AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Open Board Meeting

Wednesday, 07 November 2018

10.30am

Note:

- **Open Meeting from 10.30am**
- **Public Excluded to follow**

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

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Published 1 November 2018

Agenda
Meeting of the Board
07 November 2018

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

Time: 10.30am

Board Members	**Auckland DHB Executive Leadership**	
Pat Snedden (Board Chair)	Ailsa Claire	Chief Executive Officer
Jo Agnew	Karen Bartholomew	Acting Director of Health Outcomes – Auckland and Waitemata DHBs
Doug Armstrong		
Michelle Atkinson	Margaret Dotchin	Chief Nursing Officer
Judith Bassett	Joanne Gibbs	Director Provider Services
Zoe Brownlie	Dame Naida Glavish	Chief Advisor Tikanga and General Manager Māori Health – ADHB/WDHB
Penelope Ginnen (Deputy Board Chair)		
Dr Lee Mathias	Dr Debbie Holdsworth	Director of Funding – ADHB/WDHB
Robyn Northey	Fiona Michel	Chief Human Resources Officer
Sharon Shea	Rosalie Percival	Chief Financial Officer
Gwen Tepania-Palmer	Meg Poutasi	Chief of Strategy, Participation and Improvement
	Shayne Tong	Chief Digital Officer
	Sue Waters	Chief Health Professions Officer
	Dr Margaret Wilsher	Chief Medical Officer
	Auckland DHB Senior Staff	
	Bruce Levi	General Manager Pacific Health
	Rachel Lorimer	Director Communications
	Auxilia Nyangoni	Deputy Chief Financial Officer
	Marlene Skelton	Corporate Business Manager
	(Other staff members who attend for a particular item are named at the start of the respective minute)	

Agenda

Please note that agenda times are estimates only

10.30am **1. ATTENDANCE AND APOLOGIES**

Board members Robyn Northey and Judith Bassett.
Executive Leadership Team members, Dame Naida Glavish, Chief Advisor Tikanga and General Manager Māori Health – Auckland and Waitemata DHBs and Shayne Tong, Chief Digital Officer.

2. REGISTER OF INTEREST 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?

3. CONFIRMATION OF MINUTES 26 SEPTEMBER 2018

10.35am **4. ACTION POINTS**

[Secretarial Note: Item 9.3 - Fit for Future evaluation results with a presentation from Trish Palmer is to be brought forward.]

11.00am	**5.**	**EXECUTIVE REPORTS**
	5.1	Chief Executives Report
	5.2	Health and Safety Report
	5.3	Human Resources Report
11.40pm	**6.**	**PERFORMANCE REPORTS**
	6.1	Financial Performance Report
	6.2	Funder Report
12.10pm	**7.**	**COMMITTEE REPORTS**
	7.1	Hospital Advisory Committee Referral Report
12.15pm	**8.**	**DECISION REPORTS**
	8.1	Disability Advisory Support Committee Membership
	8.2	Amendment to Committee Membership and Outside Appointments
12. 25pm	**9.**	**INFORMATION REPORTS**
	9.1	Diversity and Inclusion – Deep Dive
	9.2	Talent and Succession – Deep Dive
	9.3	Fit for Future evaluation results - Trish Palmer to present results [Given Trish's business commitments on Board day, this item will be taken at 10.35am]
12.40pm	9.4	SLM Quarterly Update
	9.5	2017 Research Report - A presentation in support to be made by M Wilsher)
1.00pm	**10.**	**GENERAL BUSINESS**
1.00pm	**11.**	**RESOLUTION TO EXCLUDE THE PUBLIC**

Next Meeting:	Wednesday, 19 December 2018 at 9:00am A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton

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Attendance at Board Meetings

