both activities will support the wider work on diabetes care within the Auckland DHB/Waitemata DHB Diabetes Service Level Alliance (DSLAA).
- The Directorate has met the 62 day treatment target in 100% of patients with high suspicion of melanoma for the first time. We are expecting to maintain this.
- A new programme of work has commenced with ACC to resign the care pathways within non-acute rehabilitation services for older adults and implement a new case mix funding model. This has the potential to further improve the LOS and clinical outcomes and integration of care



for the frail older adult. New funding jointly approved by the Board and ACC will see enhanced falls prevention services and fracture liaison services in place across Auckland in the coming months. Recruitment to these new services has progressed and services have been launched.

- The Directorate have implemented electronic prescribing in two of the four wards in Reablement Services. A plan to embed the system in the remaining two wards has been finalised and received capital funding to proceed. The staff across the service are enthusiastic and proud of this achievement which will improve medicines safety.
- The Directorate have agreed a set of clinical outcome measures, which complement the Directorate business plan measures, within each of the six services which will be monitored and reviewed regularly. This work will be part of the implementation of clinical governance and quality service frameworks in each service group.
- A number of our services use HCC to record activity. The Community Services and Sexual Health Service new business rules and reporting arrangements are now complete and implemented. This ensures the services record waiting times, activity and volumes accurately which has an impact on revenue, funding, projection planning and understanding patient flow.
- Several leadership roles within the Directorate have been successfully recruited to. Dr Lalit Kalra has commenced as Medical Director, Dr Ole Schmiedel has commenced as SCD Diabetes Services and Beth Rogers has commenced as SCD Community Services.

### **Areas off track and remedial plans**

- DNA action plan for the Directorate has been developed and is being implemented across all services.
- Recruitment to clinical positions has proved challenging, particularly in community services. We have completed a recruitment initiative with HR support.

### **Key issues and initiatives identified in coming months**

- Complete recruitment to the Directorate Leadership team. Recruitment to the last two key leadership posts in the Directorate is in progress currently.
- Implementation, orientation and development of the revised Directorate structure, which embeds the Clinician Leadership model.
- Embed improved clinical governance processes and decision making systems across the Directorate at service level.
- Implementation and further development of the locality model within community services, integrating Diabetes Services, Palliative Care and Geriatric Medical Services into the model during 2016/17.
- Implement the new Clinician Leadership model in the Adult Palliative Care Services across the district and integrate specialist palliative care.

- Implement the outpatient improvement programme in all relevant areas of our directorate.
- Implement the Specialist Diabetes Plan across Auckland DHB and continue to support the DSLA in their work to redesign the care pathway for people with diabetes in Waitemata DHB/Auckland DHB.
- Develop the full business case for the integrated stroke unit.
- Deliver the recommendations of the Reablement Clinical Review which will contemporise the rehabilitation model of care and support patients in achieving the most effective outcomes/level of independence.
- Continue the development of work streams to improve the quality and outcome of the patient's journey including intermediate care, dementia care, frailty pathway and the stroke pathway.
- Development of a capital planning programme for the Directorate and the facilities our services utilise.
- Continue work to improve our skill mix and use of support staff in all aspects of our service provision, in particular nursing and allied health workforce in Community and Reablement Services.

# Scorecard

## Auckland DHB - Adult Community & Long Term Conditions HAC Scorecard for January 2017

5.10

	Measure	Actual	Target	Prev Period
Patient Safety	Medication Errors with major harm	0	0	0
	Number of falls with major harm	2	0	0
	Nosocomial pressure injury point prevalence (% of in-patients)	0%	<=6%	3.85%
	Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	3.6%	<=6%	3.8%
	Number of reported adverse events causing harm (SAC 1&2)	2	0	0
	Unviewed/unsigned Histology/Cytology results < 90 days	1	0	0
	Unviewed/unsigned Histology/Cytology results > 90 days	0	0	0
Better Quality Care	(ESPI-1) % Services acknowledging 90% of FSA referrals in 15 calendar days or less	R/U	100%	100%
	(ESPI-2) Patients waiting longer than 4 months for their FSA	0%	0%	0%
	% DNA rate for outpatient appointments - All Ethnicities	12.44%	<=9%	13.81%
	% DNA rate for outpatient appointments - Maori	28.38%	<=9%	25.64%
	% DNA rate for outpatient appointments - Pacific	23.35%	<=9%	28.57%
	% Patients cared for in a mixed gender room at midday - Adult	17.85%	<=2%	11.89%
	% Very good and excellent ratings for overall inpatient experience	R/U	>=90%	70%
	% Very good and excellent ratings for overall outpatient experience	R/U	>=90%	89.8%
	Number of complaints received	5	No Target	2
	% Inpatients on Older Peoples Health waiting list for 2 calendar days or less	75.89%	>=80%	91.62%
	% Inpatients on Rehab Plus waiting list for 2 business days or less	100%	>=80%	100%
	% Discharges with Length of Stay less than 21 days (midnights) for OPH and Rehab Plus combined	67.42%	>=80%	76.56%
Improved Health Status	% Hospitalised smokers offered advice and support to quit	100%	>=95%	92%
Engaged Workforce	Excess annual leave dollars (\$M)	\$0.04	0	\$0.07
	% Staff with excess annual leave > 1 year	30.59%	0%	33.2%
	% Staff with excess annual leave > 2 years	3.52%	0%	6.47%
	% Staff with excess annual leave and insufficient plan to clear excess by the end of financial year	R/U	0%	R/U
	Number of Pre-employment Screenings (PES) cleared after the start date	0	0	1
	Sick leave hours taken as a percentage of total hours worked	3.6%	<=3.4%	3.5%
	% Voluntary turnover (annually)	15.94%	<=10%	15.33%
	% Voluntary turnover <1 year tenure	9.88%	<=6%	8.97%

**Amber** Variance from target not significant enough to report as non-compliant. This includes percentages/rates within 1% of target, or volumes within 1 value from target. Not applicable for Engaged Workforce KRA.

**R/U** Result unavailable

**(ESPI-1) % Services acknowledging 90% of FSA referrals in 15 calendar days or less**  
Result unavailable until after the 16th of the next month.

**% Very good and excellent ratings for overall inpatient experience**

**% Very good and excellent ratings for overall outpatient experience**

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

## Scorecard Commentary

There were two significant adverse events in January 2017. Both were falls with harm in Reablement Services and are currently being investigated.

Overall there has been a clear downward trend in actual falls in Reablement Services over 2015/16 and the ward staff are being congratulated for their achievements in creating a safer rehabilitation environment for our patients.

Point prevalence data on pressure injuries indicates a stable picture, and the 12 month rolling average continues within target. There is a daily focus on pressure injury management in all our wards.

We are compliant with ESPI 1 and ESPI 2. Our performance with FCT targets has improved significantly and we have achieved 100% of high suspicion of melanoma patients treated within the 62 day target this month.

We continue to work with services to support improvement in waiting times and are working towards a three month maximum waiting time within the Directorate. Our DNA rates continue to be monitored closely and there is a small reduction in DNA rates in January 2017. Our DNA action plan continues in all services. We remain committed to reducing these rates.

We only had ten patient experience reports in the month of January and are concerned to see our rate drop below target of 90% good or excellent. We are working on a range of strategies to improve the feedback we receive from our patients including hard copy surveys for patients in the ward to complete at the end of their admission.

The Directorate remains committed to minimising the number of patients in mixed gender rooms but were above target in January 2017. This was in part due to an increased short term use of acute observation units in Reablement Services which are routinely excluded from reports but cannot be when the use is only short term. In addition, additional demand in early January for Reablement beds required us to offer patients a bed in a mixed gender room. No patient was in a mixed gender room for more than 24 hours and all patients consented to be placed there rather than wait for admission to our service. We have seen a significant improvement in this metric in the last month and expect our normal standard of less than 2% use to be maintained. Plans are in progress to change the current way we support patients with behaviours of concern so that acute observation units become single sex.

Patient flow targets were not met in January 2017 however; this was due to the additional demand, which was greater than expected in early January 2017. Improved flow remains one of our goals and overall our trajectory is one of improved flow and we have met our targets in recent weeks. We continue to work to reduce LOS and minimise the number of patients who have an extended LOS which could be avoided through improved discharge planning with stakeholders and other providers.

Complaints are being actively managed within our Directorate and action plans to address any learning points have been created and are being monitored. There were five complaints received in the month of January.

The Directorate has achieved a significant reduction in excess leave in the last year and we continue to see a reduction in levels linked to the summer plan. Sick leave is monitored monthly and currently just above target and is being actively managed applying the Auckland DHB Wellness Guide. We have established the Directorate Wellness Group to support staff health. Turnover has increased and is being actively monitored including regrettable turnover levels by service. As a Directorate with a significant change agenda, some turnover is to be expected. We have also completed a plan with Recruitment Services to work more strategically on hard to fill posts and recruitment at all levels as we have some significant recruitment challenges in leadership roles and in some specific clinical posts at this time. It is positive to note most of our senior leadership positions are now filled and the leadership team is now almost complete.

## Financial Results

<b>STATEMENT OF FINANCIAL PERFORMANCE</b>						
<i>Adult Community and LTC</i>						
						Reporting Date <b>Jan-17</b>
(\$000s)	MONTH			YEAR TO DATE (7 months ending Jan-17)		
	Actual	Budget	Variance	Actual	Budget	Variance
<b>REVENUE</b>						
Government and Crown Agency	1,076	1,072	4 F	8,008	7,541	467 F
Funder to Provider Revenue	5,264	5,264	0 F	41,848	41,848	0 F
Other Income	9	28	(19) U	201	198	2 F
<b>Total Revenue</b>	<b>6,349</b>	<b>6,364</b>	<b>(15) U</b>	<b>50,057</b>	<b>49,587</b>	<b>469 F</b>
<b>EXPENDITURE</b>						
<b>Personnel</b>						
Personnel Costs	4,003	4,095	91 F	27,596	28,489	893 F
Outsourced Personnel	126	70	(57) U	840	488	(352) U
Outsourced Clinical Services	127	143	15 F	1,003	998	(5) U
Clinical Supplies	632	553	(79) U	4,801	4,544	(257) U
Infrastructure & Non-Clinical Supplies	116	116	(0) U	1,046	811	(235) U
<b>Total Expenditure</b>	<b>5,005</b>	<b>4,976</b>	<b>(29) U</b>	<b>35,286</b>	<b>35,329</b>	<b>44 F</b>
<b>Contribution</b>	<b>1,344</b>	<b>1,389</b>	<b>(44) U</b>	<b>14,771</b>	<b>14,258</b>	<b>513 F</b>
Allocations	335	388	54 F	2,839	3,068	229 F
<b>NET RESULT</b>	<b>1,010</b>	<b>1,000</b>	<b>9 F</b>	<b>11,932</b>	<b>11,190</b>	<b>742 F</b>
<b>Paid FTE</b>						
	MONTH (FTE)			YEAR TO DATE (FTE) (7 months ending Jan-17)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	69.2	73.3	4.1 F	68.7	73.3	4.6 F
Nursing	268.1	293.1	25.0 F	272.3	293.1	20.8 F
Allied Health	122.4	137.0	14.6 F	125.5	137.0	11.5 F
Support	0.0	0.0	0.0 F	0.0	0.0	0.0 F
Management/Administration	34.2	28.7	(5.5) U	36.2	28.7	(7.6) U
<b>Total excluding outsourced FTEs</b>	<b>493.9</b>	<b>532.0</b>	<b>38.1 F</b>	<b>502.8</b>	<b>532.0</b>	<b>29.2 F</b>
Total :Outsourced Services	14.6	4.2	(10.5) U	11.9	4.2	(7.7) U
<b>Total including outsourced FTEs</b>	<b>508.5</b>	<b>536.2</b>	<b>27.7 F</b>	<b>514.7</b>	<b>536.2</b>	<b>21.5 F</b>

## Comments on Major Financial Variances

The current month result for January is \$9k F, and the year to date result is \$742k F.

### Current Month

The significant drivers in the directorate's result are:

#### *Income:*

- ACC revenue \$62k U driven by lower volumes in Reablement Services;
- Contract revenue from new service level agreements: In-home Strength and Balance Falls Prevention Program, the Fracture Liaison Service, and Transgender Clinical Leadership – all partly offset by higher personnel costs.

#### *Expenditure:*

- Personnel costs, including outsourced, were \$50k F in January as an effect of the planned seasonal plan, and some continuing vacancies in Community Services. High annual leave taken as planned has resulted in average nursing costs per FTE being slightly favourable to budget. All vacancies are being managed and progress on recruitment is being made despite limited candidate selection pools for some positions. The vacancy situation is on the directorate's risk register.
- Clinical supplies were \$79k U in the month, due to high-cost blood product use required, plus the continuing pressure for continence and ostomy supplies.

### YTD result

Total net result YTD is \$742k F. Significant drivers of this are:

- Personal health contract revenue \$334k F predominantly reflecting the two new service level agreements;
- Personnel costs, including outsourced, \$536k F, due to the number of vacancies within Reablement and Community Services, for which recruitment is ongoing;
- Clinical supplies are \$257k U due to scheduled high-cost drug treatments, and the high volumes of patients requiring ostomy and continence supplies. Some of these supply cost pressures will be offset by an expected pharmacy rebate later in the year.

### Volumes

Price volume schedule (PVS) volumes are \$2,830k (6.8%) below base contract. The key driver of the under-delivery is the Auckland DHB population in Community Services. The directorate has implemented a number of major improvements in Community Service, including the accurate mapping of volumes and the measuring of activity on actuals (in previous years recorded at budget). This has resulted in a change in counting but not the underlying activity. The service has made progress in increasing volumes however Community Services remains at 80% of contract YTD.

The estimated inter-district flow (IDF) wash-up liability has reduced slightly in the month to \$96k. This is mainly in Ambulatory Services, which forecasts to achieve delivery overall by year end. The net under delivery of volumes is not recognised in the overall directorate result.

**Savings**

The directorate’s savings are favourable against target by \$54k YTD due to mitigating strategies, especially regarding additional revenue and other projects.

**Forecast**

The directorate is forecasting to achieve a surplus on budget by June 2017 largely due to the new unbudgeted service level agreements and other projects, which will have a positive impact on the bottom line.





## Surgical Directorate

Speaker: Arend Merrie, Director

### Service Overview

The Surgical Services Directorate is responsible for the provision of secondary and tertiary Surgical Services for the adult Auckland District Health Board population, but also provides national and regional services in several specialities.

The services in the Directorate are now structured into the following four portfolios:

- Orthopaedics, Urology
- General Surgery, Trauma, Transplant,
- Ophthalmology
- ORL, Neurosurgery, Oral Health

The Surgical Directorate is led by:

<b>Director</b>	Arend Merrie (From 1 March 2017)
<b>General Manager</b>	Duncan Bliss
<b>Nurse Director</b>	Anna MacGregor
<b>Director of Allied Health</b>	Kristine Nicol
<b>Director of Primary Care</b>	Kathy McDonald

Supported by Les Lohrentz (HR), and Jack Wolken (Finance)

### Directorate Priorities for 16/17

**In 2016/17 our Directorate will contribute to the delivery of the key Provider Arm work programmes. In addition to this we will also focus on the following Directorate priorities:**

1. Throughput of cases at the Greenlane Surgical Unit
2. Achieve all health targets including discharges and ESPI targets within financial constraints and efficiency expectations
3. Surgical OR list/Clinic templates need to be designed to accommodate the FCT demand
4. The standardisation of surgical pathways within Auckland DHB, across the region and nationally
5. Establish multidisciplinary pathways in all departments to optimise and streamline the patient journey

## Q3 Actions

### 1. Throughput of cases at the Greenlane Surgical Unit

Activity	Progress
Urology phase 1	Additional capacity allocated and cases moved to GSU from level 8
Urology phase 2	The stack system with 3D capability was approved by CAMP in December 2016. Once this arrived it will create greater flexibility for Urology operating at GSU.
Ophthalmology Ocular Plastics and increased Cataract capacity	Previously unallocated all day OR sessions are being utilised for additional Ocular Plastic sessions. This will continue through to the new financial year.

### 2. Achieve all health targets including discharges and ESPI targets within financial constraints and efficiency expectations

Activity	Progress
Manage discretionary spend	Each specialty has a 5% savings target built into their budget for delivery which is being performance managed through monthly service reviews.
Review of all activity being undertaken in non-Clinic/OR settings to ensure all activity is captured and funded	Review of Nursing MOC and activity underway including: <ul style="list-style-type: none"> <li>• Additional nursing activity not being captured, with potential revenue generation</li> <li>• Use of patient attenders for patients on the behaviour of concern pathway (BOC) requiring support – capturing data and ensuring we have up to date info of where these patients are.</li> </ul>
Weekly Service ESPI Reviews	From October there has been a weekly ESPI and PVS review at service level to track compliance to explore ways of increasing discharge volumes. Services are on track with their recovery plans with the exception of Orthopaedics which has dispensation from the Ministry until 1 July 2017.
End to End Stock Management	Just in time project has been initiated that reports to the surgical board. This is to reduce waste in OR's with only opening consumables when required and procedure for use if high cost disposable products. Margaret Wilsher is the executive sponsor for this project.

### 3. Surgical OR list/Clinic templates need to be designed to accommodate the FCT demand

Activity	Progress
Managing capacity and demand	FCT – Priority code is now visible on the WT05 report / waiting list. PAS team leaders now need to ensure that all bookers are trained to enter the field to show the FCT status of the patient. This will improve our reporting and scheduling of patients from a surgical perspective.

Waitlist management and SCRUM	This continues to be effective in the OR setting and is now being rolled out in surgical outpatients to ensure that clinic capacity matches the demand for FCT FSA slots. The Surgical Board also now monitor a 'watch list' of the least used OR sessions with a view to reallocate to services that will use them.
Preadmission project	Feedback from a number of Anaesthetists and Pre assessment Clinic Staff on what the guiding principles should be Develop matrix of procedures and patient ASA score to determine standard pre-admit requirements. Neurosurgery to explore benefit of pre-admit service at Auckland DHB avoiding patients having multiple visits. GSU Ophthalmology staff have been moved into Perioperative Services to ensure consistent approach to quality and safety throughout the ORs at Auckland DHB.

#### 4. The standardisation of surgical pathways within Auckland DHB, across the region and nationally

Activity	Progress
National Bowel Screening	Representatives from Surgery are working as part of a regional group to deliver the service specification for the National Bowel Screening programme
National Intestinal Failure Service	Meeting with the MoH Governance Board to review progress of NIFS to date. Successful Education Day held. Advances with the database and the national network. NIFS contract will be extended for a further 3 years from July 2017.

#### 5. Establish multidisciplinary pathways in all departments to optimise and streamline the patient journey

Increase ERAS with orthopaedic unit	Awaiting Orthopaedic productivity model agreement
Preadmission project	Pilot underway with Urology
>40 BMI pathway	Orthopaedics and Dietetic services are working together to manage the patients already on the waiting list. GP liaison working with GP forums to ensure that the new pathway is communicated and managed effectively to prevent inappropriate referrals. This pathway is now embedded and routinely reviewed to ensure inappropriate patients are not accepted into the service.
EQ-QD questionnaire	GP liaison to work with SMOs to evaluate the feasibility of implementing this process with GPs prior to referring a patient

## Measures

Measure		Current	Target	Previous Period
ESPI compliance	ESPI 2	1.15%	0.41%	0.67%
	ESPI 5	6.59%	0%	3.93%
	ESPI 8	99.85%	100%	99.79%
DNA rates for all ethnicities (%)		10.74%	9%	10.62%
Elective day of surgery admission rate (DOSA) %		79.61%	≥68%	75.79%
Day surgery rate (%)		70.43%	≥70%	58.48%
FCT delivery		87%	85%	

## Key achievements in the month

- Acute services maintained throughout industrial action with excellent cross service working to meet acute service needs.
- Successful appointment of Mr Arend Merrie as Director of Surgical Services
- Patient activity volumes achieved were 7.1% above contract, with inpatient activity 9.4% over delivered against contract. This is reflected in the favourable Funder to Provider revenue result of \$600k (including impact of industrial action)
- Continued reduction in Surgical Length of Stay (LOS) across Acute Surgery.
- 57% feedback across the services for the Auckland DHB Employee survey.
- Patient Experience feedback comments circulated to wards weekly.
- Active participation in Discharge Planning processes to reduce delayed discharges and in turn length of stay (LOS)
- Continued delivery of bed savings through daily flexing of the surgical bed base.
- Successful summer planning for elective surgical delivery in line with bed flexing, resulting in improved financial performance.
- Administration validation complete for Ophthalmology “follow up pending list” resulting in over 300 patients being removed from the waiting list and ensuring we have the most accurate data to clinically risk assess patients waiting beyond their intended wait time.

## Key issues and initiatives identified in coming months

- Weekly performance management of ESPI and Discharge targets at service level.
- Capacity planning for 17/18 PVS delivery for both elective and acute services.
- Establishing model of care to deliver increased Ophthalmology volumes at WDHB
- Written expression of interest for Auckland DHB to be considered to provide breast screening services when it goes out to tender.
- Continuation of preadmission project in Urology to be rolled out across other specialities.
- Working with Clinical Support Services to ensure that clinic letters are being produced and reaching patients in a timely fashion (via email or hard copy) to reduce the current increase in DNAs seen across the organisation.
- Orthopaedic external review to be commenced March 2017

# Scorecard

## Auckland DHB - Surgical Services HAC Scorecard for January 2017

5.11

	Measure	Actual	Target	Prev Period
Patient Safety	Medication Errors with major harm	0	0	0
	Number of falls with major harm	0	0	0
	Nosocomial pressure injury point prevalence (% of in-patients)	6.1%	<=6%	1.8%
	Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	3.3%	<=6%	4%
	Number of reported adverse events causing harm (SAC 1&2)	0	0	0
	Unviewed/unsigned Histology/Cytology results < 90 days	94	0	90
	Unviewed/unsigned Histology/Cytology results > 90 days	103	0	90
Better Quality Care	HT2 Elective discharges cumulative variance from target	0.94	>=1	0.92
	(ESPI-1) % Services acknowledging 90% of FSA referrals in 15 calendar days or less	R/U	100%	71.43%
	(ESPI-2) Patients waiting longer than 4 months for their FSA	1.15%	0%	0.67%
	(ESPI-5) Patients given a commitment to treatment but not treated within 4 months	6.59%	0%	3.93%
	(ESPI-8) Proportion of patients prioritised using nationally recognised processes or tools	99.85%	100%	99.79%
	% DNA rate for outpatient appointments - All Ethnicities	10.74%	<=9%	10.62%
	% DNA rate for outpatient appointments - Maori	20.37%	<=9%	21.35%
	% DNA rate for outpatient appointments - Pacific	18.93%	<=9%	20.13%
	Elective day of surgery admission (DOSA) rate	79.61%	>=68%	75.79%
	% Day Surgery Rate	70.43%	>=70%	58.48%
	Inhouse Elective WIES through theatre - per day	42.35	TBC	66.38
	Number of CBU Outliers - Adult	104	0	162
	% Patients cared for in a mixed gender room at midday - Adult	7.74%	TBC	9.81%
	% Very good and excellent ratings for overall inpatient experience	R/U	>=90%	85.3%
	% Very good and excellent ratings for overall outpatient experience	R/U	>=90%	84.6%
	Number of complaints received	16	No Target	8
	28 Day Readmission Rate - Total	R/U	<=10%	9.81%
	Average Length of Stay for WIES funded discharges (days) - Acute	2.67	TBC	3.02
	Average Length of Stay for WIES funded discharges (days) - Elective	1.11	TBC	1.31
	31/62 day target - % of non-surgical patients seen within the 62 day target	R/U	>=85%	92.71%
31/62 day target - % of surgical patients seen within the 62 day target	R/U	>=85%	83.78%	
62 day target - % of patients treated within the 62 day target	R/U	>=85%	87.92%	
Improved Health Status	% Hospitalised smokers offered advice and support to quit	96.95%	>=95%	97.73%
Engaged Workforce	Excess annual leave dollars (\$M)	\$1.24	0	\$1.33
	% Staff with excess annual leave > 1 year	30.51%	0%	31.1%
	% Staff with excess annual leave > 2 years	15.61%	0%	17.74%
	% Staff with excess annual leave and insufficient plan to clear excess by the end of financial year	R/U	0%	R/U
	Number of Pre-employment Screenings (PES) cleared after the start date	0	0	0
	Sick leave hours taken as a percentage of total hours worked	3.4%	<=3.4%	3.4%
	% Voluntary turnover (annually)	11.81%	<=10%	12.26%
	% Voluntary turnover <1 year tenure	6.74%	<=6%	7.61%

**Amber** Variance from target not significant enough to report as non-compliant. This includes percentages/rates within 1% of target, or volumes within 1 value from target. Not applicable for Engaged Workforce KRA.

**R/U** Result unavailable

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

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

% Very good and excellent ratings for overall inpatient experience

% Very good and excellent ratings for overall outpatient experience

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

**28 Day Readmission Rate - Total**

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

**31/62 day target - % of non-surgical patients seen within the 62 day target**

**31/62 day target - % of surgical patients seen within the 62 day target**

**62 day target - % of patients treated within the 62 day target**

Results unavailable from NRA until after the 20th day of the next month.

## Scorecard Commentary

- In January, the cumulative achievement across Surgery was 96% of the discharge target. The biggest area of over delivery against the plan is in General Surgery and Urology who have been utilising some of the lists released by Orthopaedics. There was also 3 days of industrial action in January resulting in over 200 OR hours of elective surgical time being lost. The net effect remains a shortfall against the target. The negative revenue impact of this is noted in the financial report.
- At the end of January the Adult ESPI 2 position was non-compliant for Auckland DHB at 1.15%. This worsened position was in part due to an increase of 16% FSA's in Orthopaedics without the increased capacity to deliver it. Also high annual leave and industrial action restricted services to increase capacity.
- The organisational position for ESPI 5 is reported as non-compliant for patients not receiving a date for surgery within 4 months at 6.59% (the target is <1.0%). This is predominantly due to the continuing Orthopaedic under-delivery of 157 cases by the end of January. This position was also impacted from the loss of over 200 OR hours across all surgical services through the RMO industrial action for 3 days.
- Ophthalmology Services increased weekend activity throughout January in an attempt to increase cataract volumes that will continue for the rest of the year. The service will also be outsourcing 290 cataracts between January and April 2017.
- There were 0 SAC 1 and SAC 2 events reported in the month of January.
- There were 0 medication errors reported for the month of January, with major harm. The Directorate continues to work towards undertaking audits on medication administration compliance.
- There were 0 falls reported for the month of January where patients came to major harm.
- There were 14 pressure injuries reported for January, categories for which are as follows:
  - 4 x Category 1 (Non-blanchable erythema) – 2 acquired on site, 2 noted on admission
  - 9 x Category 2 (Partial thickness skin loss) – 4 acquired on site, 5 noted on admission
  - 0 x Category 3 (Full thickness skin loss)
  - 1 x Category 4 (Full thickness tissue loss) – This was noted on admission.
- The DNA rate for appointments for all ethnicities in January is 10.74%. This has moved the Directorate back into red for this measure on the scorecard. There is continued work around patient focused booking to improve this in the future.
- The number of outliers dropped in January to 104. Where possible, teams have been working to align the capacity, cohorting and repatriating patients to reduce the outliers across the surgical bed base, to support the rest of the hospital and the patient flow.
- Smoking Cessation - Performance has improved in January to 96.95%. This is as a result of the on-going work undertaken by the Charge Nurses to ensure that the information is being captured correctly.

## Summary Net Result

<b>STATEMENT OF FINANCIAL PERFORMANCE</b>						
<i>Surgical Services</i>						Reporting Date <b>Jan-17</b>
(\$000s)	MONTH			YEAR TO DATE (7 months ending Jan-17)		
	Actual	Budget	Variance	Actual	Budget	Variance
<b>REVENUE</b>						
Government and Crown Agency	650	773	(123) U	5,335	5,411	(76) U
Funder to Provider Revenue	18,088	18,088	0 F	144,478	148,878	(4,400) U
Other Income	455	376	79 F	2,740	2,631	109 F
<b>Total Revenue</b>	<b>19,193</b>	<b>19,237</b>	<b>(44) U</b>	<b>152,552</b>	<b>156,920</b>	<b>(4,368) U</b>
<b>EXPENDITURE</b>						
Personnel Costs	7,757	7,661	(96) U	53,872	53,583	(289) U
Outsourced Personnel	269	265	(4) U	2,257	1,855	(402) U
Outsourced Clinical Services	48	581	533 F	1,233	3,694	2,461 F
Clinical Supplies	1,999	1,887	(112) U	16,519	15,512	(1,007) U
Infrastructure & Non-Clinical Supplies	136	120	(16) U	1,628	842	(786) U
<b>Total Expenditure</b>	<b>10,208</b>	<b>10,515</b>	<b>307 F</b>	<b>75,509</b>	<b>75,487</b>	<b>(23) U</b>
<b>Contribution</b>	<b>8,985</b>	<b>8,722</b>	<b>262 F</b>	<b>77,043</b>	<b>81,433</b>	<b>(4,390) U</b>
Allocations	2,037	2,160	123 F	16,291	17,030	740 F
<b>NET RESULT</b>	<b>6,947</b>	<b>6,562</b>	<b>385 F</b>	<b>60,752</b>	<b>64,403</b>	<b>(3,651) U</b>
<b>Paid FTE</b>						
	MONTH (FTE)			YEAR TO DATE (FTE) (7 months ending Jan-17)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical - SMO	94.9	104.5	9.6 F	98.0	104.5	6.4 F
Medical - MOSS/GP	2.4	2.6	0.2 F	2.0	2.6	0.7 F
Medical - JRMO	128.1	97.2	(30.8) U	109.6	97.2	(12.4) U
Nursing	470.7	460.8	(9.9) U	479.9	465.8	(14.1) U
Allied Health	39.0	37.4	(1.7) U	37.4	37.4	(0.0) U
Support	0.0	0.0	0.0 F	0.0	0.0	0.0 F
Management/Administration	69.6	70.4	0.9 F	69.3	71.3	1.9 F
Savings	0.0	-24.9	(24.9) U	0.0	-24.9	(24.9) U
<b>Total excluding outsourced FTEs</b>	<b>804.7</b>	<b>747.9</b>	<b>(56.8) U</b>	<b>796.3</b>	<b>753.8</b>	<b>(42.4) U</b>
Total :Outsourced Services	25.0	12.5	(12.5) U	19.0	12.5	(6.5) U
<b>Total including outsourced FTEs</b>	<b>829.7</b>	<b>760.4</b>	<b>(69.3) U</b>	<b>815.3</b>	<b>766.3</b>	<b>(48.9) U</b>

For the Month and YTD position commentaries please refer to the separate reports by

- Surgical excluding Orthopaedics
- Orthopaedics

Surgicals End of Year forecast is \$2.9M U and remains unchanged from the October month's year end forecast. This is based on additional Directorate revenue generation of \$2.8M plus a neutral Funder to Provider revenue position and direct savings management by services.

## Summary Net Result

STATEMENT OF FINANCIAL PERFORMANCE							Reporting Date
<i>Surgical excluding Orthopaedics</i>							Jan-17
(\$000s)	MONTH			YEAR TO DATE (7 months ending Jan-17)			
	Actual	Budget	Variance	Actual	Budget	Variance	
<b>REVENUE</b>							
Government and Crown Agency	545	562	(18) U	4,080	3,937	143 F	
Funder to Provider Revenue	14,780	14,180	600 F	116,192	116,492	(300) U	
Other Income	426	362	64 F	2,669	2,531	138 F	
<b>Total Revenue</b>	<b>15,751</b>	<b>15,104</b>	<b>646 F</b>	<b>122,942</b>	<b>122,961</b>	<b>(19) U</b>	
<b>EXPENDITURE</b>							
Personnel Costs	6,387	6,155	(233) U	44,185	43,078	(1,107) U	
Outsourced Personnel	269	265	(4) U	2,241	1,855	(386) U	
Outsourced Clinical Services	54	125	71 F	1,267	872	(394) U	
Clinical Supplies	1,176	1,185	9 F	9,703	9,653	(50) U	
Infrastructure & Non-Clinical Supplies	107	119	12 F	1,453	835	(618) U	
<b>Total Expenditure</b>	<b>7,993</b>	<b>7,848</b>	<b>(145) U</b>	<b>58,848</b>	<b>56,293</b>	<b>(2,555) U</b>	
<b>Contribution</b>	<b>7,758</b>	<b>7,256</b>	<b>502 F</b>	<b>64,094</b>	<b>66,668</b>	<b>(2,574) U</b>	
Allocations	1,673	1,803	129 F	13,612	14,241	629 F	
<b>NET RESULT</b>	<b>6,085</b>	<b>5,453</b>	<b>631 F</b>	<b>50,482</b>	<b>52,427</b>	<b>(1,945) U</b>	
<b>Paid FTE</b>							
	MONTH (FTE)			YEAR TO DATE (FTE) (7 months ending Jan-17)			
	Actual	Budget	Variance	Actual	Budget	Variance	
Medical - SMO	80.8	87.3	6.4 F	84.3	87.3	2.9 F	
Medical - MOSS/GP	0.3	1.2	0.9 F	0.3	1.2	0.9 F	
Medical - JRMO	95.2	76.0	(19.2) U	83.3	76.0	(7.3) U	
Nursing	374.6	356.5	(18.1) U	379.0	361.5	(17.5) U	
Allied Health	38.6	36.6	(2.1) U	37.1	36.6	(0.5) U	
Support	0.0	0.0	0.0 F	0.0	0.0	0.0 F	
Management/Administration	64.6	64.9	0.3 F	63.9	65.8	1.9 F	
Savings	0.0	-13.3	(13.3) U	0.0	-13.3	(13.3) U	
<b>Total excluding outsourced FTEs</b>	<b>654.2</b>	<b>609.1</b>	<b>(45.1) U</b>	<b>648.0</b>	<b>615.0</b>	<b>(33.0) U</b>	
Total :Outsourced Services	25.0	12.5	(12.5) U	18.6	12.5	(6.0) U	
<b>Total including outsourced FTEs</b>	<b>679.2</b>	<b>621.6</b>	<b>(57.6) U</b>	<b>666.5</b>	<b>627.5</b>	<b>(39.0) U</b>	

## Comments on major financial variances

### Month

Patient activity volumes achieved were 7.1% above contract, with inpatient activity 9.4% over delivered against contract and is reflected in the favourable Funder to Provider revenue result of \$600k. Reduced savings gains were made this month through personnel costs being impacted by the high volumes with the associated reduced ability to close beds and the impact of the JRMO strike. Allocations, being primarily internally charged Radiology, Labs and MRI charges have been trending down on a volume adjusted basis and despite the higher volumes against contract this month, are still favourable.



**YTD**

Total patient volumes are 101% of contract year to date despite the two JRMO strikes reducing capacity, with Neurosurgery are at 107% of contract to date and of those, inpatient acutes are 17% over delivered.

Service	YTD performance against contract	End of year forecast
General Surgery	101%	101%
Neurosurgery	107%	100%
Ophthalmology	99%	100%
Oral health	98%	100%
ORL	100%	100%
Transplants - Liver	118%	129%
Transplants - renal	96%	100%
Urology	100%	102%
Total	101%	102%

Surgical excluding Orthopaedics annual expenditure savings budget is \$4.9M and amounts to \$2.8M for the seven months YTD (\$2.1 M personnel and \$0.7M infrastructure) with \$1.1M achieved to date (\$1.0M personnel and \$0.1M infrastructure).

Personnel gains are being made primarily in

- ORL savings, of \$382k F primarily resulting from vacant positions.
- General Surgery, \$323k F due to lower medical costs, together with some vacant admin positions whose workload is currently met by temporary staff.
- Ophthalmology of \$396k F, due to lower medical costs through vacancies (although significant outsourcing is required to ensure patient volumes are met) and a reduced cost per FTE.

Outsourced personnel costs are unfavourable pending permanent recruitment to positions in some business units (Ophthalmology, Oral Health primarily).

Outsourced clinical services of \$394k U primarily relate to costs to date of additional cataract volumes being met through outsourcing to external providers, which were part of the additional PVS volumes of 400 that were proposed to be outsourced when the contract volumes were agreed.

Clinical supply costs are \$50k U in total with increasing Ophthalmology eye treatment pharmaceutical usage as more patients with macular degeneration require this drug, \$467k U, mitigated by lower Neurosurgery implant and consumable costs of \$358k F (despite Neurosurgery patient volumes being 7% over delivered).

Infrastructure costs reflect the savings budget of \$0.7M against which \$0.1M has been achieved to date.

Allocations, being primarily internally charged Radiology, Labs and MRI charges etc are \$629k or 4.4% of budget favourable despite the volumes overdelivery due to a reducing rate of spend that is 6.5% lower than last year (11.01 cents per \$ of PVS revenue YTD vs 11.78 cents per \$ average last year).

## Summary Net Result

STATEMENT OF FINANCIAL PERFORMANCE						
Orthopaedics						Reporting Date <b>Jan-17</b>
(\$000s)	MONTH			YEAR TO DATE (7 months ending Jan-17)		
	Actual	Budget	Variance	Actual	Budget	Variance
<b>REVENUE</b>						
Government and Crown Agency	105	211	(105) U	1,254	1,474	(219) U
Funder to Provider Revenue	3,308	3,908	(600) U	28,285	32,385	(4,100) U
Other Income	29	14	15 F	71	100	(29) U
<b>Total Revenue</b>	<b>3,442</b>	<b>4,133</b>	<b>(691) U</b>	<b>29,610</b>	<b>33,959</b>	<b>(4,349) U</b>
<b>EXPENDITURE</b>						
Personnel Costs	1,370	1,507	137 F	9,687	10,505	818 F
Outsourced Personnel	0	0	0 F	16	0	(16) U
Outsourced Clinical Services	(6)	457	462 F	(34)	2,822	2,856 F
Clinical Supplies	823	702	(121) U	6,816	5,859	(957) U
Infrastructure & Non-Clinical Supplies	29	1	(28) U	176	7	(168) U
<b>Total Expenditure</b>	<b>2,215</b>	<b>2,667</b>	<b>451 F</b>	<b>16,661</b>	<b>19,194</b>	<b>2,532 F</b>
<b>Contribution</b>	<b>1,227</b>	<b>1,466</b>	<b>(239) U</b>	<b>12,949</b>	<b>14,765</b>	<b>(1,816) U</b>
Allocations	364	357	(7) U	2,678	2,789	111 F
<b>NET RESULT</b>	<b>863</b>	<b>1,109</b>	<b>(246) U</b>	<b>10,271</b>	<b>11,976</b>	<b>(1,706) U</b>
<b>Paid FTE</b>						
	MONTH (FTE)			YEAR TO DATE (FTE) (7 months ending Jan-17)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical - SMO	14.1	17.2	3.1 F	13.7	17.2	3.5 F
Medical - MOSS/GP	2.1	1.4	(0.7) U	1.7	1.4	(0.3) U
Medical - JRMO	32.9	21.2	(11.7) U	26.3	21.2	(5.1) U
Nursing	96.1	104.3	8.2 F	100.9	104.3	3.4 F
Allied Health	0.4	0.8	0.4 F	0.3	0.8	0.5 F
Support	0.0	0.0	0.0 F	0.0	0.0	0.0 F
Management/Administration	4.9	5.5	0.6 F	5.4	5.5	0.1 F
Savings	0.0	-11.6	(11.6) U	0.0	-11.6	(11.6) U
<b>Total excluding outsourced FTEs</b>	<b>150.5</b>	<b>138.8</b>	<b>(11.7) U</b>	<b>148.3</b>	<b>138.8</b>	<b>(9.5) U</b>
Total :Outsourced Services	0.0	0.0	0.0 F	0.4	0.0	(0.4) U
<b>Total including outsourced FTEs</b>	<b>150.5</b>	<b>138.8</b>	<b>(11.7) U</b>	<b>148.7</b>	<b>138.8</b>	<b>(9.9) U</b>

## Comments on major financial variances

### Month and YTD

Funder Revenue is unfavourable this month and YTD reflecting the shortfall in meeting the inpatient volumes elective contract. Year on year the full year increase in contracted volumes over last year is 18.5% and \$9.2M.

ACC revenue is \$105k unfavourable for the month and \$219k YTD reflecting a mildly declining trend.

Personnel and outsourced clinical services costs are both favourable due to the lower elective volumes being achieved, while clinical supply costs are unfavourable reflecting the high risk implant savings target of \$250k per month and \$1.75M YTD, due to the ongoing pressures within the service.

## Cardiovascular Directorate

Speaker: Dr Mark Edwards, Director

5.12

### Service Overview

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

#### The Cardiovascular Team is led by

Director:	Dr Mark Edwards
Nurse Director:	Anna MacGregor
Allied Health Director:	Kristine Nicol
Primary Care Director:	Dr Jim Kriechbaum
General Manager:	Sam Titchener

### Directorate Priorities for 16/17

**In 2016/17 our Directorate will contribute to the delivery of the six Provider Arm work programmes. In addition to this we will also focus on the following Directorate priorities:**

1. Continue to develop Clinical Governance and quality frameworks supported by our Clinician Leadership model
2. Reconfigure service delivery for patient pathway(s)
3. Plan for future service delivery
4. Continued focus on communication and development of partnerships across our Directorate staff
5. Financial sustainability

## **Q3 Actions – 90 day plan**

### **1. Develop Clinical Governance and quality frameworks supported by our Clinician Leadership model**

Regular clinical leadership meetings are in place; engagement is ongoing in development of a Metric Dashboard encompassing clinical outcome measures for each service in conjunction with Business Intelligence over this quarter. We are continuing to develop our Clinical Governance arrangements by refining our Directorate leadership meetings and reporting from services.