Members	09 Aug. 17	20 Sept 17	01 Nov. 17	13 Dec. 17	28 Feb. 18	11 Apr. 18	23 May. 18
Lester Levy (Chair) ***(resigned 1/2/18)***	1	1	1	x	r	r	r
Joanne Agnew	1	1	1	x	1	1	1
Doug Armstrong	1	1	1	1	1	1	1
Michelle Atkinson	1	1	1	1	1	1	1
Judith Bassett	1	1	1	1	1	1	1
Zoe Brownlie	1	1	1	1	1	1	1
James Le Fevre (Deputy Chair) ***(resigned 16/4/18)***	x	1	1	1	1	1	r
Lee Mathias	1	1	1	1	1	1	1
Robyn Northey	1	1	1	1	1	1	1
Sharon Shea	1	x	1	1	1	1	1
Gwen Tepania-Palmer, Chair ***(Board Chair from 2/2/18)***	1	1	1	1	1	1	1
Key: 1 = present, x = absent, # = leave of absence, c = cancelled, resigned = r							

Members	04 Jul. 18	15 August 18	26 Sep. 18	07 Nov. 18	19 Dec. 18
Pat Snedden (Board Chair)	1	1	1		
Joanne Agnew	x	1	1		
Doug Armstrong	1	1	1		
Michelle Atkinson	1	1	1		
Judith Bassett	1	1	1		
Penelope Ginnen (Deputy Board Chair)	N/A	N/A	N/A		
Zoe Brownlie	1	x	1		
Lee Mathias	1	1	1		
Robyn Northey	1	1	1		
Sharon Shea	1	1	x		

Gwen Tepania-Palmer	1	1	1		

Conflicts of Interest Quick Reference Guide

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

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

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

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

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

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

IMPORTANT

If in doubt – declare.

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

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

Register of Interests – Board

Member	Interest	Latest Disclosure
Pat SNEDDEN	Director and Shareholder – Snedden Publishing & Management Consultants Limited Director and Shareholder – Ayers Contracting Services Limited Director and Shareholder – Data Publishing Limited Trustee - Recovery Solutions Trust Director – Recovery Solutions Services Limited Director – Emerge Aotearoa Limited and Subsidiaries Director – Mind and Body consultants Ltd Director – Mind and Body Learning & Development Ltd Shareholder – Ayers Snedden Consultants Ltd Executive Chair – Manaiakalani Education Trust Chair – National Science Challenge Programme – A Better Start Chair – The Big Idea – Not-for-profit-trust Director – Te Urungi o Ngati Kuri Ltd Director – Wharekapua Ltd Director – Te Paki Ltd Director – Ngati Kuri Tourism Ltd Director – Waimarama Orchards Ltd Chair – Auckland District Health Board Director – Ports of Auckland Ltd Board Member – Counties Manukau DHB Chair – Counties Manukau Audit, Risk and Finance Committee	9.10.18
Jo AGNEW	Professional Teaching Fellow – School of Nursing, Auckland University Casual Staff Nurse – Auckland District Health Board Director/Shareholder 99% of GJ Agnew & Assoc. LTD Trustee - Agnew Family Trust Shareholder – Karma Management NZ Ltd (non-Director, minority shareholder) Karma Food New Zealand LTD [50% shareholding, non-Director]	22.11.2017
Michelle ATKINSON	Evaluation Officer – Counties Manukau District Health Board Director – Stripey Limited Trustee - Starship Foundation Contracting in the sector	18.04.2018
Doug ARMSTRONG	Shareholder - Fisher and Paykel Healthcare Shareholder - Ryman Healthcare Shareholder – Orion Healthcare Trustee – Woolf Fisher Trust Trustee- Sir Woolf Fisher Charitable Trust Member – Trans-Tasman Occupations Tribunal Daughter – Partner Russell McVeagh Lawyers	18.09.2018
Judith BASSETT	Trustee - A+ Charitable Trust Shareholder - Fisher and Paykel Healthcare Shareholder - Westpac Banking Corporation Husband – Fletcher Building Husband - shareholder of Westpac Banking Corporation Granddaughter - shareholder of Westpac Corporation	19.09.2018
Zoe BROWNLIE	Programme Supervisor at Auckland Regional Public Health Service Member – PSA Union Board member - RockEnrol Partner – Youth Connections, Auckland Council	26.06.2018