The challenge remains for the service to submit risk adjusted data to the national Cardiac Surgery Registry in line with all other contributing DHBs. The service conducted a workshop in January to review options. The workshop was able to assist in decision making regarding the most appropriate sustainable solution to capture, record and report risk adjusted data with current technologies. An accurate cost analysis and final vendor selection is now required and a project team is in the process of being implemented.

### **2. Reconfigure service delivery for patient pathway(s)**

The draft document for the proposal to reconfigure the Nursing Model of Care in the cardiothoracic inpatient ward has been updated to support planned changes in the cardiothoracic patient pathway. Outcomes from the project to improve waiting times and equity of access will be part of the planned changes. The proposal is subject to review by relevant stakeholders in preparation for dissemination directorate wide.

Work has commenced reviewing the current nursing education model across the Cardiovascular Directorate. A draft change proposal outlining a new structure and function of the Nursing education role has been completed, and has been circulated to the directorate for feedback. This will strengthen and streamline the way in which we deliver nursing education across the Directorate.

### **3. Planning for future service delivery**

We have signalled a piece of work with Northland DHB to develop a shared plan for delivery of pacemaker clinics by local staff. Auckland DHB has provided some information to Northland DHB to inform their decision making, the long term plan will be to repatriate this service. Northland DHB have not provided any further update on this.

The draft report outlining recommendations for the Clinical perfusion review has been circulated and feedback received. The final report will be delivered to a Steering group comprising Chief Health Professions Officer and the Directors of the Cardiovascular and Child Health Directorates.

The Directorate is actively involved in assisting with development of a Solid Organ Transplant Board which will enhance advocacy for transplant services, ensure they are sustainable and enhance their governance.

Discussion took place at the Regional Cardiac network meeting regarding the impact of increasing demand for TAVI. A regional working group has had their first meeting to strengthen patient selection processes. This group will continue to report through the regional cardiac network.

The contract for the delivery of non-DHB patient services for patients from Tahiti has been secured. A meeting with CPS team in December provided an opportunity to formalise our ongoing working relationships and finalise contract negotiations.

Out of hours use of the Hybrid OR will be implemented in March 2017. The radiation committee have worked with the vendor to ensure implementation of a new application (Raysafe) for radiation safety monitoring and feedback has supported its implementation.

**4. Financial sustainability**

Please refer to the financial results section

**Measures**

Measures	Current	Target (end 16/17)
2. Adverse events: number of outstanding recommendations by due date	tba	<10
2. Adverse events: number of days from Reportable Events Brief-A submission to report ready for Adverse Events Review Committee (working days)	>100 days	<70 days
2. % of patients with email address submitted at admission	32%	85%
2. Inpatient experience very good or excellent	94.1%	>90%
3. Number of Service redesign projects timeframes off track	0	0
3. % P1 patients waiting outside priority wait times	2.63%	5%
4 Staff feedback from development and implementation of comms plan	NYC	Favourable
6. Directorate remains within budget (within 5% variance) and Savings plan projects favorable to budget	Off plan	On budget

**Key achievements in the month**

- Replacement/ refurbishment of angiography equipment room 1 Cardiac investigations unit completed on time and budget.
- Improvement of the P2 waiting times across the cardiothoracic surgery waitlist
- Successful contract negotiations for delivery of non-DHB patient services for patients from Tahiti
- Appointment of Service Clinical Director Vascular Surgery Service
- A successful RFP process has been completed for haemodynamic monitoring for the Adult, Paediatric cath labs and the SSH lab. Business case completed for presentation to the Capital Asset Management and Planning Committee in February.
- Commencement of process improvement project in Vascular Surgery Service to see improved scheduling practises
- Sustained reduction in the overall volume of cardiothoracic surgery waitlist patients
- Implemented CPS non-resident pricing increase from January 2017

## **Areas off track and remedial plans**

- The EP waitlist continues to grow with an increase in referrals and awareness of improved ways in which the service is able to manage heart rhythm issues for patients. We continue to ensure clinically appropriate scheduling and review of the longest waiting patients.
- YTD financial result shows we remain unfavourable on Non-Resident Tahiti revenue, despite a positive meeting in December 2016 to improve relationships. The service is meeting acceptable time frames for the Tahiti patients and we are expecting volumes to increase. We will continue to monitor this.
- The time frames for the implementation of the Haemodynamic monitoring are a risk to the project. As of 31 December the current system is unsupported, there is a project group in place to monitor this and clear timeline documentation has been completed.
- The elective discharge targets for cardiothoracic and vascular: the service has made some good progress on the recovery of the discharge targets and we will continue to monitor and manage this closely.

## **Key issues and initiatives identified in coming months**

- Monitoring progress against the savings plan and making budget in the context of our waitlist challenges.
- Managing the costs of clinical supplies against service delivery.
- Implementation of the new nursing education model.
- Managing the replacement process for the Haemodynamic monitoring system within the time frames
- Change proposal document to be released for Cardiothoracic pathway nursing structure
- Request for proposals for Perfusion Equipment Consumables and Services has gone out to market, this procurement process should generate financial benefits.
- Monitoring our elective discharge volumes against the recovery plan
- Review of pricing and products with regard to catheters and TAVIs in cardiology
- Reviewing our revenue/costs with regards to lead extractions

# Scorecard

## Auckland DHB - Cardiovascular Services HAC Scorecard for January 2017

5.12

	Measure	Actual	Target	Prev Period
Patient Safety	Central line associated bacteraemia rate per 1,000 central line days	0	<=1	0
	Medication Errors with major harm	0	0	0
	Number of falls with major harm	0	0	0
	Nosocomial pressure injury point prevalence (% of in-patients)	18.2%	<=6%	0%
	Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	4.4%	<=6%	3.7%
	Number of reported adverse events causing harm (SAC 1&2)	3	0	1
	Unviewed/unsigned Histology/Cytology results < 90 days	7	0	6
	Unviewed/unsigned Histology/Cytology results > 90 days	0	0	0
Better Quality Care	HT2 Elective discharges cumulative variance from target	0.97	>=1	0.85
	(ESPI-1) % Services acknowledging 90% of FSA referrals in 15 calendar days or less	R/U	100%	100%
	(ESPI-2) Patients waiting longer than 4 months for their FSA	5.4%	0%	0%
	(ESPI-5) Patients given a commitment to treatment but not treated within 4 months	0%	0%	0.28%
	% DNA rate for outpatient appointments - All Ethnicities	10.47%	TBC	10.65%
	% DNA rate for outpatient appointments - Maori	20.83%	TBC	23.53%
	% DNA rate for outpatient appointments - Pacific	24.43%	TBC	16.56%
	Elective day of surgery admission (DOSA) rate	14.49%	TBC	12.87%
	% Day Surgery Rate	12.24%	TBC	5.32%
	Inhouse Elective WIES through theatre - per day	21.94	TBC	32.31
	Number of CBU Outliers - Adult	57	0	65
	% Very good and excellent ratings for overall inpatient experience	R/U	>=90%	94.1%
	% Very good and excellent ratings for overall outpatient experience	R/U	>=90%	90.6%
	Number of complaints received	1	No Target	0
	28 Day Readmission Rate - Total	R/U	TBC	11.92%
	% Adjusted Session Theatre Utilisation	81.73%	>=85%	82.9%
	% Theatre Cancellations	7.79%	TBC	10.61%
	Average Length of Stay for WIES funded discharges (days) - Acute	4.34	No Target	5.25
	Average Length of Stay for WIES funded discharges (days) - Elective	2.58	No Target	3.39
	Cardiac bypass surgery waiting list	82	52-108	108
% Accepted referrals for elective coronary angiography treated within 3 months	100%	>=90%	100%	
Improved Health Status	% Hospitalised smokers offered advice and support to quit	98.41%	>=95%	97.75%
	Vascular surgical waitlist - longest waiting patient (days)	116	<=150	116
	Outpatient wait time for chest pain clinic patients (% compliant against 42 day target)	72%	>=70%	72.58%
Engaged Workforce	Excess annual leave dollars (\$M)	\$0.57	0	\$0.64
	% Staff with excess annual leave > 1 year	29.56%	0%	29.1%
	% Staff with excess annual leave > 2 years	13.04%	0%	14.85%
	% Staff with excess annual leave and insufficient plan to clear excess by the end of financial year	R/U	0%	R/U
	Number of Pre-employment Screenings (PES) cleared after the start date	0	0	0
	Sick leave hours taken as a percentage of total hours worked	4.1%	<=3.4%	4.2%
	% Voluntary turnover (annually)	13.33%	<=10%	13.26%
	% Voluntary turnover <1 year tenure	8.45%	<=6%	5.71%

**Amber**

Variance from target not significant enough to report as non-compliant. This includes percentages/rates within 1% of target, or volumes within 1 value from target. Not applicable for Engaged Workforce KRA.

**R/U**

Result unavailable

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

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

**% Very good and excellent ratings for overall inpatient experience**

**% Very good and excellent ratings for overall outpatient experience**

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

**28 Day Readmission Rate - Total**

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

## Scorecard Commentary

- In January there were no SAC 1 or 2 events reported for the Cardiovascular Directorate.
- There was one complaint relating to communication and information concerns. The patient has subsequently been met with and investigation commenced.
- There were three Grade 3 pressure injuries reported during January (occurring in August, December and January respectively). All three events are currently being reviewed. All three patients are noted to be high risk with very low perfusion.
- Medication errors and falls remain within previous trends with none resulting in harm.
- At the end of January the cardiac surgery eligible bypass waitlist was at 92, a decrease from 110. This was achieved through strong production and steady inflows.
- The service has also worked well towards its aim to reduce the maximum wait time for P2 patients to back under 80 days and this should be well achieved by the of February.
- The high acute demand continues to impact on Vascular elective surgery production, however the service is working well towards meeting the recovery plan put in place to achieve the Auckland DHB elective discharge numbers.
- The Vascular service is also undergoing some service improvement work to see positive changes to their scheduling practises to address the challenge of managing increasing acute volumes and the need to maintain elective throughput.
- At the end of January the cardiovascular service achieved the 4 month target for ESPI 5.
- The refurbishment of Cath Lab Room 1 was carried out in December and January and has impacted all cardiology elective waitlists. Some lists were carried in SSH and Hybrid to reduce the impact but the ability to decant was minimal due to complexity of availability with other services.
- Electrophysiology volumes have continued to rise due to higher demand and inflows.
- ESPI5 Cardiology Interventional waitlists remain compliant for January however the waitlist grew to the closure of Room 1. This is expected to reverse over in February.
- Sick leave hours taken are almost a full percentage above target despite the season
- Overall, as would be expected after the traditional summer holiday season, the number of employees with greater than 2 years accrued leave has decreased since December 2016, most particularly in the Cardiology area.
- Total leave liability for accrued leave of greater than 2 years total has increased by \$49k; Leave liability related to SMOs in this category increased by about \$30k since January 2016, despite the traditional summer holiday period.



## Financial Results

### STATEMENT OF FINANCIAL PERFORMANCE

Cardiovascular Services

Reporting Date **Jan-17**

(\$000s)

	MONTH			YEAR TO DATE (7 months ending Jan-17)		
	Actual	Budget	Variance	Actual	Budget	Variance
<b>REVENUE</b>						
Government and Crown Agency	(53)	116	(169) U	768	815	(48) U
Funder to Provider Revenue	9,427	9,127	300 F	75,729	75,729	0 F
Other Income	452	586	(134) U	3,570	4,102	(531) U
<b>Total Revenue</b>	<b>9,826</b>	<b>9,830</b>	<b>(4) U</b>	<b>80,067</b>	<b>80,646</b>	<b>(579) U</b>
<b>EXPENDITURE</b>						
<b>Personnel</b>						
Personnel Costs	5,545	5,419	(127) U	38,706	37,507	(1,199) U
Outsourced Personnel	37	48	11 F	300	336	35 F
Outsourced Clinical Services	(12)	57	69 F	396	399	3 F
Clinical Supplies	2,130	2,284	154 F	19,603	18,610	(993) U
Infrastructure & Non-Clinical Supplies	227	124	(103) U	1,075	867	(207) U
<b>Total Expenditure</b>	<b>7,928</b>	<b>7,932</b>	<b>4 F</b>	<b>60,079</b>	<b>57,718</b>	<b>(2,361) U</b>
<b>Contribution</b>	<b>1,898</b>	<b>1,898</b>	<b>1 F</b>	<b>19,988</b>	<b>22,928</b>	<b>(2,940) U</b>
Allocations	824	888	64 F	7,297	7,039	(258) U
<b>NET RESULT</b>	<b>1,074</b>	<b>1,010</b>	<b>64 F</b>	<b>12,691</b>	<b>15,889</b>	<b>(3,198) U</b>
<b>Paid FTE</b>						
	MONTH (FTE)			YEAR TO DATE (FTE) (7 months ending Jan-17)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	98.4	94.5	(3.9) U	95.2	94.5	(0.7) U
Nursing	322.7	329.0	6.3 F	319.9	329.0	9.1 F
Allied Health	67.0	66.6	(0.4) U	66.6	66.6	(0.0) U
Support	2.7	2.7	0.0 F	2.7	2.7	(0.0) U
Management/Administration	34.4	23.0	(11.5) U	31.7	23.0	(8.7) U
<b>Total excluding outsourced FTEs</b>	<b>525.2</b>	<b>515.7</b>	<b>(9.6) U</b>	<b>516.1</b>	<b>515.7</b>	<b>(0.4) U</b>
Total Outsourced Services	0.6	1.7	1.2 F	1.9	1.7	(0.1) U
<b>Total including outsourced FTEs</b>	<b>525.8</b>	<b>517.4</b>	<b>(8.4) U</b>	<b>517.9</b>	<b>517.4</b>	<b>(0.5) U</b>

### Comments on Major Financial Variances

The year to date result is \$3,198k U – driven by lower other income, higher than budgeted SMO costs and higher clinical supply costs.

Total year to date inpatient WIES are 6% higher than 2015 16 and 101% of budget. Overall year to date WIES activity now has cardiology at 102% of budget, cardio-thoracic at 101% and vascular surgery 102%. The overall total WIES position is 101% of year to date budget.

YTD FTE employed/contracted is 0.4 FTE unfavourable.

#### 1. Revenue

Overall revenue variance year to date is \$579k U due to:

- \$971k unfavourable on non-resident Tahiti patients, with a volume lower than budget (32% U). Volumes have been lower than budget all year. We met with CPS (the Tahiti patient insurer) in December, a new contract was signed and the meeting was very positive. We expect the performance on CPS revenue to improve although we are unlikely to reach the original budget level. Other non-resident revenue is ahead of budget and we expect total non-resident revenue, including CPS, to be close to budget for the year.
- \$67k unfavourable on ACC revenue. An organisational project is underway to review processes. An ACC invoicing catch-up has significantly improved the revenue position recently and we expect the YTD result to return to a favourable position in February.

## 2. Expenditure

Total Expenditure (including allocations) year to date is \$2,619k U, this is mainly due to:

- Personnel and outsourced personnel costs being net \$1,164k U; primarily due to higher SMO costs (\$1,392k U) due to higher levels of insourcing than budgeted, and savings targets.
- Outsourced Clinical services is \$3k F year to date and will remain below budget over the coming months.
- Clinical Supplies is \$993k U. There are three key drivers:
  - Cardiology clinical supply costs at \$549k U are impacted by both volume (102%) and cost drivers. In Cardiac Electrophysiology (EP), catheters are 120% of budget (\$266k U). A review of usage and price was undertaken in early September. While we have subsequently seen a significant reduction in average catheter cost/case, patient volume growth continues to trend upwards. Costs fell significantly in January (\$180k F) due to the impact of one Cath Lab being closed for refurbishment.
  - At the same time that catheter costs have pulled back we have seen very large increases in EP implant costs (\$528k U year to date) – with September, October and November being particularly high months. We are investigating this further – but the spend was much lower in December and January.
  - Cardio-thoracic costs \$446k unfavourable. Blood costs (\$195k U) due to five high cost patients. Catheter costs (\$122k U) are double last year's cost. We are investigating this further – but note that the spend was significantly less in December and January.
  - Equipment depreciation is \$70k U however much of this cost relates to 15 /16.
- In spite of the above drivers, average year to date cost per WIES equivalent (excluding depreciation) is slightly lower than last year actuals, and is now at budget levels, as volume growth has increased faster than expenditure.
- Infrastructure and Non-Clinical Supplies is \$207k U. Internal Allocations are \$258k U mainly due to Vascular Radiology charges.

We are actively working on implementation of Directorate savings initiatives, and participating in provider level projects. Other key actions to date include:

- Completing CPS non-resident pricing increase from Jan 2017 – now actioned
- Looking to introduce a different surgical skill mix into cardiac surgery for the next calendar year
- Review of pricing and products with regard to catheters and TAVIs in cardiology
- Review of other consumable costs through supplier negotiation
- Ongoing vacancy management

## Commercial and Non Clinical Support Directorate

Speaker: Clare Thompson, General Manager

### Service Overview

The Commercial and Non Clinical Support Directorate is responsible for service delivery and management of Cleaning and Waste arrangement, Security, Food and Nutrition, Linen and Laundry, Car-parking, Motor Vehicle Fleet, Property leases, Retail, Dock management, Commercial Contracts, Clinical Education Centre, Sustainability, Volunteers, Mailroom, Health Alliance Procurement and Supply Chain relationship (including NZ Health Partnerships Ltd, Pharmac and Ministry of Business Innovation and Employment).

The Directorate has undergone a review of its services which has resulted in four core service groups and with a single point of accountability for each function;

1. Commercial Services Business Improvement
2. Commercial Contracts Management
3. Operations – Non Clinical Support
4. Procurement and Supply Chain

**The leadership team of Commercial and Non Clinical Support Directorate is led by:**

- General Manager
- Operations Manager Business Improvement
- Operations Manager Non Clinical Support
- Operations Manager Procurement and Supply Chain Manager
- Finance Manager
- Commercial Contracts Manager

### Directorate Priorities for 16/17

The Commercial and Non Clinical Support Directorate developed a work programme that would align with the delivery of both the Provider Arm and Corporate Services key priorities including regional and national initiatives. This programme of work included;

1. Enhancing the Directorate's 'readiness to serve' framework to align with the Provider Arm and Corporate Services planning protocols.
2. Developing an enhanced leadership model for single point of accountability for key service teams to improve quality of stakeholder engagement and decision making.
3. Provision of values training to align with enhanced patient safety and better quality care.
4. Improving culture and team engagement to develop the workforce to improve performance and deliver on agreed plans.
5. Engagement in integrated service planning and monitoring of service delivery against key performance targets.
6. Development of systems at local, regional or national level as enablers for improved accountability and transparency within all services.
7. Identification of commercial revenue generation and other value for money opportunities.
8. Development of a sustainability framework.

## Key Actions – 16/17

The following actions are currently being progressed to ensure delivery of Strategic Initiatives for Commercial and Non Clinical Support.

Service Group	Deliverable/Action	Q3	Q4	17/18
Contracts	Contracts Database		√	
Contracts	Contracts Management framework		√	
Contracts	Transforming Food Service Delivery	√	√	
Business Improvement	Motor Vehicle – Service Review	√	√	√
Business Improvement	Motor Vehicle Fleet Strategy	√	√	√
Business Improvement	Sustainability Strategy		√	
Business Improvement	Sustainable Transport		√	√
Operations NCS	Security Access Control and CCTV	√	√	√
Operations NCS	Security-for-Safety work programme	√	√	√
Operations NCS	Security Strategy	√	√	√
Operations NCS	Waste Transformation Project	√	√	√
Procurement and Supply Chain	healthAlliance/Procurement Framework	√	√	√
Procurement and Supply Chain	Supply Chain Framework	√	√	
Procurement and Supply Chain	Auckland Regional Supply Chain Review	√	√	
Procurement and Supply Chain	Gap analysis for National Oracle system	√	√	

## Key achievements in the month

### Cleaning Services

- Combined average audit score for January 2017 is 91% for Auckland Hospital (92%) and Greenlane Clinical Centre (92%). Although February data is not yet available the 12-month average combined score is consistently at 92%.
- Increased cleaning protocols have been put in place in Starship Ward 26B due to a confirmed Norovirus patient.
- The use of Deprox machines (decontamination) is also on-going. Deprox machine cleaning for contaminated areas was conducted 27 times in January compared to 50 times in December.
- Cleaning-related slips and trips continue to be low to zero. There were no cleaning-related slips and trips reported in January.
- Workplace Literacy Course will commence at ACH and GCC in late February.
- NZQA Level 3 Certification - 59 staff have currently completed the course, with 2 pending. Graduation is expected early March.
- Leadership Training - Course and venue locations confirmed for February 2017.

## Scorecard

### Auckland DHB - Support Services HAC Scorecard for January 2017

	Measure	Actual	Target	Prev Period
Engaged Workforce	Excess annual leave dollars (\$M)	\$0.02	0	\$0.02
	% Staff with excess annual leave > 1 year	36.28%	0%	38.7%
	% Staff with excess annual leave > 2 years	7.08%	0%	7.41%
	% Staff with excess annual leave and insufficient plan to clear excess by the end of financial year	R/U	0%	R/U
	Number of Pre-employment Screenings (PES) cleared after the start date	0	0	0
	Sick leave hours taken as a percentage of total hours worked	5.7%	<=3.4%	5.9%
	% Voluntary turnover (annually)	14.94%	<=10%	14.51%
	% Voluntary turnover <1 year tenure	21.88%	<=6%	32.26%

R/U Result unavailable

### Compliments

- Cleaning staff continue to maintain high standards with 6 written compliments received in January.
- Customer Experience Portal - Cleaning standards continue to be rated highly, with an 8.5 cleanliness/hygiene rating in January. February data is not yet available. Feedback examples for the month include:

Rating	Comment	Location of Discharge
10	The shower and toilet in my ward was spotless	Ward 78
10	Very clean - all staff used the hand sanitiser and/or wore gloves	Ward 25A/B
9	Great very clean	Ward 31

### Staff Residences

- Residence occupancy for month of January was 70% (Level 3 83%, Level 5 69%, Level 6 69% and Level 7 59%). The increase in booking enquiries is expected to raise the occupancy levels after February.
- The House Rules (Terms and Conditions) is being finalised to reflect updated agreements. The final approved document will be circulated to residents in February/March.
- The plan is to implement H&S 6-monthly audits for Staff Residences to be conducted alongside audits for Cleaning and Waste Services.
- A review of fire evacuation processes and posters at the Staff Residence is planned to ensure these align with the organisation-wide processes.

### Security for Safety Programme

- All work-streams are progressing well with key milestones achieved including; obtaining approval for emergency response policy, protocols for rapid lock-down in SSH building, approval of the security access plan framework, approval of access plans for AED and CED, installation of CCTV cameras, upgrading door card readers, access control and systems upgrades.

## Supply Chain and Procurement

### Supply Chain Review

- The first 90-day work programme of the Auckland Metro Supply Chain review has been completed. The second 90-day plan is now underway. Northland DHB has been included in the planning to develop similar protocols and alignment for key actions and to identify quick wins.
- Some key actions from this work programme includes;
  - The development of a system-wide procurement and supply chain database for Auckland DHB and Counties Manukau DHB. The database will help determine procurement forecasts and supply activity planning.
  - A mathematical model for Metro regional supply chain review. This is being trialled at Auckland DHB who will assist Northland DHB in adopting this model.
- The 8 streams of work under the 90-day plan are set out below:

Stream A	<ul style="list-style-type: none"> <li>• Strategic, risk, maturity matrix, frameworks and policies including an inventory management policy for the region.</li> </ul>
Stream B	<ul style="list-style-type: none"> <li>• People – establish Responsibilities, Accountabilities, Supportive, Consulted, Informed (RASCI) across all 4 entities, appropriate staffing levels and training framework.</li> </ul>
Stream C	<ul style="list-style-type: none"> <li>• Reduced intervention and effort with simplified Procure-to-pay process.</li> <li>• The recommendations from the initial round of workshops were signed off on 24 November by the Supply Chain Operation Group (SCOG).</li> <li>• The second round of workshops to determine priorities for next 90 days commenced in January 2017.</li> </ul>
Stream D	<ul style="list-style-type: none"> <li>• Information and data integrity held on Oracle – data quality relating to product and services held on Oracle is poor.</li> <li>• DHBs and healthAlliance to work towards the data requirements for the National Oracle System (NOS) project. Clinical personnel have been included in the teams.</li> </ul>
Stream E	<ul style="list-style-type: none"> <li>• Document the physical flows at each hospital in the Auckland Metro to better meet the needs of customers and improve efficiency of the region’s distribution network.</li> <li>• This also supports the renegotiation of the Onelink contract.</li> </ul>
Stream F	<ul style="list-style-type: none"> <li>• Better represent Customer needs. The teams have been developing a regional customer matrix-model to agree on service priorities and resourcing in consultation with each DHB’s service management.</li> <li>• The expectation is this work-stream will align with healthAlliance resources and budget for its supply chain service.</li> <li>• The recommendation on the model-matrix was presented to the SCOG 24 November. The work re-commenced after Christmas to allow the DHBs to test the matrix-model and that it performed as expected.</li> </ul>

### Inventory Management Category Reviews

The team has commenced category reviews in selected services. A specialist inventory management contractor has been appointed to develop an Inventory Management Framework together with a methodology to reduce days of inventory (day’s stock on hand) that would release investment without impacting service. Key areas being targeted are the highest spend and contracted/non contracted. Although the focus is on reducing the levels of inventory investment, the team will also identify potential process improvements. Key findings will be made available to the Auckland Metro DHBs and incorporated into the above Metro Supply Chain review programme.

### **MBIE Significant Suppliers and Capability Index Implementation**

Work has commenced on establishing a DHB significant suppliers list for MBIE and Treasury annual reporting requirements. CDHB and Auckland DHB the first DHBs to implement this process and are working together. A regional workshop jointly run by NZHPL and MBIE was held at Auckland DHB end of February. A MBIE intern commenced early February.

### **Pandemic stock**

Two regional Technical Advisory Groups (TAG) have commenced to:

1. Identify the list of items required during a pandemic outbreak, and
2. Implement a procurement and supply chain framework to support the clinical requirements.

Onelink, healthAlliance and St Johns have been invited to join the Group. The aim is to minimise the participant's exposure to large amounts of slow moving items while ensuring the stock is available as required.

### **Docks and Supplier management**

- The implementation of an on-line tool to ensure H&S compliance is cross-functional including; Security, OSH, Supply Chain and clinical staff. The initial priority is for non-clinical and commercial services suppliers followed by clinical suppliers.
- Project on decommissioned/obsolete and surplus items/assets is on-going. The recent refurbishment of departments has resulted in excess furniture stored in Building 21.

### **Security – Operations**

- There was a spate of stolen vehicles and break-ins in mid-January in Car-park B. These declined significantly following additional security patrols centred in/around the area.
- Bike thefts have also declined sharply as a result of the newly secured Bike Park areas.
- Code Orange requests: A total of 86 Code Orange responses were attended in January compared to 111 in December. Data for February is not yet available. The 12-month average is trending at 76 per month.
- Patient Security Watches: There were 111 requests for the month of January compared to 126 in December. Data for February is not yet available. The 12-month average is trending at 153 per month.

### **Security – Parking**

- Non-compliant parking during nights and weekends continues to be a challenge with a focus on the ambulance bays, cars on yellow lines, disabled car-parks, LabPlus parking area with enforced parking restrictions at both sites.
- A zero tolerance approach to parking in the drop-off area has eased parking issues on Level 4.

### **Waste Services and Sustainability**

- To ensure the health and safety, education on Sharps Waste include posters in sluice rooms to instruct staff on how to lock the bins. Further education sessions have been planned for 2017.
- A mandatory e-learning module on waste awareness/ segregation for all new Auckland DHB staff is being explored.
- A General Waste audit is planned for April 2017 in participation with IPC.
- A waste awareness campaign is being developed in partnership with the waste provider. The intention is to use pop-up stalls and interactive information sessions to improve staff awareness on waste recycling.
- Clinical services are adopting a more proactive approach to waste management, waste recycling and sustainability in general. A new collection of clinical plastic and glass bottle bins has been implemented in Level 4 CVICU. General Surgery, Neurology, Renal.

- Training for cleaning staff will also be underway as part of this waste awareness campaign. The training is to provide guidance on waste handling and removal.

### **Property Leases**

- The lease for the Lab Services located in Carbine Road, Mt Wellington has been extended to September 2018 (as per the agreement). Discussions are underway to secure this property until 2020.
- St Luke's Community Mental Health lease expires in October 2017 with a right of renewal for 3 years. No suitable building has been located and the service has requested the lease is extended with an early termination clause (6 months' notice). Awaiting a response from landlord. This proposal will enable the service to continue looking for alternative premises and relocate within 6 months.
- Manaaki House, 15 Pleasant View Road, Panmure, site lease expires in March 2018. Discussions are underway with the landlord to renew with options to refurbish the property (paint, carpet etc).
- The following rent reviews or lease extensions are underway or completed in February 2017:
  - Ronald MacDonald House (RMH) – Lease renewal sent to RMH for signing.
  - Sexual Health Services- Lease renewal for 418 Glenfield Rd underway.
  - Lab Services – Lease renewal for 46 Taharoto Ave Takapuna.

### **Property Other**

- Community Mental Health Services are reviewing other MHS leased properties.
- A health and safety report was prepared by Ronald MacDonald House. This report is being reviewed to assess the impact on Auckland DHB.
- The lift at the Sexual Health Clinic in Henderson has broken down again and has become an on-going concern. We are awaiting advice from the landlord. Early indications are that the lift may take a few weeks to repair.
- JLL has completed a property inspection and health and safety report for off-site leased premises. The report has been reviewed, but further clarification on the findings is being sought from JLL in order to determine any remedial work that may be required.
- Awaiting a response from HealthAlliance on current areas occupied at Auckland DHB to negotiate a new rent. HA has requested nil rent charge which may need to be referred to the CFO.
- Awaiting information for the Blood Bank Extension – Lease will need to be varied.

### **Leased Retail Outlet**

- Foodco trading as Jamaica Blue (replacing Muffin Break) opened at GCC site on 7 February 2017. Feedback so far has been positive.
- Planet Espresso Level 5 Refurbishment is on track. The new Planet Espresso is expected to open in early March 2017.
- Negotiations with the Florists to provide a florist cart /station in the area currently occupied by Planet Espresso are on-going.
- The Bookshop licence has not been renewed. The last trading day for the bookshop will be 31 March 2017 (to be confirmed). Auckland DHB is looking at other providers and the option of opening a "Pop-Up" bookshop for 6 months. The post box service is to be managed by Auckland DHB during the transition period.



- Park Road - Auckland Barbers have exercised their right of renewal for a further term of 4 years commencing 1 May 2017.

#### **Parking and Shuttle Services**

- The Pavlovich Shuttle contract expires in April 2017. healthAlliance have negotiated the renewal of the shuttle bus contract for a further two years which is the final period for the right of renewal.
- A usage survey of Carpark A is planned for April 2017 in an effort to identify and discourage non Auckland DHB related use of the carparks.

#### **Contract Management**

##### **Linen**

- Monitoring of linen imprest levels has been completed and new dockets are to be introduced for a number of RC's and this will help rationalise supply and utilisation rates.
- Supply rate for January 2017: General Linen 95%, Disposable 100% and Sterile 98%. The current agreement for Sterile should be 100% but was 98% due to an increased order from CSSD during the Christmas period. Taylors intend to work closely with CSSD to decrease the order during holiday periods. February's data is not available at time of writing.
- Auckland Region DHBs have approved a plain blue fabric (without print) as the universal patient gowns. The Kiwiana pattern will now become obsolete. CMDHB and WDHB have commenced implementation of the universal patient gown with Auckland DHB to follow shortly. With the agreement from all the DHBs on the blue gown (no pattern), the change on this product line is underway, dates are yet to be confirmed.

#### **Food and Nutrition Services**

- Reinstatement of hot belt for Starship Hospital with formal Corrective Action Plan and weekly updates is on-going.
- The trial of Steamplicity in Older Peoples Health (Rangitoto Ward) has been extended. A business case is being prepared to fully implement Steamplicity for this service on a permanent basis.
- A review of standing orders for perishable ward supplies has been conducted, with most wards reducing their orders. This has also resulted in minimal food waste. Estimated savings of \$180k per annum. Any future changes to the standing order are to be reviewed and agreed by Commercial Services.
- Tupu Ora is reviewing the business proposal provided by Compass Group to supply and service their site.
- Boost trial completed and implemented for onsite non-Steamplicity wards. The aim is to increase the temperature of the meals on the wards without drying out or decreasing the quality. Latest audit results were positive.
- Meals on Wheels (MOW) menu has commenced with positive feedback from patients and clients.
- Waste audits have continued with marked improvement. Food contamination has been reduced in recycling waste, with no issues raised regarding contamination from waste service provider.
- Weekly food service audits have also commenced with both the DHB and Compass Group involved in this process. Some improvement has been made for example the uniform, managing fridge stock. There has also been an increase in positive feedback by Compass.
- Complaints and corrective actions continue to be managed by Commercial Services in conjunction with Compass Group.

### Hygiene and Pest Control Services

- Pest Control is running smoothly with no notable issues. We are currently working on the customer services aspect of this service as well as their on-line reporting system.
- Initial Hygiene site audit will take place within the next month. Initial Hygiene is considering purchasing weight scales to record waste data volumes removed from ACH as part of the sustainability programme – awaiting update.

### Print Services

- Commercial Services has engaged with Konica Minolta to improve the process and controls for ordering of additional equipment. An online request form has been developed for new equipment coming through the Contracts Team, with checks and balances to ensure the most effective and efficient solution is identified and implemented.
- Konica Minolta has recently activated automatic ordering for Auckland DHB networked desktop printers on CPC contracts (where there is no charge to Auckland DHB for the consumable supply). Konica Minolta has also completed a major review of all printer location/addresses in our system to help couriers with the printer locations.
- As with Sentinel (the system used to automatically ship toner for our MFDs), the key operator for each printer will receive an email notification when toner is shipped. This should reduce the order request process and reduce multiple toner units being shipped per order. Drum orders are excluded from the automation and still need to be requested manually and fitted by a KM tech.

### Uniforms – Fashion Uniforms

- The new uniform roll-out commenced from 23 January and will be conducted in 3 separate stages to accommodate all nursing staff.
- An online booking system went live from mid-January for fitting appointments. This is operating efficiently and Charge Nurses have been nominated to make the bookings on behalf of their staff. Fittings will end at GCC in the week of the 20 March with uniforms arriving in mid-August.
- Nurse uniforms will no longer be supplied by Taylors as from August 2017. The uniform room will be handed over to Fashion Uniforms at the end of August, in time for BAU to commence.
- Received positive feedback around the facilities, fitting staff and the new nurse uniforms.

### Key issues and initiatives identified in coming months

Area	Timeframe
Cleaning Services <ul style="list-style-type: none"><li>• Staff development and training programme</li><li>• Implement staff PDRs</li><li>• Cleaning staff recruitment</li></ul>	On-going Ongoing Ongoing
Sustainability – Waste Reduction Programme	Jun 17
Security for Safety Programme	Jun 17
Security CCTV and Access Control upgrade	Jun 17
Motor Vehicle Fleet Strategy	Dec 17
HealthAlliance Regional Supply Chain Review	Jun 17
Oracle V12 Upgrade	Ongoing
Oracle V12 Upgrade - data Integrity audits and recovery of moneys due	Ongoing
DHB/HealthAlliance review of OneLink contract	Jun 17
Taylor's Linen Contract – sterile linen expiry extension	March 17
Mail Services – Investigation of Mail House Service	On-going

<b>Area</b>	<b>Timeframe</b>
Sustainable Transport Programme	Jul 17

## Financial Results

5.13

<b>STATEMENT OF FINANCIAL PERFORMANCE</b>						
<i>Non-Clinical Support Services</i>						
						Reporting Date <b>Jan-17</b>
(\$000s)	MONTH			YEAR TO DATE (7 months ending Jan-17)		
	Actual	Budget	Variance	Actual	Budget	Variance
<b>REVENUE</b>						
Government and Crown Agency	0	0	0 F	0	0	0 F
Funder to Provider Revenue	23	23	0 F	162	162	0 F
Other Income	801	847	(45) U	6,129	5,926	203 F
<b>Total Revenue</b>	<b>824</b>	<b>870</b>	<b>(45) U</b>	<b>6,290</b>	<b>6,087</b>	<b>203 F</b>
<b>EXPENDITURE</b>						
<b>Personnel</b>						
Personnel Costs	890	1,036	146 F	5,947	7,002	1,055 F
Outsourced Personnel	93	0	(93) U	989	0	(989) U
Outsourced Clinical Services	0	0	0 F	0	0	0 F
Clinical Supplies	6	21	15 F	78	142	64 F
Infrastructure & Non-Clinical Supplies	2,191	2,410	219 F	17,423	16,865	(558) U
<b>Total Expenditure</b>	<b>3,181</b>	<b>3,467</b>	<b>287 F</b>	<b>24,436</b>	<b>24,009</b>	<b>(427) U</b>
<b>Contribution</b>	<b>(2,356)</b>	<b>(2,598)</b>	<b>242 F</b>	<b>(18,146)</b>	<b>(17,922)</b>	<b>(224) U</b>
Allocations	(970)	(1,027)	(56) U	(7,318)	(7,122)	195 F
<b>NET RESULT</b>	<b>(1,386)</b>	<b>(1,571)</b>	<b>185 F</b>	<b>(10,828)</b>	<b>(10,799)</b>	<b>(29) U</b>
<b>Paid FTE</b>						
	MONTH (FTE)			YEAR TO DATE (FTE) (7 months ending Jan-17)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	0.0	0.0	0.0 F	0.0	0.0	0.0 F
Nursing	0.2	0.2	0.0 F	0.2	0.2	0.0 F
Allied Health	0.2	0.0	(0.2) U	0.1	0.0	(0.1) U
Support	184.1	224.5	40.4 F	183.6	224.5	40.9 F
Management/Administration	24.4	26.9	2.5 F	26.4	26.9	0.6 F
<b>Total excluding outsourced FTEs</b>	<b>208.8</b>	<b>251.6</b>	<b>42.7 F</b>	<b>210.3</b>	<b>251.6</b>	<b>41.3 F</b>
Total :Outsourced Services	31.4	0.0	(31.4) U	40.3	0.0	(40.3) U
<b>Total including outsourced FTEs</b>	<b>240.3</b>	<b>251.6</b>	<b>11.3 F</b>	<b>250.5</b>	<b>251.6</b>	<b>1.1 F</b>

### Comments on major financial variances – Non- Clinical Support Services

YTD result is \$29K U. This is made up of offsetting variances as follows;

1. Revenue was above budget due to the sale of kitchen assets \$134K. Cafeteria revenue of \$68K was received some of which related to last year.
2. Personnel costs are \$1,055K F due to vacancies. The majority of these are in the cleaning service and offset by outsourced personnel costs.
3. Infrastructure and Non–Clinical Supplies were \$558K U. This is mainly driven by food costs being higher than budget. Some of these are one off costs.