	Partner – Aro Arataki Children's Centre Committee Son – Aro Arataki Childcare Centre	
Penelope Ginnen	Trustee – Emerge Aotearoa Trust Trustee – Emerge Aotearoa Housing Trust Director – Emerge Aotearoa Limited Director – Vaka Tautua Limited Trustee – Bruce Pulman Park Trust Trustee – Brainwave Trust Aotearoa Chairperson – Community Advisory Group to the Alcohol and Other Drug Treatment Court Member – Independent Advisory Group of Precision Driven Health Member of the Board – Auckland Philharmonic Orchestra	01.11.2018
Lee MATHIAS	Chair - Health Promotion Agency Chair - Health Innovation Hub (until the end of the Viclink contract in line with the director appointment) Chair – Medicines New Zealand Director/shareholder - Pictor Limited Director – Pictor Diagnostics India Private Limited Director - Lee Mathias Limited Director - John Seabrook Holdings Limited Trustee - Lee Mathias Family Trust Trustee - Awamoana Family Trust Trustee - Mathias Martin Family Trust Member – New Zealand National Party	29.08.2018
Robyn NORTHEY	Shareholder of Fisher & Paykel Healthcare Shareholder of Oceania Member – New Zealand Labour Party Husband - member Waitemata Local Board Husband – shareholder of Fisher & Paykel Healthcare Husband – shareholder of Fletcher Building Husband – Chair, Problem Gambling Foundation Husband – Chair, Community Housing Foundation	05.07.2017
Sharon SHEA	Principal - Shea Pita Associates Ltd Provider - Maori Integrated contracts for Auckland and Waitemata DHBs Provider – Hapai Te Hauora Board member – Alliance Health Plus Iwi Affiliations: Ngati Ranginui, Ngati Hine, Ngati Hako and Ngati Haua Sub-contractor - Te Ha Oranga/Te Runanga o Ngati Whatua Director – Healthcare Applications Ltd Husband - Part owner Turuki Pharmacy Ltd, Auckland Husband - Board member - Waitemata DHB Husband – Director Healthcare Applications Ltd	09.07.2018
Gwen TEPANIA-PALMER	Board Member - Health Quality and Safety Commission Committee Member - Lottery Northland Community Committee Chair - Ngati Hine Health Trust Life member – National Council of Maori Nurses Alumnus – Massey University Director – Hauora Whanui Limited Northland	26.04.2018

Minutes
Meeting of the Board
26 September 2018

Minutes of the Auckland District Health Board meeting held on Wednesday, 26 September 2018 in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton commencing at 9:30am

Board Members Present	**Auckland DHB Executive Leadership Team Present**	
Pat Snedden (Board Chair)	Ailsa Claire	Chief Executive Officer
Jo Agnew	Karen Bartholomew	Acting Director of Health Outcomes – AHB/WDHB
Doug Armstrong	Margaret Dotchin	Chief Nursing Officer
Michelle Atkinson	Joanne Gibbs	Director Provider Services
Judith Bassett	Dame Naida Glavish	Chief Advisor Tikanga and General Manager Māori Health – ADHB/WDHB
Zoe Brownlie	Dr Debbie Holdsworth	Director of Funding – ADHB/WDHB
Dr Lee Mathias	Rosalie Percival	Chief Financial Officer
Robyn Northey	Meg Poutasi	Chief of Strategy, Participation and Improvement
Gwen Tepania-Palmer	Dr Margaret Wilsher	Chief Medical Officer
	Auckland DHB Senior Staff Present	
	Rachel Lorimer	Director Communications
	Marlene Skelton	Corporate Business Manager
	Madeleine Willis	Corporate Board and Committee Administrator
	(Other staff members who attend for a particular item are named at the start of the minute for that item)	

1. ATTENDANCE AND APOLOGIES

That the apology of Board Member Sharon Shea be received.

That the apologies of Executive Leadership Team members Fiona Michel Chief Human Resources Officer, Shayne Tong, Chief of Informatics and Sue Waters, Chief Health Professions Officer be received.

2. REGISTER AND CONFLICTS OF INTEREST *(Pages 5-7)*

Pat Snedden asked that his interest register be amended by the addition of "Board Member, Counties Manukau DHB and Chair of the Audit, Risk and Finance Committee."

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

3. CONFIRMATION OF MINUTES 15 AUGUST 2018 (Pages 8-21)

Resolution: Moved Gwen Tepania-Palmer / Seconded Lee Mathias

That the minutes of the Board meeting held on 15 August 2018 be confirmed as a true and accurate record.