# Provider Arm Financial and Operational Performance Report

## Consolidated Statement of Financial Performance - January 2017

5.14

Provider \$000s	Month (Jan-17)			YTD (7 months ending Jan-17)		
	Actual	Budget	Variance	Actual	Budget	Variance
<b><u>Income</u></b>						
Government and Crown Agency sourced	7,159	7,952	(793) U	53,726	56,564	(2,838) U
Non-Government & Crown Agency Sourced	6,167	7,032	(865) U	46,615	49,014	(2,399) U
Inter-DHB & Internal Revenue	1,072	1,230	(158) U	7,887	9,109	(1,222) U
Internal Allocation DHB Provider	103,191	102,082	1,109 F	716,374	714,572	1,802 F
	<b>117,590</b>	<b>118,296</b>	<b>(707) U</b>	<b>824,602</b>	<b>829,259</b>	<b>(4,657) U</b>
<b><u>Expenditure</u></b>						
Personnel	73,821	73,396	(424) U	511,851	512,685	834 F
Outsourced Personnel	1,628	1,068	(560) U	13,814	7,549	(6,265) U
Outsourced Clinical Services	1,325	2,137	813 F	13,130	14,637	1,507 F
Outsourced Other	4,358	4,271	(86) U	30,312	29,898	(414) U
Clinical Supplies	18,238	17,713	(525) U	148,252	143,794	(4,459) U
Infrastructure and Non-Clinical Supplies	14,451	15,372	921 F	109,947	108,647	(1,300) U
Internal Allocations	531	531	0 F	3,720	3,720	1 F
<b>Total Expenditure</b>	<b>114,352</b>	<b>114,490</b>	<b>138 F</b>	<b>831,026</b>	<b>820,930</b>	<b>(10,096) U</b>
<b>Net Surplus / (Deficit)</b>	<b>3,238</b>	<b>3,807</b>	<b>(568) U</b>	<b>(6,425)</b>	<b>8,328</b>	<b>(14,753) U</b>

## Consolidated Statement of Financial Performance – January 2017

### Performance Summary by Directorate

By Directorate \$000s	Month (Jan-17)			YTD (7 months ending Jan-17)		
	Actual	Budget	Variance	Actual	Budget	Variance
Adult Medical Services	411	1,214	(803) U	9,950	11,311	(1,361) U
Adult Community and LTC	1,010	1,000	9 F	11,932	11,190	742 F
Surgical Services	6,947	6,562	385 F	60,752	64,403	(3,651) U
Women's Health and Genetics	1,568	1,754	(186) U	18,356	19,235	(879) U
Child Health	3,872	3,947	(75) U	38,814	42,846	(4,032) U
Cardiac Services	1,074	1,010	64 F	12,691	15,889	(3,198) U
Clinical Support Services	(3,088)	(2,838)	(250) U	(14,338)	(12,808)	(1,530) U
Non-Clinical Support Services	(1,386)	(1,571)	185 F	(10,828)	(10,799)	(29) U
Perioperative Services	(10,826)	(10,682)	(144) U	(79,459)	(77,551)	(1,908) U
Cancer & Blood Services	1,164	1,186	(22) U	10,635	11,628	(993) U
Operational - Other	5,508	5,159	349 F	34,634	36,783	(2,149) U
Mental Health and Addictions	284	253	31 F	2,254	1,303	951 F
Ancillary Services	(3,301)	(3,200)	(101) U	(101,818)	(105,180)	3,362 F
<b>Net Surplus / (Deficit)</b>	<b>3,238</b>	<b>3,795</b>	<b>(557) U</b>	<b>(6,425)</b>	<b>8,250</b>	<b>(14,675) U</b>

### Consolidated Statement of Personnel by Professional Group – January 2017

Employee Group \$000s	Month (Jan-17)			YTD (7 months ending Jan-17)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical Personnel	27,853	26,662	(1,191) U	195,335	191,417	(3,918) U
Nursing Personnel	25,689	25,634	(55) U	170,823	170,828	5 F
Allied Health Personnel	11,564	11,610	46 F	82,012	83,669	1,657 F
Support Personnel	1,664	1,769	105 F	10,911	11,632	721 F
Management/ Admin Personnel	7,051	7,721	670 F	52,771	55,139	2,369 F
<b>Total (before Outsourced Personnel)</b>	<b>73,821</b>	<b>73,396</b>	<b>(424) U</b>	<b>511,851</b>	<b>512,685</b>	<b>834 F</b>
Outsourced Medical	715	744	29 F	5,779	5,253	(526) U
Outsourced Nursing	247	45	(202) U	2,100	316	(1,784) U
Outsourced Allied Health	75	80	5 F	528	565	36 F
Outsourced Support	119	6	(113) U	950	40	(910) U
Outsourced Management/Admin	473	194	(279) U	4,457	1,376	(3,081) U
<b>Total Outsourced Personnel</b>	<b>1,628</b>	<b>1,068</b>	<b>(560) U</b>	<b>13,814</b>	<b>7,549</b>	<b>(6,265) U</b>
<b>Total Personnel</b>	<b>75,449</b>	<b>74,464</b>	<b>(984) U</b>	<b>525,665</b>	<b>520,234</b>	<b>(5,431) U</b>

### Consolidated Statement of FTE by Professional Group – January 2017

FTE by Employee Group	Month (Jan-17)			YTD (7 months ending Jan-17)		
	Actual FTE	Budget FTE	Variance	Actual FTE	Budget FTE	Variance
Medical Personnel	1,428	1,331	(97) U	1,376	1,333	(44) U
Nursing Personnel	3,496	3,384	(113) U	3,547	3,420	(127) U
Allied Health Personnel	1,851	1,846	(5) U	1,832	1,853	21 F
Support Personnel	383	417	34 F	385	419	34 F
Management/ Admin Personnel	1,223	1,293	70 F	1,228	1,283	55 F
<b>Total (before Outsourced Personnel)</b>	<b>8,382</b>	<b>8,270</b>	<b>(111) U</b>	<b>8,369</b>	<b>8,308</b>	<b>(62) U</b>
Outsourced Medical	31	28	(3) U	27	28	0 F
Outsourced Nursing	28	6	(22) U	12	6	(6) U
Outsourced Allied Health	12	4	(9) U	9	4	(5) U
Outsourced Support	33	0	(33) U	37	0	(37) U
Outsourced Management/Admin	86	25	(61) U	103	26	(77) U
<b>Total Outsourced Personnel</b>	<b>191</b>	<b>62</b>	<b>(128) U</b>	<b>188</b>	<b>63</b>	<b>(125) U</b>
<b>Total Personnel</b>	<b>8,572</b>	<b>8,333</b>	<b>(240) U</b>	<b>8,557</b>	<b>8,371</b>	<b>(186) U</b>

### Consolidated Statement of FTE by Directorate – January 2017

Employee FTE by Directorate Group (including Outsourced FTE)	Month (Jan-17)			YTD (7 months ending Jan-17)		
	Actual FTE	Budget FTE	Variance	Actual FTE	Budget FTE	Variance
Adult Medical Services	874	841	(34) U	861	836	(25) U
Adult Community and LTC	509	536	28 F	515	536	22 F
Surgical Services	830	760	(69) U	815	766	(49) U
Women's Health & Genetics	376	379	3 F	383	379	(4) U
Child Health	1,127	1,118	(8) U	1,134	1,114	(19) U
Cardiac Services	526	517	(8) U	518	517	(1) U
Clinical Support Services	1,396	1,404	8 F	1,401	1,408	7 F
Non-Clinical Support Services	240	252	11 F	251	252	1 F
Perioperative Services	819	857	38 F	826	857	31 F
Cancer & Blood Services	324	328	4 F	324	327	3 F
Operational - Others	0	(212)	(212) U	0	(178)	(178) U
Mental Health & Addictions	786	761	(25) U	748	758	10 F
Ancillary Services	766	767	1 F	782	781	(1) U
<b>Total Personnel</b>	<b>8,572</b>	<b>8,309</b>	<b>(264) U</b>	<b>8,557</b>	<b>8,354</b>	<b>(204) U</b>

## Month Result

The Provider Arm result for the month is \$0.6M unfavourable. This result is revenue driven, reflecting lower revenue for non-core activity. Expenditure is close to budget for the month.

Overall base volumes are 100.9% of the seasonally phased contract - this equates to \$0.7M above contract for the month.

Total revenue for the month is \$0.7M (0.6%) unfavourable, with the key variances as follows:

- Funder to Provider base contract revenue \$1.1M favourable reflecting Funder washup to Cancer & Blood Services for additional costs of PCT (cancer) drugs incurred year to date (primarily in the last three months).
- Non Resident income \$0.3M unfavourable – this revenue varies from month to month, with year to date remaining close to budget.
- Laboratory external revenue \$0.3M unfavourable, reflecting lower volumes over the January period, although revenue is expected to increase again in February.
- Haemophilia funding \$0.4M unfavourable for low blood product usage, bottom line neutral as offset by reduced expenditure.
- Financial Income \$0.3M unfavourable driven by term deposit rates lower than budget assumptions.

Total expenditure is \$0.1M (0.1%) favourable, with the key variances as follows:

- Personnel/Outsourced Personnel costs are \$1.0M (1.3%) unfavourable. Total FTE at 8,572 remain consistent with the trend throughout this financial year, but are 240 (2.9%) above budget due to FTE savings targets incorporated into the budget. The total cost variance is less unfavourable than the total FTE variance due to lower cost per FTE (reflecting initiatives to reduce overtime and other premium payments).
- Outsourced Clinical Services \$0.8M (62.0%) favourable, primarily reflecting no Orthopaedic elective surgery outsourcing, which is offset by an unfavourable revenue position for Orthopaedics.
- Clinical Supplies \$0.5M (3.0%) unfavourable, due entirely to very high costs of chemotherapy PCT drugs, particularly Herceptin – these costs are reimbursed by Funders via washup (ADHB and IDF), so it is bottom line neutral to the Provider.
- Infrastructure and Non Clinical Supplies \$0.9M (6.0%) favourable, primarily due to lower laundry, facilities, and transport costs associated with lower activity for January.

## Year to Date Result

The Provider Arm result for the year to date is \$14.8M unfavourable. This result reflects a combination of revenue below budget due to base volumes under contract and unfavourable expenditure due primarily to savings targets not fully achieved.

Overall volumes are reported at 99.2% of base contract - this equates to \$5.2M below contract (which is incorporated into the result in the estimated washup liability).

Total revenue for the year to date is \$4.7M (0.6%) unfavourable, with the key variances as follows.

- Favourable variances:
  - Funder to Provider additional revenue outside of price volume schedule contract \$6.1M favourable.



- Research Income \$1.9M favourable, offset by equivalent expenditure and bottom line neutral.
- ACC revenue \$1.0M favourable – primarily due to one off revenue for new contracts and high value revenue for a small number of very high cost patients.
- Unfavourable variances:
  - Funder to Provider base contract revenue \$5.7M unfavourable for estimated washup liability for base elective and IDF volumes.
  - Donations \$1.9M unfavourable – revenue fluctuates from month to month, depending on timing of key projects, with the full year budget still expected to be achieved.
  - MOH Public Health Funding \$1.2M unfavourable, in line with services delivered – this revenue is expected to be closer to budget by year end.
  - Haemophilia funding \$1.7M unfavourable for low blood product usage, bottom line neutral as offset by reduced expenditure.
  - Financial Income \$1.4M unfavourable driven by term deposit rates lower than budgeted rates.
  - Inter DHB revenue \$1.2M unfavourable – primarily reflecting budgeted targets for additional IDF funding not yet achieved.

Total expenditure is \$10.1M (1.2%) unfavourable, with the key variances as follows:

- Personnel/Outsourced Personnel costs \$5.4M (1.0%) unfavourable reflecting total FTE 240 (2.9%) above budget due to FTE savings targets incorporated into the budget, partially offset by lower cost per FTE (reflecting reductions in overtime and other premium payments).
- Clinical Supplies \$4.5M (3.1%) unfavourable, comprising the following key variances:
  - Haemophilia blood products \$1.5M favourable due to low product usage year to date (highly variable), but offset by reduced income.
  - PCT (cancer) drugs \$1.8M unfavourable due to increased volumes of Herceptin and melanoma drugs combined with unbudgeted new high cost drug Pertuzumab (note partially offset by additional revenue of \$1.1M year to date, will be subject to full washup at year end and be bottom line neutral in Provider Arm).
  - Cardiovascular \$1.0M unfavourable reflecting volume growth over the same period last year for both Cardiology and Cardiothoracic combined with a small number of patients with very high blood costs.
  - One off costs for loss on disposal of assets \$0.4M.
  - Savings targets for procurement and logistics not yet achieved \$2.1M unfavourable
- Outsourced Clinical Services \$1.5M (10.3%) favourable, reflecting no Orthopaedic elective surgery outsourcing for year to date (\$2.9M favourable but this is offset by an unfavourable Orthopaedics elective revenue position), and this is offset by costs of additional outsourcing in Ophthalmology to address waitlist, and for MRIs to meet MOH targets.
- Infrastructure & Non Clinical Supplies \$1.3M (1.2%) unfavourable primarily reflecting unfavourable facilities costs due to additional health and safety related expenditure.

## FTE

Total FTE (including outsourced) for January month were 8,572 which is 240 FTE above budget. Total FTE remain consistent with the trend throughout the year (averaging 8,577 per month from July), with the unfavourable variance for the month reflecting FTE targets incorporated into the budget – this is partially offset by lower cost per FTE (reflecting reductions in overtime and other premium payments).

## 2016/17 Savings Programme

Significant steps have been taken to reduce costs at Auckland DHB over the past four years, underpinned by a comprehensive savings programme. Living within our means is core to sustaining our services and for 2016/17 our savings programme will continue with a Provider target of \$37.35M and the key priority being to deliver services in a cost efficient and productive manner.

### Key Strategies

For 2016/17, the \$37.35M savings have been targeted within one of three key strategies – Managing cost growth, Purchasing/Productivity Improvement and Service Reconfiguration.

**Table 1: Provider 16/17 Savings Target (\$000's)**

Strategy	Revenue	Personnel	Clinical Supp.	Infra-structure	Total
Managing Cost Growth	2,000	19,098	4,573	0	26,263
Purchasing/Productivity	1,425	3,091	1,271	1,300	7,287
Service Reconfiguration	580	3,220			3,800
<b>Grand Total</b>	<b>\$4,005</b>	<b>\$25,409</b>	<b>\$5,844</b>	<b>\$1,300</b>	<b>\$37,350</b>

### Year to Date Result – 7 months to January 2017

For the 7 months to January, the Provider arm reported \$10.1M savings against the budget of \$21.8M, resulting in an unfavourable variance of \$11.7M U. The year to date unfavourable result continues to be affected by timing - although initiatives are being implemented, savings are not yet being achieved. In addition, the initiatives cover a range of directorates/services and the approach taken to implement the same initiatives will vary in timing in achieving the savings.

The year to date savings of \$10.1M are from personnel/FTE/vacancy management, bed closures, ACC Levy, Laboratory/Radiology efficiencies and supply chain. The total savings of \$10.1M includes unbudgeted savings (offsets) of \$3.6M.

**Table 2: Savings Update – 7 months to January 17 (\$000's)**

Strategic Initiative	MOH Category	16-17 Target	YTD Act	YTD Bud	YTD Var.
Managing Cost Growth	Revenue	2,000	236	1,167	-931
	Personnel	19,098	6,675	11,140	-4,465
	Outsourced Services	0	253	0	253
	Clinical Supplies	4,573	968	2,668	-1,700
	Infrastructure	592	338	345	-7
<b>Managing Cost Growth Total</b>		<b>\$26,263</b>	<b>\$8,469</b>	<b>\$15,320</b>	<b>-\$6,851</b>
Purchasing/Productivity Improvement	Revenue	1,425	0	831	-831
	Personnel	3,091	547	1,803	-1,256
	Outsourced Services	1,300	257	758	-501
	Clinical Supplies	1,271	351	741	-390
	Infrastructure	200	15	117	-102
<b>Purchasing/Productivity Improvement Total</b>		<b>\$7,287</b>	<b>\$1,170</b>	<b>\$4,251</b>	<b>-\$3,080</b>
Service reconfiguration	Revenue	580	0	338	-338
	Personnel	3,220	482	1,878	-1,396
<b>Service reconfiguration Total</b>		<b>\$3,800</b>	<b>\$482</b>	<b>\$2,217</b>	<b>-\$1,735</b>
<b>Grand Total</b>		<b>\$37,350</b>	<b>\$10,121</b>	<b>\$21,787</b>	<b>-\$11,666</b>

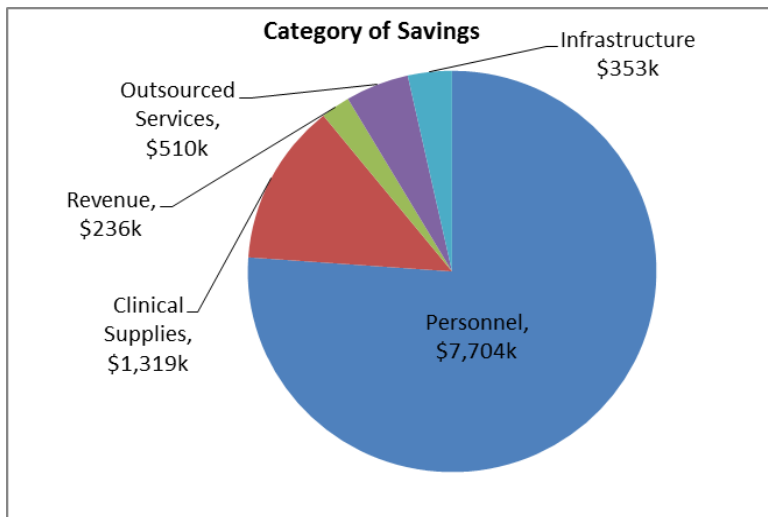
**Offsets**

The \$3.6M offsets are from Personnel (\$2.3M), Clinical Supplies (\$855k), Revenue (\$236k) and Outsourced Services (\$253k).

**Category of Savings**

Personnel-related initiatives continue to be the major source of savings at \$7.7M (77%), followed by Clinical Supplies \$1.3M (13%); Outsourced Services \$510k (5%); Infrastructure \$353k (3%) and Revenue \$236k (2%)

**Table 3: Category of savings**



**Key Points by Programme**

The 16/17 savings programme for the Provider arm covers 15 key work-streams and although some have no reported savings, the overall programme is being progressed to address the funding gaps. Some directorates have reported unbudgeted savings (\$3.6M) to help offset other unfavourable initiatives but this has not been sufficient to reduce the year to date unfavourable position. A programme summary and commentary is set out below.

**1. Address funding shortfalls 16/17 Target \$1,750k – Unfavourable variance \$1,021k U**

The programme initiatives relate to tertiary services review of methodologies in relation to charging for multidisciplinary meetings for IDF patients (not currently charged), national and regional work to cover the increased costs of clot retrieval consumables and cover investment costs in personnel, and additional IDF funding for Ophthalmology.

The services involved in this programme are Surgical, Women’s and Clinical Support. No savings are reported to date but work is progressing on all streams with additional revenue expected in by year end.

**2. Using the Hospital Wisely 16/17 Target \$3,250k – Unfavourable variance \$1,527k U**

This programme relates to productivity improvements and rationalisation of beds in line with seasonal occupancy and reduced length of stay. Savings of \$369k are reported to date against target of \$1,896k, resulting in an unfavourable variance of \$1,527k U. This programme is led by Community and LTC (\$203k savings) and Surgical Services (\$166k savings) and covers service reconfiguration of pre/post and early discharge planning pathways to enable the closure of beds. Considerable work has been undertaken by the Get on Track project and savings are expected through additional bed rationalisation.

**3. Contract Management 16/17 Target \$550k – YTD Unfavourable variance \$4k U**

Year to date savings of \$317k have been reported against a year to date target of \$321k, resulting in a minor unfavourable variance of \$4k U. This is a Non Clinical Services programme and the savings are attributed to reducing linen costs through standardised bed making. Opportunities for fleet management savings are being progressed.

**4. Sustainability 16/17 Target \$200k – YTD Unfavourable variance \$102k U**

This is a Non Clinical Services programme and relates to the sustainability initiatives from waste reduction savings and cleaning resources. Increased recycling has diverted waste to landfill and resulted in savings of \$15k from waste minimisation initiatives.

**5. Corporate Services 16/17 Target \$2,290k – YTD Unfavourable variance \$552k U**

Year to date savings of \$784k have been reported by Corporate Services mainly from personnel/ vacancy management. The programme also covers insurance cost savings.

**6. Directorate Savings 16/17 Target \$5,059k – YTD Unfavourable variance \$1,340k U**

This programme involves a number of opportunities to achieve business as usual savings within each Directorate including reduction in management infrastructure, personnel/vacancy management. Year to date savings of \$1,610k have been reported against a target of \$2,951k resulting in an unfavourable variance of \$1,340k U. The savings is attributed to ACC Levy/Vodafone (\$817k), business as usual personnel (\$517k) and Directorate management infrastructure (\$276k).

**7. Junior Doctors 16/17 Target \$335k – YTD Unfavourable variance \$195k U**

This is an organisation-wide programme which covers review of rosters, management of timing/cover for the RMO training programme, additional payments and RMO meal costs. No savings have been reported to date.

**8. Outpatients Redesign 16/17 Target \$895k – YTD Unfavourable variance \$409k U**

This programme covers out-patient clinical services (excluding Mental Health and Perioperative) to ensure robust processes are in place and all outputs are captured and coded, including ward reviews and virtual advice clinics. Due to the number of directorates involved in this programme of work, there are some timing factors. Savings of \$113k are reported to date from Surgical Service skill mix review.

**9. Pay and reward strategy 16/17 Target \$500k - YTD Unfavourable variance \$292k U**

The pay and reward strategy covers all clinical services and involves the audit of current systems and processes for compliance with MECAs and policies. Although no savings reported against this programme, this workstream is underway.

**10. Procurement and logistics 16/17 Target \$4,500k - YTD Unfavourable variance \$2,271k U**

This programme relates to Pharmaco pricing and rebates, rationalisation of surgical implants and tunnel programme to improve efficiencies in stock management, reduce waste and cost across the organisation. There are a number of work-streams underway expected to deliver savings, but mostly in the latter part of the year. Savings of \$354k have been reported against the year to date target of \$2,625k resulting in an unfavourable variance of \$2,271k U.

**11. Commercial Opportunities 16/17 Target \$950k - YTD Unfavourable variance \$554k U**

The commercial opportunities are mainly from generation of additional revenue from services such as genetic testing, fertility services, review of business model for Tahitian cardiac patients and retail pharmacy pricing. No savings have been reported to date but work-streams are now underway.

**12. Regional collaboration 16/17 Target \$580k – YTD Unfavourable variance \$338k U**

This is an Adult Medical programme involving endoscopy services for Waitemata DHB patients. Although no savings have been reported, this is due to the timing of the implementation of this initiative. This work has commenced in February 2017 and the savings will be achieved by 30 June.

**13. Regional Infrastructure 16/17 Target \$130K - YTD Unfavourable variance \$76k U**

This is an initiative to reduce regional infrastructure costs. No savings have been reported to date.

**14. Service Model/Standardisation 16/17 Target \$5,190k - YTD Unfavourable variance \$2,114k U**

This programme includes reduction in clinical variation within Ophthalmology, re-design model of service for Interpreter services, Laboratory/Radiology redesign, diagnostic testing and blood transfusion. Savings of \$917k are reported to date against target of \$3,028k resulting in an unfavourable variance of \$2,114k U. The year to date savings have been driven by Clinical Support Laboratory/Radiology Redesign/ Diagnostic testing/Interpreters (\$717k), Surgical and Women's blood transfusion (\$51k) and Surgical LOS (\$146k).

**15. Personnel Initiatives 16/17 Target \$11,171k – YTD unfavourable variance \$872k U**

Savings of \$5,645k (including offsets) have been reported to date against target of \$6,516k, resulting in an unfavourable variance of \$872k U. This is organisation wide focus on personnel costs and the savings are reported by; Adult Medical (\$1,067k) Adult Community (\$752k), Surgical (\$450k), Child Health (\$655k), Cardiovascular (\$524k), Clinical Support (\$990k), Non Clinical Support (\$481k), Perioperative (\$59k), Cancer & Blood (\$227k) and Mental Health (\$455k). Unbudgeted savings (offsets) of \$3,607k are mainly from personnel (\$2,263k, 63%), clinical supplies (\$855k, 24%), outsourced services (\$253k, 7%) and revenue (\$236k, 6%).

**Table 3:** Summary of Savings by Programme/by Directorate – 7 Months to January 2017 (\$000's)

Programme	January 2017 YTD Variance by Directorate														16-17 Target Savings	7 months - January YTD		
	Med	C & LTC	Surgical	Women	Child	Cardio	ClinSupp	Non ClinSupp	Periop	C&B	MH	Corp	Provider Wide	YTD Var		Act	Bud	Var.
Address Funding Shortfalls			-584	-29			-408							-1,021	1,750	-1	1,021	-1,021
Using the Hospital Wisely	-146	-235	-417		-583	-146								-1,527	3,250	369	1,896	-1,527
Contract Management								-4						-4	550	317	321	-4
Sustainability								-102						-102	200	15	117	-102
Corporate Services												-552		-552	2,290	784	1,336	-552
Directorate Savings	-182	-43	61	-263	-89	-133	-103	-4	-146	-324	-75	-38		-1,340	5,059	1,611	2,951	-1,340
Junior Doctors	-13	-4	-17	-5	-15	-7	-4	-117	-7	-4	-4			-195	335	0	195	-195
Outpatients redesign	-36	-25	-106	-16	-82	-18				-126				-409	895	113	522	-409
Pay and Reward Strategy	-34	-14	-38	-12	-48	-23	-44		-44	-13	-23			-292	500	0	292	-292
Procurement / Logistics	-330	-126	-1,748	-58	-111				198	-95				-2,271	4,500	354	2,625	-2,271
Commercial Opportunities			-88	-146		-88	-117					-117		-554	950	0	554	-554
Regional Collaboration	-338													-338	580	0	338	-338
Regional Infrastructure												-76		-76	130	0	76	-76
Service Model/Standardisation	-10	-5	-274	-27	-9	-105	-1,086		-583	-15				-2,114	5,190	914	3,028	-2,114
Personnel initiatives	619	496	28	-171	92	227	390	427	-353	66	101	64	-2,858	-872	11,171	5,645	6,516	-872
<b>Provider Total</b>	<b>-\$471</b>	<b>\$45</b>	<b>-\$3,182</b>	<b>-\$728</b>	<b>-\$845</b>	<b>-\$292</b>	<b>-\$1,371</b>	<b>\$201</b>	<b>-\$935</b>	<b>-\$510</b>	<b>-\$0</b>	<b>-\$719</b>	<b>-\$2,858</b>	<b>-\$11,666</b>	<b>\$37,350</b>	<b>\$10,121</b>	<b>\$21,787</b>	<b>-\$11,666</b>

## Volume Performance

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

5.14

Directorate	Service	January 2017				YTD (7 months ending Jan-17)			
		\$000s				\$000s			
		Cont	Act	Var	Prog %	Cont	Act	Var	Prog %
Adult Community & LTC	Ambulatory Services	772	736	(36)	95.4%	6,888	6,560	(327)	95.2%
	Community Services	1,725	1,385	(340)	80.3%	14,548	11,565	(2,983)	79.5%
	Diabetes	379	415	37	109.7%	3,206	3,239	33	101.0%
	Palliative Care	39	39	0	100.0%	273	273	0	100.0%
	Reablement Services	2,007	1,837	(171)	91.5%	14,036	14,158	122	100.9%
	Sexual Health	342	420	78	122.8%	2,897	3,222	325	111.2%
<b>Adult Community &amp; LTC Total</b>		<b>5,264</b>	<b>4,833</b>	<b>(431)</b>	<b>91.8%</b>	<b>41,848</b>	<b>39,018</b>	<b>(2,830)</b>	<b>93.2%</b>
Adult Medical Services	AED, APU, DCCM, Air Ambulance	2,100	2,226	127	106.0%	14,390	15,035	646	104.5%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	10,279	9,604	(675)	93.4%	77,642	75,748	(1,894)	97.6%
<b>Adult Medical Services Total</b>		<b>12,379</b>	<b>11,831</b>	<b>(548)</b>	<b>95.6%</b>	<b>92,031</b>	<b>90,783</b>	<b>(1,248)</b>	<b>98.6%</b>
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	6,322	6,669	348	105.5%	57,129	57,375	247	100.4%
	N Surg, Oral, ORL, Transpl, Uro	7,173	7,785	612	108.5%	61,754	62,478	724	101.2%
	Orthopaedics Adult	3,297	3,421	124	103.8%	30,646	27,943	(2,702)	91.2%
<b>Surgical Services Total</b>		<b>16,791</b>	<b>17,875</b>	<b>1,084</b>	<b>106.5%</b>	<b>149,528</b>	<b>147,797</b>	<b>(1,732)</b>	<b>98.8%</b>
<b>Cancer &amp; Blood Services</b>		<b>6,900</b>	<b>7,743</b>	<b>843</b>	<b>112.2%</b>	<b>55,510</b>	<b>55,793</b>	<b>283</b>	<b>100.5%</b>
<b>Cardiovascular Services</b>		<b>8,203</b>	<b>8,641</b>	<b>438</b>	<b>105.3%</b>	<b>76,071</b>	<b>77,207</b>	<b>1,136</b>	<b>101.5%</b>
Children's Health	Child Health & Disability	900	901	1	100.1%	6,558	6,475	(83)	98.7%
	Medical & Community	5,275	3,776	(1,499)	71.6%	46,204	44,906	(1,298)	97.2%
	Paediatric Cardiac & ICU	4,224	3,755	(469)	88.9%	32,037	31,708	(329)	99.0%
	Surgical & Community	3,278	3,708	430	113.1%	31,555	29,620	(1,934)	93.9%
<b>Children's Health Total</b>		<b>13,677</b>	<b>12,140</b>	<b>(1,536)</b>	<b>88.8%</b>	<b>116,353</b>	<b>112,709</b>	<b>(3,644)</b>	<b>96.9%</b>
<b>Clinical Support Services</b>		<b>2,615</b>	<b>2,882</b>	<b>267</b>	<b>110.2%</b>	<b>21,866</b>	<b>22,575</b>	<b>709</b>	<b>103.2%</b>
<b>Non-Clinical Support</b>		<b>23</b>	<b>23</b>	<b>0</b>	<b>100.0%</b>	<b>162</b>	<b>162</b>	<b>0</b>	<b>100.0%</b>
<b>DHB Funds</b>		<b>6,178</b>	<b>6,178</b>	<b>(0)</b>	<b>100.0%</b>	<b>43,248</b>	<b>43,248</b>	<b>(0)</b>	<b>100.0%</b>
<b>Perioperative Services</b>		<b>2</b>	<b>2</b>	<b>0</b>	<b>100.0%</b>	<b>17</b>	<b>17</b>	<b>0</b>	<b>100.0%</b>
<b>Public Health Services</b>		<b>130</b>	<b>130</b>	<b>0</b>	<b>100.0%</b>	<b>907</b>	<b>907</b>	<b>0</b>	<b>100.0%</b>
<b>Support Services</b>		<b>101</b>	<b>101</b>	<b>0</b>	<b>100.0%</b>	<b>709</b>	<b>709</b>	<b>0</b>	<b>100.0%</b>
Women's Health	Genetics	191	184	(6)	96.7%	1,802	1,824	22	101.2%
	Women's Health	5,652	6,222	570	110.1%	47,866	50,020	2,153	104.5%
<b>Women's Health Total</b>		<b>5,843</b>	<b>6,406</b>	<b>564</b>	<b>109.6%</b>	<b>49,668</b>	<b>51,844</b>	<b>2,175</b>	<b>104.4%</b>
<b>Grand Total</b>		<b>78,105</b>	<b>78,785</b>	<b>680</b>	<b>100.9%</b>	<b>647,919</b>	<b>642,769</b>	<b>(5,151)</b>	<b>99.2%</b>

## 2) Total Discharges for the YTD (7 Months to January 2017)

		Cases Subject to WIES Payment		All Discharges			Same Day discharges		Same Day as % of all discharges	
		Inpatient								
Directorate	Service	2016	2017	Last YTD	This YTD	% Change	Last YTD	This YTD	Last YTD	This YTD
Adult Community & LTC	A+ Links, HOP, Rehab	0	0	1,260	0	(100.0%)	2	0	0.2%	0.0%
	Ambulatory Services	953	1,038	1,176	1,244	5.8%	1,099	1,183	93.5%	95.1%
	Reablement Services	0	0	0	1,368	0.0%	0	35	0.0%	2.6%
<b>Adult Community &amp; LTC Total</b>		<b>953</b>	<b>1,038</b>	<b>2,436</b>	<b>2,612</b>	<b>7.2%</b>	<b>1,101</b>	<b>1,218</b>	<b>45.2%</b>	<b>46.6%</b>
Adult Medical Services	AED, APU, DCCM, Air Ambulance	7,254	8,026	7,257	8,029	10.6%	5,167	5,718	71.2%	71.2%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	11,788	11,510	11,886	11,654	(2.0%)	2,116	2,005	17.8%	17.2%
<b>Adult Medical Services Total</b>		<b>19,042</b>	<b>19,535</b>	<b>19,143</b>	<b>19,683</b>	<b>2.8%</b>	<b>7,283</b>	<b>7,723</b>	<b>0.0%</b>	<b>0.0%</b>
<b>Cancer &amp; Blood Total</b>		<b>2,921</b>	<b>2,935</b>	<b>3,159</b>	<b>3,325</b>	<b>5.3%</b>	<b>1,618</b>	<b>1,747</b>	<b>51.2%</b>	<b>52.5%</b>
<b>Cardiovascular Services Total</b>		<b>4,868</b>	<b>4,986</b>	<b>5,032</b>	<b>5,155</b>	<b>2.4%</b>	<b>1,231</b>	<b>1,257</b>	<b>24.5%</b>	<b>24.4%</b>
Children's Health	Medical & Community	8,757	8,317	9,498	9,063	(4.6%)	5,340	5,205	56.2%	57.4%
	Paediatric Cardiac &	1,302	1,351	1,409	1,416	0.5%	292	313	20.7%	22.1%
	Surgical & Community	5,182	5,192	5,491	5,487	(0.1%)	2,602	2,572	47.4%	46.9%
<b>Children's Health Total</b>		<b>15,241</b>	<b>14,860</b>	<b>16,398</b>	<b>15,966</b>	<b>(2.6%)</b>	<b>8,234</b>	<b>8,090</b>	<b>50.2%</b>	<b>50.7%</b>
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	10,218	10,364	11,837	11,847	0.1%	6,711	6,570	56.7%	55.5%
	N Surg, Oral, ORL, Transpl, Uro	6,466	6,700	6,842	7,109	3.9%	2,640	2,860	38.6%	40.2%
	Orthopaedics Adult	2,828	2,810	3,016	2,962	(1.8%)	557	519	18.5%	17.5%
<b>Surgical Services Total</b>		<b>19,512</b>	<b>19,873</b>	<b>21,695</b>	<b>21,918</b>	<b>1.0%</b>	<b>9,908</b>	<b>9,949</b>	<b>45.7%</b>	<b>45.4%</b>
<b>Women's Health Total</b>		<b>12,148</b>	<b>13,105</b>	<b>12,588</b>	<b>13,603</b>	<b>8.1%</b>	<b>0</b>	<b>0</b>	<b>0.0%</b>	<b>0.0%</b>
<b>Grand Total</b>		<b>74,685</b>	<b>76,333</b>	<b>80,451</b>	<b>82,262</b>	<b>2.3%</b>	<b>29,375</b>	<b>29,984</b>	<b>36.5%</b>	<b>36.4%</b>



### 3) Caseweight Activity for the YTD (7 Months to January 2017 (All DHBs))

Directorate	Service	Acute							Elective							Total						
		Case Weighted Volume			\$000s				Case Weighted Volume			\$000s				Case Weighted Volume			\$000s			
		Con	Act	Var	Con	Act	Var	Prog %	Con	Act	Var	Con	Act	Var	Prog %	Con	Act	Var	Con	Act	Var	Prog %
<b>Adult Community &amp; LTC</b>		<b>484</b>	<b>458</b>	<b>(26)</b>	<b>2,335</b>	<b>2,210</b>	<b>(125)</b>	<b>94.6%</b>	<b>64</b>	<b>50</b>	<b>(14)</b>	<b>308</b>	<b>241</b>	<b>(67)</b>	<b>78.3%</b>	<b>548</b>	<b>508</b>	<b>(40)</b>	<b>2,643</b>	<b>2,451</b>	<b>(192)</b>	<b>92.7%</b>
Adult Medical Services	AED, APU, DCCM, Air Ambulance	2,063	2,194	131	9,952	10,586	634	106.4%	0	0	0	0	0	0	0.0%	2,063	2,194	131	9,952	10,586	634	106.4%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	10,867	10,586	(281)	52,429	51,075	(1,354)	97.4%	4	0	(4)	18	0	(18)	0.0%	10,871	10,586	(284)	52,447	51,075	(1,372)	97.4%
<b>Adult Medical Services Total</b>		<b>12,930</b>	<b>12,780</b>	<b>(149)</b>	<b>62,381</b>	<b>61,661</b>	<b>(720)</b>	<b>98.8%</b>	<b>4</b>	<b>0</b>	<b>(4)</b>	<b>18</b>	<b>0</b>	<b>(18)</b>	<b>0.0%</b>	<b>12,933</b>	<b>12,780</b>	<b>(153)</b>	<b>62,399</b>	<b>61,661</b>	<b>(738)</b>	<b>98.8%</b>
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	5,197	5,257	60	25,075	25,365	290	101.2%	4,407	4,288	(119)	21,263	20,690	(573)	97.3%	9,604	9,546	(59)	46,338	46,056	(283)	99.4%
	N Surg, Oral, ORL, Transpl, Uro	5,007	5,264	256	24,158	25,396	1,238	105.1%	4,098	4,030	(68)	19,770	19,442	(328)	98.3%	9,105	9,293	188	43,928	44,837	909	102.1%
	Orthopaedics Adult	3,302	3,488	186	15,930	16,829	899	105.6%	2,563	1,686	(877)	12,366	8,134	(4,231)	65.8%	5,865	5,174	(691)	28,296	24,963	(3,332)	88.2%
<b>Surgical Services Total</b>		<b>13,506</b>	<b>14,009</b>	<b>503</b>	<b>65,164</b>	<b>67,590</b>	<b>2,426</b>	<b>103.7%</b>	<b>11,068</b>	<b>10,004</b>	<b>(1,064)</b>	<b>53,398</b>	<b>48,266</b>	<b>(5,132)</b>	<b>90.4%</b>	<b>24,574</b>	<b>24,013</b>	<b>(561)</b>	<b>118,562</b>	<b>115,856</b>	<b>(2,706)</b>	<b>97.7%</b>
<b>Cancer &amp; Blood Services</b>		<b>3,565</b>	<b>3,479</b>	<b>(86)</b>	<b>17,201</b>	<b>16,787</b>	<b>(414)</b>	<b>97.6%</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0.0%</b>	<b>3,565</b>	<b>3,479</b>	<b>(86)</b>	<b>17,201</b>	<b>16,787</b>	<b>(414)</b>	<b>97.6%</b>	
<b>Cardiovascular Services</b>		<b>8,516</b>	<b>8,835</b>	<b>319</b>	<b>41,088</b>	<b>42,626</b>	<b>1,537</b>	<b>103.7%</b>	<b>5,773</b>	<b>5,660</b>	<b>(113)</b>	<b>27,851</b>	<b>27,306</b>	<b>(545)</b>	<b>98.0%</b>	<b>14,289</b>	<b>14,495</b>	<b>206</b>	<b>68,939</b>	<b>69,932</b>	<b>993</b>	<b>101.4%</b>
Children's Health	Medical & Community	6,567	6,648	80	31,686	32,072	387	101.2%	0	1	1	0	3	3	0.0%	6,567	6,648	81	31,686	32,076	390	101.2%
	Paediatric Cardiac & ICU	3,468	3,319	(149)	16,732	16,012	(721)	95.7%	1,423	1,469	46	6,867	7,088	221	103.2%	4,891	4,788	(104)	23,600	23,099	(500)	97.9%
	Surgical & Community	3,169	2,932	(238)	15,291	14,144	(1,147)	92.5%	2,597	2,443	(154)	12,530	11,786	(744)	94.1%	5,766	5,374	(392)	27,821	25,930	(1,891)	93.2%
<b>Children's Health Total</b>		<b>13,205</b>	<b>12,898</b>	<b>(307)</b>	<b>63,709</b>	<b>62,228</b>	<b>(1,481)</b>	<b>97.7%</b>	<b>4,020</b>	<b>3,913</b>	<b>(108)</b>	<b>19,397</b>	<b>18,877</b>	<b>(521)</b>	<b>97.3%</b>	<b>17,225</b>	<b>16,810</b>	<b>(415)</b>	<b>83,106</b>	<b>81,105</b>	<b>(2,001)</b>	<b>97.6%</b>
<b>Women's Health Services</b>		<b>6,095</b>	<b>6,300</b>	<b>205</b>	<b>29,406</b>	<b>30,397</b>	<b>991</b>	<b>103.4%</b>	<b>1,154</b>	<b>1,236</b>	<b>82</b>	<b>5,569</b>	<b>5,964</b>	<b>395</b>	<b>107.1%</b>	<b>7,249</b>	<b>7,537</b>	<b>287</b>	<b>34,975</b>	<b>36,361</b>	<b>1,386</b>	<b>104.0%</b>
<b>Grand Total</b>		<b>58,301</b>	<b>58,760</b>	<b>459</b>	<b>281,284</b>	<b>283,500</b>	<b>2,216</b>	<b>100.8%</b>	<b>22,083</b>	<b>20,862</b>	<b>(1,220)</b>	<b>106,541</b>	<b>100,654</b>	<b>(5,887)</b>	<b>94.5%</b>	<b>80,384</b>	<b>79,623</b>	<b>(761)</b>	<b>387,826</b>	<b>384,154</b>	<b>(3,672)</b>	<b>99.1%</b>
<i>Excludes caseweight Provision</i>																						

5.14

## Acute

The number of cases presenting when comparing the same period last year have risen but the total WIES has dropped, which is due to a drop in average WIES. This is to be expected over the summer period as the acute medical cases generally are less complex over summer.