Carried

4. ACTION POINTS *(Page 22)*

There were no updates outstanding.

5. EXECUTIVE REPORTS

5.1 CHIEF EXECUTIVE'S REPORT *(Pages 23-33)*

Ailsa Claire, Chief Executive asked that the report be taken as read, advising as follows:

Prime Minister Jacinda Ardern announces $305 million in Facilities Funding

Prime Minister Jacinda Ardern, Minister of Health David Clark, and Director General of Health, Ashley Bloomfield visited Auckland DHB on 23 August to announce a $305 million investment to replace and upgrade critical infrastructure at Auckland City Hospital, Starship Hospital and Greenlane Clinical Centre.

Ailsa Claire acknowledged the work undertaken by Rosalie Percival, Chief Financial Officer and her team in getting this business case through every stage and to completion. It is one of the very few proposals that had gone through the process so swiftly. Positive comment had been forthcoming in regard to the quality of the business case.

Cartwright Inquiry - Apology

Auckland DHB marked the 30th anniversary of the Cartwright Inquiry by making the first formal organisational apology to all those who were adversely affected by these failures. Board Chair, Pat Snedden was filmed delivering the apology in the presence of Clare Matheson, who was one of the first patients to speak out about her experience at National Women's.

The Board noted with sadness, that since that meeting with Clair Matheson, she had passed away.

Hyper acute stroke service extended to metro Auckland

Following a successful pilot in partnership with St John Ambulance, our after-hours hyper acute stroke service has been extended to the full metropolitan Auckland region.

The new pathway selects patients who are most likely to be a candidate for an acute stroke intervention such as intravenous thrombolysis or percutaneous clot retrieval and transporting these patients directly to Auckland Hospital. Interventions can then be delivered much sooner after the onset of symptoms and significantly increase the chances of a complete recovery. The numbers of these patients coming through Auckland DHB has increased as a result.

Integrated Community Pharmacy Services Agreement

The integrated Community Pharmacy Services Agreement – which will take effect from 1 October 2018.

This has involved extensive consultation and engagement with the pharmacy sector,

consumer groups and other health bodies. Ailsa Claire acknowledged the contribution made by Tim Wood, Deputy Director of Funding in being instrumental in seeing this challenging consultation and engagement process through to a successful conclusion.

High number of patients in our hospitals

Auckland DHB is still experiencing record demand for hospital services, with more than 1,400 patients presenting to our adult emergency department (ED) in a single week.
Of concern too is the cardiac wait time. Discussions are being had with the Ministry of Health in relation to how to fund Ecmo separately.

The following point was covered in discussion:

- It was advised that excluding mental health, women and children the Auckland DHB has 720 adult beds. Currently everything is open and every space is being used. On Monday, 24 September 2018, the hospital had 730 adult patients in its care.

Equity at Auckland DHB – Staying Connected

Challenging conversation on the inequities in our health system and how we aim to address these issues in the coming year has been addressed at four recent Staying Connected sessions. Interest has been high and three extra sessions have been scheduled.

Recognising Diversity

Ailsa Claire drew attention to the new cultural competency courses and the Rainbow Diversity e-learning module outlined on pages 30 and 31 of the agenda.

Clinical Governance

Ailsa Claire drew attention to Professor Lesley McGowan this year's recipient of the Gluckman Medal for outstanding contributions to research and the visit by Jill Glendon, Acting Chief Nurse for the Ministry of Health who spent the day at Auckland DHB on 11 August. Jill's visit focused on the progress of our Releasing Time to Career programme.

Action

The Board asked that letters of appreciation and congratulation be sent to those staff members highlighted by Ailsa during the overview of her report.

Resolution:

That the Chief Executives report for September 2018 be received.

Carried

5.2 Health and Safety Report *(Pages 34-93)*

Rosalie Percival, Chief Financial Officer, in the absence of Sue Waters, Chief Health Professions asked that the report be taken as read highlighting that at the last Board meeting a change in format had been requested. As Sue Waters had been on leave this had yet to be addressed in full and further work was to be undertaken.

The following points were covered in discussion:

- Pat Snedden commented that if a Board member were to be looking for the

management of risk and opportunities for excellence it would be hard to identify when scanning the current reporting format. There is a need for commentary to accompany any metrics. Attention needs to be drawn to what management wants the Board to focus on.

- Disappointment was expressed that the Lone Workers project, as described on page 52 of the agenda, was still not completed, or that the work assessment for Lone Workers still appeared to be in progress, as reported on page 53 of the agenda. Ailsa Claire advised that the pilot for Lone Workers had to be concluded and that it had been identified that a technology solution would address many of the issues raised.
- It was commented that the LTIFR rate appears to be becoming imbedded at its current level. Ailsa Claire advised that there was work being done with ACC to address this problem.
- There was a general discussion around AON Insurance and the mechanism for funding of accidents occurring on Auckland DHB property.
- Zoe Brownlie noted that the health and safety induction levels were still sitting at 70% and was advised that a significant proportion of the outstanding number related to staff who were rotational RMO's and that this was being addressed with other regional DHBs, with contract documentation being reviewed to carry a requirement for this training.

Resolution:

That the Board:

1. **Receives the Health and Safety Performance report for August 2018.**
2. **Endorses reporting of progress.**

Carried

5.3 Human Resources Report *(Pages 94-97)*

Ailsa Claire in the absence of Fiona Michel, Chief Human Resources Officer asked that the report be taken as read drawing attention to:

- Talent Placement and specifically the implementation of State Services Commission Talent and Leadership programme
- Making it easier to work here, as outlined on pages 95-96 of the agenda acknowledging some of the key pieces of work that had been and were to be undertaken in support of this initiative.
- Ailsa also referred to the learnHR programme and a talk to be given in relation to what it is like to be recruited as a Maori or Pasifika person.

There were no questions.

Resolution:

That the Board:

1. **Receives the Auckland DHB Human Resources report for September 2018.**
2. **Notes progress on Auckland DHB People Strategy commitments.**

Carried

6. PERFORMANCE REPORTS

6.1 Financial Performance Report *(Pages 98-104)*

Rosalie Percival, Chief Financial Officer asked that the report be taken as read advising that:

- The financial performance for the year to date (YTD) shows a net deficit of $9.3M which is unfavourable to the budgeted deficit of $5.3M by $3.9M. The budget is still affected by a large revenue impact attributable to the loss of activity due to the nurse's strike.
- The clinical supplies area is also showing $1.7M (-3.5%) unfavourable variance driven by variations in volume and usage of clinical consumables, mainly in Opthalmology due to new drugs introduced by Pharmac, Paediatric Haematology due to higher pharmaceuticals costs and in Clinical support costs.

The following points were covered in discussion:

- Advice was given that the hospital was at capacity with acute patients from the Auckland population which impacted on the ability to deliver elective services and IDFs and thus made reversing the deficit in the revenue position problematic. 50% of the revenue is driven by activity from tertiary services. It also needed to be noted that if more IDFs had to be delivered than funded for then the hospital was morally bound to do so.
- A discussion was had and advice provided in relation to the type of real time data that the Chief Financial Officer and Executive leadership Team had at their disposal to monitor the financial situation on a day-by-day and week-by-week basis. Ailsa Claire cautioned that the indicators were showing that recovery following the revenue impact of the nurse's strike was becoming more problematic due to increased acute activity. Rosalie Percival advised that in general, over a period of time, the swings and roundabouts in the financial position enabled a recovery to be managed however; the volumes experienced in the acute area over the last two months, should they persist, would make this recovery more difficult.

Resolution:

That the Board receives this Financial Report for the two months ended August 2018

Carried

6.2 Funder Report *(Pages 105-126)*

Debbie Holdsworth, Director, Funding asked that the report be taken as read and to note that:

- Trish Palmer – Manager of the Mental Health and Addictions Funding team has resigned, and that this will be a loss due to her significant contribution to the organisation. There is a large work programme in mental health and the team are working on preparation for the outcome of the mental health enquiry.

Karen Bartholomew drew attention to:

- The Maori health pipeline projects which are now making good progress. These are specific projects designed to advance Maori health gain, and we will continue to update progress to the Board.