Activity by service type:

- There were 5% more medical discharges in January 2017 compared to the previous year, reversing the drop off in December. The average WIES remains higher than last year, due to the high WIES cases. However, average length of stay (ALOS) continues to drop reflecting more effective discharge practices.
- Acute surgical discharges are still 3% higher than last year overall, with January being 4% higher than last year. Average WIES has increased again, with a number of high WIES cases discharged in January due to a higher than usual number of acute cases in Cardiothoracic, Neurosurgery, Paediatric Cardiac and Vascular.
- Discharges for Obstetrics are now at the same level they were two years ago, completely reversing the trend of 2015/16. Performance to contract for both services is slightly under contract, driven by Newborn, but it may well reach contract by year end if birth numbers continue to increase.

## Elective

There has been a further improvement in performance to contract for elective services in YTD January, although that does reflect in part the phasing over the holiday period. However, there was a continuation of the December trend, with January having a higher number of discharges compared to the same period last year, reflecting the efforts to meet elective targets.

- Cardiovascular continues to improve, with only a 2% variance to contract. This was partly driven by increased average WIES.
- Child Health has also improved compared to contract YTD January. However, discharges in Paediatric Surgery and Paediatric ORL in particular continue to lag.
- Women's Health continues to exceed contract, although there was a slight drop off over the holiday period.
- There was a no change in Adult Surgical performance over the period.

Total performance for ADHB population is sitting at 84% of contract, and is lower than the same period last year (514 WIES lower overall).

## 4) Non-DRG Activity (ALL DHBs)

		January 2017				YTD (7 months ending Jan-17)			
		\$000s				\$000s			
Directorate	Service	Cont	Act	Var	Prog %	Cont	Act	Var	Prog %
Adult Community & LTC	Ambulatory Services	425	405	(20)	95.4%	4,245	4,109	(136)	96.8%
	Community Services	1,725	1,385	(340)	80.3%	14,548	11,565	(2,983)	79.5%
	Diabetes	379	415	37	109.7%	3,206	3,239	33	101.0%
	Palliative Care	39	39	0	100.0%	273	273	0	100.0%
	Reablement Services	2,007	1,837	(171)	91.5%	14,036	14,158	122	100.9%
	Sexual Health	342	420	78	122.8%	2,897	3,222	325	111.2%
<b>Adult Community &amp; LTC Total</b>		<b>4,917</b>	<b>4,502</b>	<b>(415)</b>	<b>91.6%</b>	<b>39,205</b>	<b>36,567</b>	<b>(2,638)</b>	<b>93.3%</b>
Adult Medical Services	AED, APU, DCCM, Air Ambulance	649	604	(44)	93.2%	4,437	4,449	12	100.3%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	3,262	2,887	(375)	88.5%	25,195	24,673	(522)	97.9%
<b>Adult Medical Services Total</b>		<b>3,911</b>	<b>3,492</b>	<b>(419)</b>	<b>89.3%</b>	<b>29,632</b>	<b>29,122</b>	<b>(510)</b>	<b>98.3%</b>
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	1,091	1,157	67	106.1%	10,790	11,320	529	104.9%
	N Surg, Oral, ORL, Transpl, Uro	2,267	2,212	(55)	97.6%	17,826	17,641	(185)	99.0%
	Orthopaedics Adult	244	332	87	135.8%	2,350	2,980	630	126.8%
<b>Surgical Services Total</b>		<b>3,602</b>	<b>3,701</b>	<b>99</b>	<b>102.8%</b>	<b>30,966</b>	<b>31,941</b>	<b>974</b>	<b>103.1%</b>
<b>Cancer &amp; Blood Services</b>		<b>4,459</b>	<b>5,240</b>	<b>781</b>	<b>117.5%</b>	<b>38,309</b>	<b>39,006</b>	<b>697</b>	<b>101.8%</b>
<b>Cardiovascular Services</b>		<b>864</b>	<b>861</b>	<b>(3)</b>	<b>99.7%</b>	<b>7,132</b>	<b>7,275</b>	<b>144</b>	<b>102.0%</b>
Children's Health	Child Health & Disability	900	901	1	100.1%	6,558	6,475	(83)	98.7%
	Medical & Community	1,723	1,391	(332)	80.7%	14,518	12,831	(1,688)	88.4%
	Paediatric Cardiac & ICU	1,111	1,099	(12)	99.0%	8,437	8,608	171	102.0%
	Surgical & Community	391	366	(26)	93.5%	3,734	3,690	(44)	98.8%
<b>Children's Health Total</b>		<b>4,125</b>	<b>3,757</b>	<b>(368)</b>	<b>91.1%</b>	<b>33,247</b>	<b>31,604</b>	<b>(1,643)</b>	<b>95.1%</b>
<b>Clinical Support Services</b>		<b>2,615</b>	<b>2,882</b>	<b>267</b>	<b>110.2%</b>	<b>21,866</b>	<b>22,575</b>	<b>709</b>	<b>103.2%</b>
<b>Non-Clinical Support</b>		<b>23</b>	<b>23</b>	<b>0</b>	<b>100.0%</b>	<b>162</b>	<b>162</b>	<b>0</b>	<b>100.0%</b>
<b>DHB Funds</b>		<b>6,178</b>	<b>6,178</b>	<b>(0)</b>	<b>100.0%</b>	<b>43,248</b>	<b>43,248</b>	<b>(0)</b>	<b>100.0%</b>
<b>Perioperative Services</b>		<b>2</b>	<b>2</b>	<b>0</b>	<b>100.0%</b>	<b>17</b>	<b>17</b>	<b>0</b>	<b>100.0%</b>
<b>Public Health Services</b>		<b>130</b>	<b>130</b>	<b>0</b>	<b>100.0%</b>	<b>907</b>	<b>907</b>	<b>0</b>	<b>100.0%</b>
<b>Support Services</b>		<b>101</b>	<b>101</b>	<b>0</b>	<b>100.0%</b>	<b>709</b>	<b>709</b>	<b>0</b>	<b>100.0%</b>
Women's Health	Genetics	191	184	(6)	96.7%	1,802	1,824	22	101.2%
	Women's Health	1,396	1,475	79	105.7%	12,891	13,658	767	106.0%
<b>Women's Health Total</b>		<b>1,586</b>	<b>1,659</b>	<b>73</b>	<b>104.6%</b>	<b>14,693</b>	<b>15,482</b>	<b>789</b>	<b>105.4%</b>
<b>Grand Total</b>		<b>32,514</b>	<b>32,528</b>	<b>14</b>	<b>100.0%</b>	<b>260,094</b>	<b>258,615</b>	<b>(1,479)</b>	<b>99.4%</b>

Cancer and Blood Services has again improved against contract and overall non DRG performance is now 102% of contract reflecting the lumpiness of service delivery (high numbers of events clustering around a patient means that if the patients do not present as expected the outputs can be significantly lower). The improvement in Cancer performance has eliminated the wash up risk for this service, previously sitting at \$1.5M for YTD November.



## TOP THREE

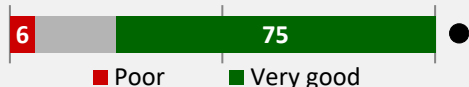
Our inpatients are asked to choose the three things that matter most to their care and treatment.

### 1. Communication (51%)

Communication is the aspect of our care most patients (51%) say makes a difference to the quality of their care and treatment.

*"The staff described [my] condition in words I could understand, in addition to medical terminology." (Rated excellent)*

How are we doing on communication?

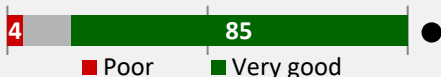


### 2. Confidence (44%)

Two in every five patients (44%), say that feeling confident about their care and treatment is one of the top three things that matter to the quality of their care and treatment.

*"Everything that everyone said would happen happened in the [time]frame they said it would. They built confidence through demonstrating competence and efficiency..." (Rated excellent)*

How are we doing with patients feeling confident about their care and treatment?



### 3. Consistency (39%)

Nearly four out of every 10 patients (39%) rate getting consistent and coordinated care while in hospital as one of the things that make the most difference.

*"I felt like I mattered to the staff and they did everything possible to make my stay in hospital informative and comfortable." (Rated excellent)*

How are we doing with consistent and coordinated care?



'+' = positive change; ● = no change; '-' = negative change

## Support from whānau, family, friends

6.1

Enabling support for whānau, family and friends is something we have always rated consistently highly on. In spite of our already high ratings we have also seen some improvement over the last two years, particularly in the Cancer and Blood and Adult Medical directorates.

**Nine out of every 10 respondents to our inpatient survey who wanted their whānau, family or friends involved in their care said that whānau, family or friends were "definitely" able to support them and were made to feel welcome.**

It's important to note that having support from whānau, family and friends is particularly important to some patients more than others. Our Māori patients, for example, are twice as likely to say this is one of the three things that make the most difference to their care and treatment than other inpatients, and respondents in the Child Health and Women's Health directorates are also significantly more likely to indicate this makes the most difference to their care than respondents from other directorates. These patients are also more likely to rate our performance on this measure 9.2 out of 10, which is slightly higher than the average nine out of 10.

Our Pasifika and Asian respondents, however, are slightly less likely to tell us their support people felt welcome and involved, or that they had an opportunity to speak with their healthcare team.

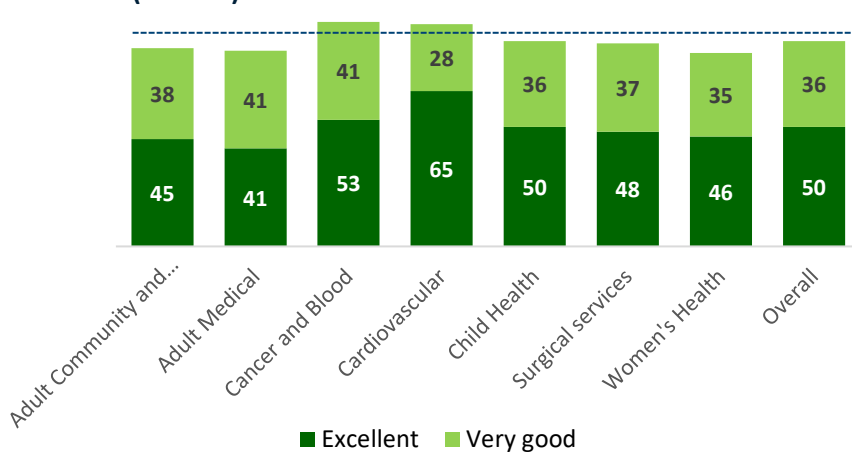
Our Partners in Care Programme currently being developed at Auckland City Hospital aims to build on our culture of inclusion with whānau and family through involvement with care planning, discharge planning, ward rounds and handovers. This programme enables each patient to have the opportunity to nominate and have access to a lead support person 24/7 enhancing their experience.

**Margaret Dotchin, Chief Nursing Officer**

## VERY GOOD AND EXCELLENT RATINGS

"Very good" and "excellent" ratings are reasonably high across all directorates. Although ratings for several directorates are trending upwards, none of these are yet statistically significant.

**INPATIENT OVERALL EXPERIENCE OF CARE RATING, AUGUST 2015 TO JULY 2016 (n=5904)**



Adult CLT n=136; Adult Medical n=440; Cancer & Blood n=133; Cardiovascular n=418; Child Health n=964; Surgical n=1352; Women's Health n=505. Overall n=3950

# FOCUS ON SUPPORT

Enabling support from whānau, family and friends is one of the three things that makes the most difference for one in 10 of our inpatients. Note, however, that the percentage of Māori patients who say this is important is double: 20% say it makes the most difference to their care and treatment.



One in 10 respondents say that allowing whānau, family and friends to support them is one of the three things that makes the most difference to the quality of their care and treatment

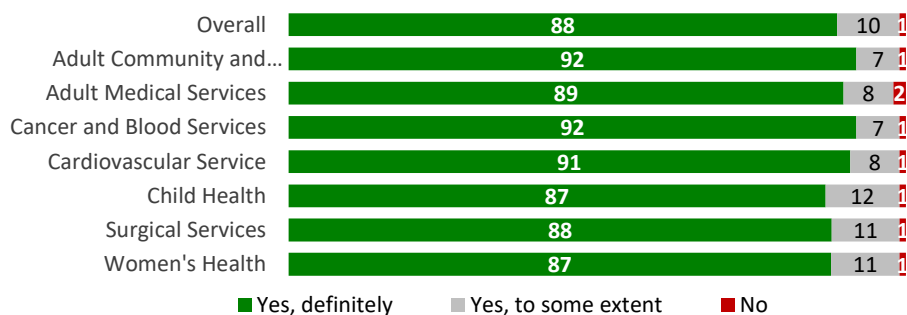
## HOW ARE WE DOING?

The following data are from August, 2014 to July 30, 2016. \* The comparative data is taken from the previous report on support, in August 2014.

### Support people made to feel welcome and involved

*Nine out of every 10 respondents who wanted their whānau, family or friends involved in their care said their whānau, family or friends were “definitely” able to support them and were made to feel welcome.*

#### Percentage of patients who say their support people felt welcome & involved



Overall n=6335 Adult Community and Long-term Conditions n=184; Adult Medical Services n=604; Cancer and Blood n=207; Cardiovascular Services n=705; Child Health n=1660; Surgical Services n=1928; Women's Health n=1042

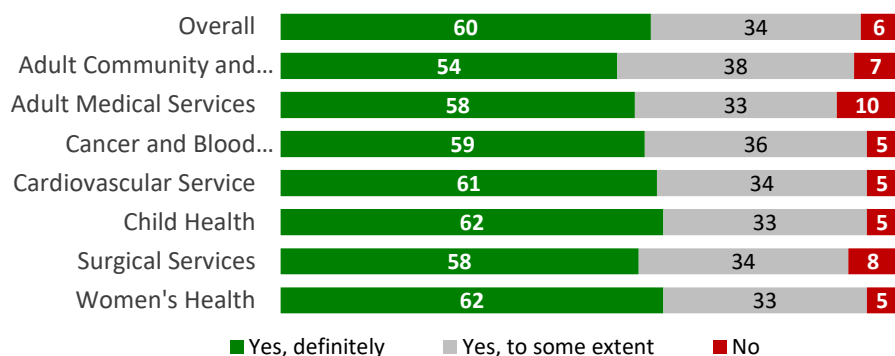


**Cancer and Blood and Adult Medical directorates have both had a statistically significant 3-point improvement in ratings since August 2014.**

Not all respondents say that they want their family, whānau or friends to speak with their healthcare team. Around one in 5 (23%) say that their whānau, family or friends either did not want or need information, they do not want them to talk to their healthcare team or they do not have any whānau, family or friends involved in their care.

Six out of every 10 respondents say their support people were “definitely” able to talk with their healthcare team, although a minority say they were not able to do so.

#### Percentage of patients who say their support people had the opportunity to talk with members of their healthcare team



Overall n=4797; Adult Community and Long-term Conditions n=156; Adult Medical Services n=442; Cancer and Blood n=176; Cardiovascular Services n=552; Child Health n=1244; Surgical Services n=1380; Women's Health n=846



**Whilst there has been a two-percentage point improvement on this overall measure, the results are not statistically significant**

\*note numbers were too low for comparison the 12-month period from August 2015

#### AVERAGE RATINGS ON ENABLING SUPPORT, BY DEMOGRAPHIC & DIRECTORATE (AUGUST 2014 TO JULY 2016, n=656)

These ratings are from patients who tell us that enabling support from whānau, family and friends is one of the three things that make the most difference to their care.

Note that directorate and age data with less than 100 respondents have been excluded.

##### AVERAGE RATING

Overall: 9.0

##### AVERAGE RATING BY GENDER

Female: 9.0

Male: 9.0

##### AVERAGE RATING BY ETHNICITY

NZ European: 9.1

Māori: 9.2

Pasifika: 8.6

Asian: 8.9

Other: 9.1

##### AVERAGE RATING BY AGE

17 and under: 9.0

25 – 44: 9.1

45 – 64: 8.9

##### AVERAGE RATING BY DIRECTORATE

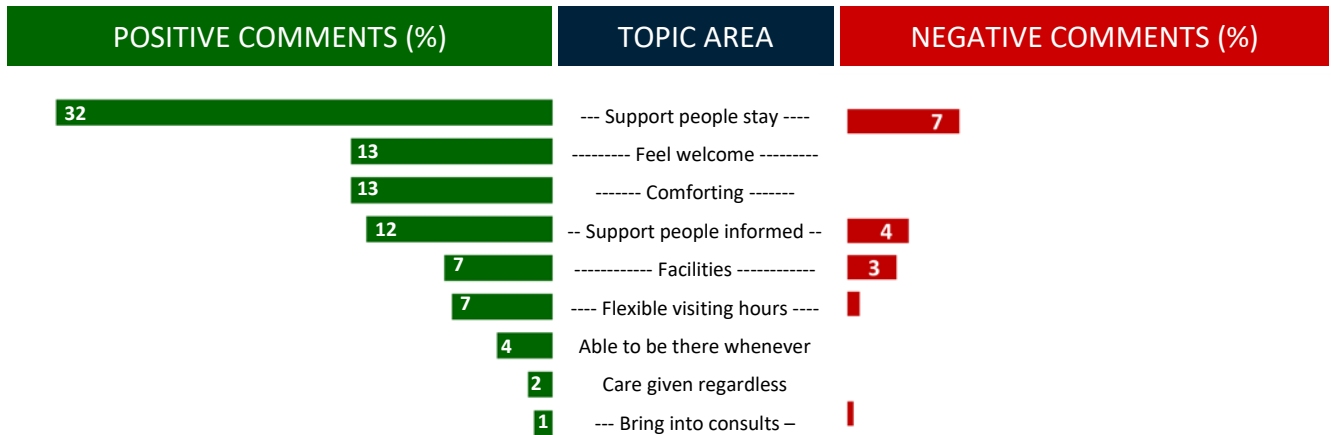
Children's Health: 9.2

Surgical Services: 8.8

Women's Health: 9.2

# A CLOSER LOOK AT PATIENT COMMENTS

A total of 293 patients commented on support from family, whānau and friends. It should be noted that these data differ from usual in three important respects. First, comments about whānau, friends and family support were overwhelmingly positive (84.7%), and only a small minority (18%, or 45 respondents) commented negatively. Second, nearly one-third of patients have commented on just one specific area; that is, that support people could stay with patients, either overnight or when they visited theatre or during consultations. Third, there were no negative comments for some topic areas, hence the slightly different layout for this report.



## PATIENT COMMENTS

### SUPPORT PEOPLE ALLOWED TO STAY (OVERNIGHT, THEATRE) (32%)

**A number of respondents, especially parents of young children, said how important it was for support people to be able to stay overnight. This helped to relieve anxiety – of both the patient and the support person – and was both helpful and comforting.**

*Having dad spend the night with our young son was good for both our whanau and our son. Our son wasn't scared and the whanau didn't have to worry.*

*We were so glad that I was able to stay at Ronald McDonald house and my wife could stay on ward with daughter it was so good to just walk up and spend all day with her till she went to sleep.*

*The fact that my husband was able to stay with me in my room for the three nights that I was there for the birth of our baby put me at ease and meant I felt supported at all times. I really appreciated that the mattress was already in the post-natal room ready for him*

**Support people appreciated being able to be in the operating room area, especially with young children.**

*Access into operating theatre for the mum, was great assurance for our son.*

**Flexibility with regards to how many people can stay with a patient was appreciated.**

*We were told that only one person could stay overnight but her twin and younger sibling were with us. The staff made a bed up for her sisters to stay as well. It was particularly important to (our child) that her twin stay with her. [Because of their circumstances] it means a lot to them that they can make choices regarding who stays with them when they are upset or ill.*

### SUPPORT PEOPLE NOT ALLOWED TO STAY / ONLY ONE SUPPORT PERSON ALLOWED (7%)

**Some respondents talked about how their support people were not allowed to stay.**

*I would have liked it if my wife was allowed to stay with me over night post operation. We had asked but were told because we were in a shared room it was against hospital policy.*

*Sometimes... they were not allowed to stay at night with you when you needed them the most.*

**A small minority would have liked to have had their whānau stay together or to have had more than one support person stay.**

*I have [newborn] twins & I couldn't have the twins on the ward as the room didn't accommodate that. Also my husband and I both couldn't stay with our baby so our family was split up and our child passed around as the hospital couldn't accommodate our whanau.*

*I had my 2yr old there, but the nurse only allow one of us which I did not like, she was crying for both the parents.*

## PATIENT COMMENTS (cont...)

### SUPPORT PEOPLE MADE TO FEEL WELCOME, CARED FOR AND RESPECTED (13%)

Respondents greatly appreciated how welcoming staff were to their support people. Many said their support people were *always* made to feel welcome. Some said this made a big difference to how they felt about their stay in hospital.