The following points were covered in discussion:

- Antenatal vaccination coverage important improvements over time in all DHBs, with Auckland DHB performing the best. It was noted that there remains an equity gap in access to antenatal vaccination, and it is important to focus on coverage for Maori and for Pacific women to close that gap. Auckland DHB has established a vaccinator role in antenatal clinics which is an important additional strategy to the primary care quality improvement work in this area.
- There was discussion on the reason for improvement in the antenatal vaccination indicator and Karen noted the criticality of the data – there is no national indicator data available as there has not previously been a way to identify a cohort of pregnant women (until after birth). Through the System Level Measures (SLM) work programme the unique data work had been undertaken to allow the offer of antenatal vaccination in pregnancy through primary care. The creation and use of this data, supported by general practice level quality improvement was key to the success.
- Debbie Holdsworth noted that the importance of data use to improve services was also seen in relation to the example of the National Child Health Information Platform (NCHIP). NCHIP allowed any healthcare practitioner to know who last had contact with a child and for what purpose, and to offer it an intervention if it had been missed.
- It was noted that appropriate procurement processes were in place regarding the radiotherapy outsourcing.
- Advice was given that the Northland DHB cardiac laboratory service was a planned change in access to service. The focus in Auckland is now on managing any stranded cost as well as the smooth transition of the service.
- Gwen Tepania-Palmer commented on the need for value based outcomes and the need to obtain robust data for good analytics to occur. She felt the team were doing well in continuing to address gaps in this area.
- In answer to a question from the Board Chair, Pat Snedden, about what success in 12 months would look like for the use of data and improvement in the SLM programme, advice was given that the increasing ability to routinely and systemically provide and use data would align with the evolution of the programme to focus on a smaller

number of concrete activities that are equity focused, and we would see real change in those indicators.

Resolution:

That the Board note the key activities within the Planning, Funding and Outcomes Unit since the last update provided on 15 August 2018.

Carried

7. COMMITTEE REPORTS

7.1 Hospital Advisory Committee Referral Report *(Pages 127-142)*

The Chair of the Hospital Advisory Committee, Judith Bassett, asked that the report be taken as read highlighting the following areas:

- The after-hours hyper acute stroke service extension to the full metropolitan Auckland region
- The regional cooperation and initiative entered into with Waitemata and Counties Manukau DHBs for the local delivery of chemotherapy for women with breast cancer that will enable services to be delivered closer to the home of the patient.

Resolution: Moved Judith Bassett / Seconded Gwen Tepania-Palmer

That the Hospital Advisory Committee unconfirmed minutes of the meeting held on 5 September 2018 be received.

Carried

8. DECISION REPORTS

8.1 Appointment to healthAlliance NZ Limited Board of Directors *(Pages 143-145)*

Rosalie Percival, Chief Financial Officer asked that the report be taken as read.

There were no questions.

Resolution: Moved Doug Armstrong / Seconded Jo Agnew

That the Board:

1. **Approve the appointment of Dr Andrew Brant as a Class A shareholder director of healthAlliance NZ Limited, replacing Mr Russell Jones who was appointed in June 2016**
2. **Approve the appointment of Mr Russell Jones as an independent director of healthAlliance NZ Limited, replacing Mr Paul Harper**
3. **Approve the appointment of Mr Clayton Wakefield as an independent director of healthAlliance NZ limited, replacing Mr David Clarke.**
4. **Delegate authority to the DHB's Chair to execute all documentation necessary to formalise the appointment of Dr Andrew Brant as a Class A shareholder director, Mr Russell Jones as an independent director of healthAlliance NZ Limited and Mr Clayton Wakefield as an independent director of healthAlliance NZ Limited.**

Carried

8.2 Review of Appointments to Committee Structure *(Pages 146-148)*

The Board Chair, Pat Snedden advised that this was a procedural matter to address vacancies on Committees. There being no questions resolutions one to three were put together.

Resolution: Moved Lee Mathias / Seconded Judith Bassett

That the Board:

1. **Receives the Review of Appointments to Committee Structure report dated September 2018**
2. **Approves the appointment of Gwen Tepania-Palmer to the Finance, Risk and Assurance Committee**
3. **Approves the appointment of Michelle Atkinson as Deputy Chair of the Hospital Advisory Committee**

Carried

Pat Snedden provided additional information in regard to the position of Deputy Board Chair relaying that he had been in contact with the Ministry of Health and had been advised that this matter was to be put to Cabinet this week and that a decision would be forthcoming.

Zoe Brownlie raised the issue of her appointment to the Human Resources Sub-Committee pointing out that this needed to be endorsed by the Board also. A further resolution was put appointing Zoe Brownlie to the Human Resources Sub-Committee.

Resolution: Moved Pat Snedden / Seconded Lee Mathias

4. **That the Board approves the appointment of Zoe Brownlie to the Human Resources Sub-Committee.**

Carried

8.3 Regional Advisory Committee *(Pages 149-152)*

The Board Chair, Pat Snedden advised that he would deal with the two advisory committees separately.

Manawa Ora

Pat Snedden advised that there was a need to pause and have a conversation with the Ngati Whatua Runanga before proceeding.

The following points were covered in discussion:

- Concern was expressed that the iwi from the Counties Manukau area did not appear to be fully engaged with this proposal. While many conversations had been had and work begun, they were not yet at the same place as the iwi for Auckland and

Waitemata DHB were.

- Pat Snedden reminded members that when the idea of these regionally combined advisory committees was first conceived, the thinking was at a particular level from which it had now moved forward. The process for engagement needed to be readdressed in light of this.
- Doug Armstrong asked whether the Auckland DHB was now in a position of being inhibited from having meetings because the third party was not as well as advanced as Auckland and Waitemata DHBs and was advised by the Board Chair that this issue would be addressed by the various Runanga's involved.

Disability Support Advisory Committee

Pat Snedden advised that the setting up of this committee now rested with the various committee chairs.

Ailsa Claire added that at a recent Community and Public Health Advisory Committee meeting discussion had taken place regarding the forging a closer alliance between the Community and Public Health Advisory Committee and the Disability Support Advisory Committee. There was an evident overlap with the type of work undertaken by the two advisory committees and the Funder team was attempting to service both committees.

Gwen Tepania-Palmer offered to continue to provide assistance to Jo Agnew in getting the new regional Disability Support Advisory Committee up and running keeping in mind that this was a new government with a different view and approach to these issues.

Resolution: Moved Pat Snedden / Seconded Jo Agnew

That the Board:

1. **Receives the Regional Advisory Committees report dated September 2018**
2. **Notes the creation of a combined Maori Health Gains Advisory Committee**
3. **Notes that Gwen Tepania-Palmer and Jo Agnew will work with management to have in place the required process and people to set up the new regional Disability Support Advisory Committee.**

Carried

9. INFORMATION REPORTS

9.1 Organisational Culture – Deep Dive *(Pages 153-157)*

This item was withdrawn due to the unavailability of Fiona Michel, Chief Human Resources Officer to present and answer questions. It is to be considered at the 7 November 2018 Board meeting.

9.2 Auckland DHB Engagement Survey 2018 *(Pages 158-159)*

Ailsa Claire in the absence of Fiona Michel, Chief Human Resources Officer asked that the report be taken as read advising that it was the intent to repeat the survey that was first

undertaken in 2016 with the aim of obtaining a minimum of 75% participation.

There were no questions.

That the Board:

1. Receives the Auckland DHB Engagement Survey update report for September 2018.
2. Notes the Auckland DHB Engagement Survey progress.

Carried

9.3 Statement of Performance Expectations (SPE) Performance Report: Quarter Four 2017/2018 *(Pages 160-169)*

Karen Bartholomew, Acting Director of Health Outcomes – Auckland and Waitemata DHBs asked that the report be taken as read.

Karen clarified that this report provided a consolidated and more regular view of indicators that appeared within the Annual Plan and Annual Report. The detail pertaining to these indicators is covered at various advisory committees reporting and discussion.

The following points were covered in discussion:

- Comment was made that the cervical screening research that is being undertaken by Karen herself was a very positive move. Ailsa Claire added that breast and cervical screening was a very important concern particularly for Maori.
- It was noted on page 163 of the agenda that the enrolment rate for Maori and associated trend line appeared to be showing a very small improvement. A discussion was had around enrolment and what was known about why it was below target. It was advised that enrolment levels had been low for many years and that there was a specific project in the Maori Health Pipeline, matching Maori Provider and primary care data, to identify gaps. This has not been done before and will be an important way to understand the gap. It was noted that there are data issues with the indicator, including the census data and that a significant number of patients changed their practice or the practice itself moved PHOs.