*My whanau was always treated with respect which made my stay better.*

*Starship was amazing with allowing my family to support me. They welcomed them and let us spend time with them*

*During our stay all members of the family were welcome and staff went beyond their duty to make everyone feel comfortable.*

Some respondents said that staff went to an effort to make their support people comfortable, and were willing to accommodate large families or whānau where necessary.

*The nurses and doctors were very comfortable and willing to have my whanau around. They also were very good at communicating with my family when I was in the HDU*

*My family (it's big) brought me meals most nights and we were able to use the kitchen in the ward and the whanau rooms to share meals if we wanted. I only once felt that we were not accommodated but that was when there were more than 6 visitors at once and it was nearing the end of visiting hours*

### HAVING SUPPORT PEOPLE THERE IS COMFORTING (13%)

Family support helped respondents feel comfortable, safe and supported.

*Family support makes me feel very comfortable and worry less and strong especially in the hospital.*

*My family came and waited with me providing moral support before I went into surgery. This was important for me.*

Support people being there to help with practical needs also helped.

*My friends and my partner were always by my side helping me out during my stay at the hospital. It was nice to have them near me - they brought me food, care and attention and I am sure it has helped me feel more comfortable while in hospital.*

### SUPPORT PEOPLE SPOKEN WITH, KEPT INFORMED, INVOLVED, LISTENED TO (12%)

Respondents said that having their support people with them through tests and procedures was a big help, particularly around communication or remembering details.

*My partner was able to accompany me to every appointment in the lead up to surgery and was with me until I walked into the surgery room. He was invited to sit with me whilst having MRI and other tests and was also included in all the discussions about my care and treatment.*

*I am profoundly deaf, so can miss a lot of what is being said... having a family member with me when Doctors made their rounds was extremely important to me so that I could go over later what had been said.*

### SUPPORT PEOPLE NOT INFORMED / IGNORED (4%)

Some respondents said that their support people were not well informed, or that they felt 'ignored' or 'brushed off'.

*My husband was told that I would be 30 minutes in surgery. I did not get back to the ward for 5 hours, and I understand that my surgery took 3 1/2 hours. When my husband asked the nursing staff at the ward to find out where I was, they brushed him off and said I would be back sometime soon. He was extremely agitated and upset by this.*

Although practical help from support people was needed by only a small minority of respondents, it was important to them that they got this help.

*I don't have good English so I wish family or friend can be around when doc is around to explain to me.*

### EXCELLENT FACILITIES (7%)

Some respondents commented on the excellent facilities available for support people, such as mattresses, chairs, tea and coffee. Several said that having room for support people to stay was much appreciated.

*Having our own room made a huge difference to feeling comfortable in having family come in each day. Staff were never worried about how many people were in the room and they were always considerate of the timing of their visits. Whilst other patients had a lot of visitors also it seemed to work really well and everyone respected each other's space and needs.*

### POOR FACILITIES (3%)

A small number of respondents felt the facilities were below par e.g. the lack of tea or coffee. In some cases, support people could stay, but respondents felt they could have been better catered for.

*I know there is limited space for visitors in a shared room, maybe having chairs available for visitors to collect and put back at the end of their visit would be helpful as I only had one chair in my space.*

*While my caregiver was permitted to stay with me overnight, there was no bed (although a Lazyboy was given with blankets) and my caregiver was not given meals.*



## Support from whānau, family, friends

Family-centered care is defined as an approach to healthcare that is respectful of and responsive to individual families' needs and values. Enabling support from whānau, family and friends is something we do particularly well; nine out of 10 outpatients (91%) who say this dimension of care is important to them rate our performance on this measure as 8-10 on a 10-point scale.

It is worth noting that not all patients want or need their whānau, family or friends to be involved in their healthcare. When they do, however, their comments show that treating their support people as a key part of their healthcare team is important to their positive experience of care.

Enabling support from whānau, family and friends is particularly important to our Maori and Pasifika patients, who are twice as likely to say this is one of the three things that makes the most difference to their care than are other patients. They are also, however, slightly less likely than other patients to say that whānau, family and friends were made to feel welcome and that they were given the opportunity to speak with a doctor when they wanted to.

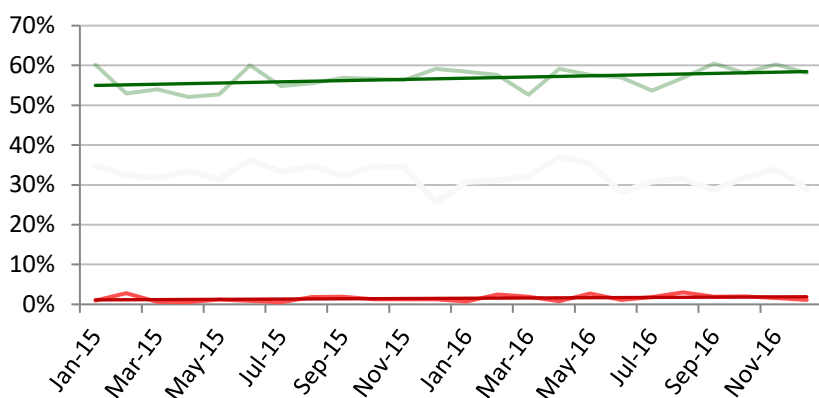
Learning from the experience of patients and whānau is essential in designing our outpatient services of the future. As we look to meet the challenges of a diverse and growing Auckland, it is important that patients, whānau and our community help to shape how we deliver care, whether that be in our traditional outpatient clinics or taking advantage of new technology and different settings to provide the best possible service. We have commenced the Outpatient Models of Care programme which will work with hospital-based services, primary care, patients and whānau to look at new and innovative ways to provide outpatient care in a way that is sustainable and meets the needs of the communities we serve.

**Margaret Dotchin Chief Nursing Officer**

### POOR AND EXCELLENT RATINGS @2 YEARS

Our "excellent" ratings continue to trend upwards and now average 56%, whilst our "poor" ratings have stayed largely static. The differences are significant and sustained when demographic factors such as the age and gender of respondents are controlled for.

#### OUTPATIENT OVERALL EXPERIENCE OF CARE RATING BY DIRECTORATE, JAN 2015 TO DEC 2016



### TOP THREE

Our outpatients are asked to choose the three things that matter most.

6.1

#### 1. Information (66%)

Getting good information is the aspect of our care two thirds of patients (66%) say makes a difference to the quality of their care and treatment.

*"Doctor communicated in a way to make me feel consulted rather than talked at and was comfortable using medical language when appropriate."*

##### How are we doing on information?



#### 2. Organisation (54%)

For more than half of all our patients (54%), organisation, appointments and correspondence matter to the quality of their care and treatment.

*"I waited over an hour to see the doctor beyond my appointment time, it would have been helpful if someone had explained that this would happen, and I would have been feeling less anxious."*

##### How are we doing with organisation?

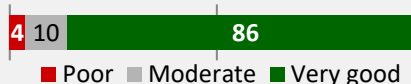


#### 3. Confidence (51%)

Half our patients (51%) rated having confidence in their care and treatment as one of the things that make the most difference.

*"It is apparent to me that whoever I dealt with had read my somewhat extensive file and understood what treatment I required..."*

##### How are we doing with confidence?



# A focus on enabling support

Overall, five percent of respondents to the outpatient experience survey say that enabling support from whānau, family and friends is one of the three things that makes the most difference. Note, however that twice as many Māori and Pasifika patients (11%) say this is important to them.



One in every 20 outpatients (5%) say that enabling support from whanau, family and friends is one of the three things that makes the most difference to the quality of their care & treatment.

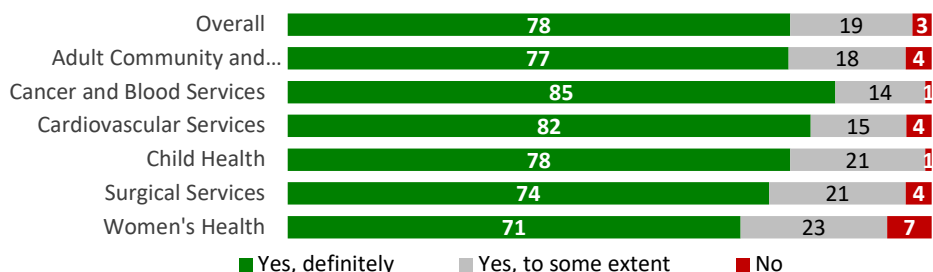
## HOW ARE WE DOING?

The following data from the period August, 2014 to July 2016\* have been compared with data from the year to July 2014 to establish whether there have been any significant changes. Please note that 'not applicable' answers have been removed from these data and the data recalculated.

### SUPPORT PEOPLE SPEAKING WITH MEMBERS OF THE HEALTHCARE TEAM

*There has been an overall improvement of four percentage points in the percentage of patients who say their support people could 'definitely' talk with their healthcare team (from 74% to 78%) since July 2014. Note that ratings for all directorates on this measure have trended upwards, with a significant improvement for both Child Health and Surgical Services directorates.*

#### Percentage of patients who say their support people could talk with a doctor



**4% improvement**

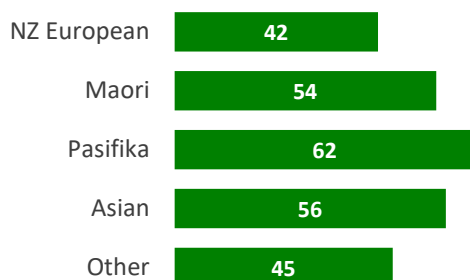
in overall ratings since July 2014, with significant improvements for both Child Health (+8) and Surgical Services directorates (+5). The difference is significant (p<0.05).

Adult Community and Long-term Conditions n=246; Cancer and Blood Services n=1306; Cardiovascular Services n=217; Child Health n=739; Surgical Services n=1736; Women's Health n=434, Overall n=4733

### SUPPORT PEOPLE SPEAKING WITH A DOCTOR, BY ETHNICITY

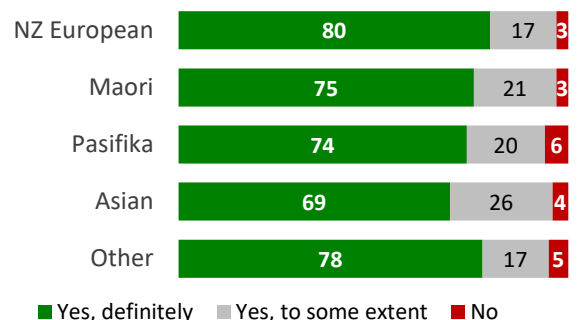
*Not all patients want their whānau, family or friends involved in their healthcare. Overall, just over half of patients said their whānau, family and friends were either not involved, did not want or need information, or they did not want them involved in their healthcare. What is interesting is when we compare ethnic groups by those who want or need their whānau, family or friends to speak with a doctor, against those who say they had a chance to do so. As an example, Pasifika and Asian people are most likely (62% & 56%) to say they have support people involved in their care, yet less than three quarters say these support people 'definitely' had a chance to speak with a doctor.*

#### Percentage of patients who say support people are involved, by ethnicity



Overall n=4733; NZ European n=3147; Maori n= 430; Pasifika n=389; Asian n=559; Other n=700. The differences between groups are significant

#### Percentage of patients who say their support people could talk with a doctor, by ethnicity



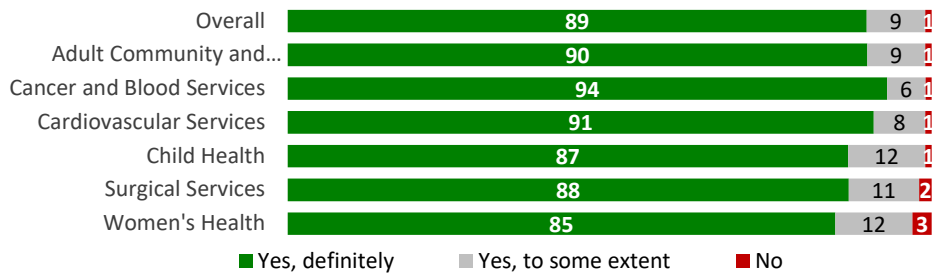
Overall n=4733; NZ European n=3147; Maori n= 430; Pasifika n=389; Asian n=559; Other n=700. The differences between groups are significant

\*note numbers were too low for comparison the 12-month period from August 2015

## SUPPORT PEOPLE WELCOME AND INVOLVED

Most patients agree that whānau, family and friends were made to feel welcome and could support them where this was needed. Overall, the percentage of patients who said that their whānau, family or friends had the opportunity to support them in their clinic visit and were made to feel welcome has increased by two percentage points, and Cancer and Blood Services have also had a statistically significant three percentage point gain. Most other directorates have an upwards trend on this measure, however the differences are not significant.

Percentage of patients who say their support people were welcome and able to give the support they needed



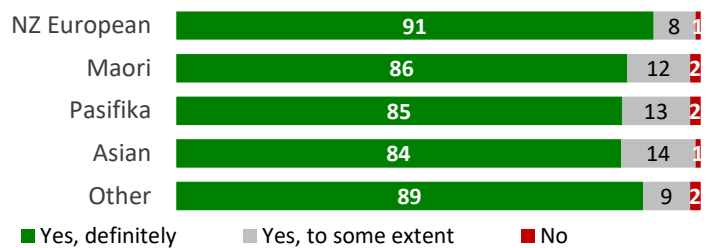
**2% improvement**  
 in overall ratings since July 2014, with a significant improvement for both Cancer and Blood Services (+3). The difference is significant (p<0.05).

Adult Community and Long-term Conditions n=271; Cancer and Blood Services n=1379; Cardiovascular Services n=233; Child Health n=893; Surgical Services n=1939; Women's Health n=548; Overall n=5319

## SUPPORT PEOPLE WELCOME AND INVOLVED, BY ETHNICITY

There are several small but significant differences between ethnic groups who say their whānau, family and friends were made to feel welcome and could support them. Although most said this 'definitely' happened, Asian, Pasifika and Maori respondents were more likely to say that they did not feel welcome, or only felt welcome and involved to some extent.

## Percentage of patients who say their support people felt welcome and involved, by ethnicity



NZ European n=3547; Maori n=491; Pasifika n=437; Asian n=636; Other n=791. The differences between groups are significant

# A closer look at patient comments

A total of 215 patients commented on whānau, friends and family support. Comments were overwhelmingly positive (97%).

### SUPPORT PEOPLE INFORMED, INVOLVED, LISTENED TO (31%)

Respondents valued staff involving and informing their support people. It was important for patients not to feel alone. Having support people was also important for language, hearing, or access challenges.

*Due to the language barrier, I need our daughter to assist. The work team is always to explain every detail to us.*

*My children were able to support me at every appointment. They were also interpreting for me in my native language. This made me feel comfortable knowing my medical information was known to myself and my children.*

**Involving support people in decision making helped patients too.**

*We needed to decide whether or not to proceed with major surgery - surgeon and anaesthetist were very frank and open to our family.*

### SUPPORT PEOPLE NOT INFORMED, IGNORED (1%)

Only a very small number of patients said that their support people were not informed and involved.

*My support person was ignored.*

*The treatment is about the patient, so the staff usually talk to the patient not the family. This is because there is not enough time, I guess.*

*The doctor announced the appointment was over before we had a chance to ask final questions*

## PATIENT COMMENTS (cont...)

### SUPPORT PEOPLE MADE TO FEEL WELCOME, CARED FOR AND RESPECTED (16%)

#### Respondents often mentioned how important it was that support people were made to feel welcome

*On my initial consultation two of my children and my wife insisted on being present which I thought might have been 'over-kill' but there was no problem at all. I was very impressed.*

*At no point time was my support discounted from the procedure. My support was allowed to follow me through, ask questions and hold my hand during treatment.*

*Whānau were welcome to be actively supportive before and after the operation and received up to date communication when the surgery was completed.*

*When I have wanted my husband with me this has always been possible and he was always treated with respect and allowed to ask questions or raise concerns about my treatment.*

*My father... commented to me about the friendliness & openness of the consultant. Also, that he was treated with respect.*

#### Treating whānau, family and friends with respect and remembering who they were was highly valued.

*The staff treated my whānau with respect, and the nurses and doctors remembering who they were was a big deal. They ensured my whānau were comfortable and helped them when needed.*

*(The doctor) greeted my husband and my friend. The second time we saw her she greeted my husband and asked about my friend. I was amazed that she had remembered and it felt great.*

*I have a partner of the same sex. At no time did we feel that our relationship was different from the 'norm' and we were both treated with respect. Her questions and opinions were listened to and answered.*

#### This welcoming respectful approach was especially important for whānau Māori.

*Hand shake to whānau, eye contact to whānau member when discussing my progress, allowing questions from whānau, using easy to understand words.*

### HAVING SUPPORT PEOPLE MAKES IT EASIER TO REMEMBER AND GET MISSED DETAILS (8%)

#### Having whānau support was very important to make sure no details or questions were missed, especially for older people, and people with hearing and language challenges

*I have been married for 52 years and my wife and I share everything including medical issues. I am also hard of hearing and my wife often picks up on things the doctor said that I have missed.*

### HAVING SUPPORT PEOPLE AROUND ALLEVIATES ANXIETY (5%)

#### Several respondents commented how comforting it was to have support people with them.

*Aspects of my experience were difficult to face alone. It was a great comfort to know that family could access the consultation process where appropriate or necessary.*

### SUPPORT PEOPLE ALLOWED TO STAY (8%)

#### Respondents appreciated that their support people were welcomed to be with them through all parts of the care.

*(The staff) seemed please that I had a support person who was involved in the whole process with me.*

*I was told that my family support was most welcome at any stage of my treatment. My husband stayed with me at the hospital overnight very very very thankful for that.*

### SUPPORT PEOPLE NOT ALLOWED TO STAY (1%)

#### For a very small number of respondents not having their support people allowed to stay or being restricted to one support person at a time was not helpful.

*I only had my mum there because you're only allowed one support person, but I had 2 other support people, I wanted them to be with me also*

*We found when my aunty had chemotherapy there was not a lot of room to accommodate more than 1 support person and the rooms were very crowded with patients.*

## OTHER COMMENTS

#### One patient suggested having a support person present when you wake after surgery would be very comforting.

*If you can have a family member there ready beside your bed before you wake up that would be even better.*

#### There were a very small number of comments (3) about needing more regulation around the number of support people and visiting hours allowed.

*The idea of whānau, family and friends is a good idea and everybody in hospital needs support, but also comes with issues. (Some large groups) stay for hours making jokes and talking for hours on end...*

## Resolution to exclude the public from the meeting

### Recommendation

That in accordance with the provisions of Clauses 34 and 35, Schedule 4, of the New Zealand Public Health and Disability Act 2000 the public now be excluded from the meeting for consideration of the following items, for the reasons and grounds set out below:

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
1. Apologies		That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
2. Register and 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 07 December 2016	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]
4. Confidential Action Points 07 December 2016	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]

<p>5.1 Hospital Advisory Committee Forward Programme for 2017</p>	<p><b>Commercial Activities</b> To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]</p>	<p>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&amp;D Act 2000]</p>
<p>5.2 Hyperacute Stroke Service – Progress Report</p>	<p><b>Commercial Activities</b> To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] <b>Negotiations</b> Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]</p>	<p>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&amp;D Act 2000]</p>
<p>5.3 Auckland DHB Organisation Wide Certification Audit – Draft Report</p>	<p><b>Commercial Activities</b> To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] <b>Prejudice to Health or Safety</b> Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time [Official Information Act 1982 s9(2)(c)]</p>	<p>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&amp;D Act 2000]</p>
<p>6.1 Faster Cancer Treatment</p>	<p><b>Commercial Activities</b> Information contained in this report related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]</p>	<p>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&amp;D Act 2000]</p>
<p>6.2 Security for Safety</p>	<p><b>Prejudice to Health or Safety</b> Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time [Official Information Act 1982 s9(2)(c)] <b>Commercial Activities</b> Information contained in this report related to commercial activities and Auckland DHB would be prejudiced or</p>	<p>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&amp;D Act 2000]</p>

	<p>disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]</p> <p><b>Negotiations</b></p> <p>Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]</p>	
6.3 Food Services	<p><b>Commercial Activities</b></p> <p>Information contained in this report related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]</p> <p><b>Negotiations</b></p> <p>Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]</p>	<p>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&amp;D Act 2000]</p>
6.4 Reablement Services	<p><b>Commercial Activities</b></p> <p>Information contained in this report related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]</p> <p><b>Negotiations</b></p> <p>Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]</p>	<p>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&amp;D Act 2000]</p>
7.0 Quality Report	<p><b>Privacy of Persons</b></p> <p>Information relating to natural person(s) either living or deceased is enclosed in this report [Official Information Act s9(2)(a)]</p> <p><b>Prejudice to Health or Safety</b></p> <p>Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time [Official Information Act 1982 s9(2)(c)]</p>	<p>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&amp;D Act 2000]</p>

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