Resolution: Moved Pat Snedden / Seconded Lee Mathias

That the Statement of Performance Expectations (SPE) Performance Report: Quarter Four 2017/18 Report be received.

Carried

10. GENERAL BUSINESS

At the beginning of the meeting the Board Chair, Pat Snedden advised members that there was an item of extraordinary business to be considered and that he required them to pass a resolution to allow consideration and a decision to be made.

Resolution: Moved: Pat Snedden / Seconded Gwen Tepania-Palmer

In accordance with Standing Order 3.2.9 (5) the Board agrees to consider the item *2018-2019 Annual Plan.*

This item is required to be considered under urgency as the Ministry of Health have indicated that they may require the 2018-2019 Annual Plan to be submitted by District Health Boards within the month. This would occur before the next Board meeting to be held on 7 November 2018 and provision needs to be made so that the final version of the 2018-2019 Annual Plan can be approved, signed and submitted.

Carried

10.1 2018-2019 Annual Plan

Board Chair, Pat Snedden asked that the tabled report [Attachment 10.1] be taken as read.

Resolution: Moved Doug Armstrong / Seconded Lee Mathias

That the Board give delegated authority to the Board Chair and the Chief Executive Officer to approve and sign off the final version of the 2018-2019 Annual Plan.

Carried

11. RESOLUTION TO EXCLUDE THE PUBLIC *(Pages 170-173)*

Resolution: Moved Pat Snedden / Seconded Lee Mathias

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

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
1.Apologies		
2. Register of Interest 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 15 August 2018	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

4. Confidential Action Points	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4.1 Pedestrian Safety Grafton and Greenlane		That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.1 Risk Management – Board Update	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time [Official Information Act 1982 s9(2)(k)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.1 Chief Executives Confidential Report	**Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)] **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time [Official Information Act 1982 s9(2)(k)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.1 Human Resources Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Negotiations**	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 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)]	
8.1 Finance, Risk and Assurance Committee Referral Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.2 Hospital Advisory Committee Referral Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	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]
9.1 2018/2019 Budget Related Risks	**Obligation of Confidence** Information which is subject to an express obligation of confidence or which was supplied under compulsion is enclosed in this report.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.2 Philips Service Agreement	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.3 2017/2018 Annual Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	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]
10.1 People Dashboard – Discussion Paper	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which

	information was made public [Official Information Act 1982 s9(2)(i)]	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]
11.1 Employment Relations – Deep Dive	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
11.2 Orthopaedic Update	**Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)] **Prejudice to Health or Safety** Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
12 General Business	N/A	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

Carried

The meeting closed at 2.10pm.

Signed as a true and correct record of the Board meeting held on Wednesday, 26 September 2018

Chair: _____ Date: _____

Pat Snedden

Action Points from 26 September 2018 Open Board Meeting

As at Wednesday, 07 November 2018

Meeting and Item	Detail of Action	Designated to	Action by
Item 5.1	**Letters of Appreciation** The Board asked that letters of appreciation and congratulation be sent to those staff members highlighted by Ailsa during the overview of her report.	Corporate Business Manager	Completed

Chief Executive's Report

Recommendation

That the report be received.

Prepared by: Ailsa Claire (Chief Executive)

1. Introduction

This report covers the period from 8 September – 19 October. It includes an update on the management of the wider health system and is a summary of progress against the Board's priorities to confirm that matters are being appropriately addressed.

2. Events and News

2.1 Notable visits and programmes

20 years of Liver Transplants at Auckland DHB

Twenty years ago the first Liver transplant was carried out in New Zealand. Professor Stephen Munn has been with our New Zealand Transplant Unit since it opened performing the very first life-saving procedure and recently completed his 800th live transplant.

To mark the occasion recipients of liver transplants, came together with clinicians to celebrate life and the remarkable difference that has been made to so many over the last 20 years. The event was reported on by TVNZ.

Blue Coats celebrate their 15 year anniversary

Blue Coat volunteers provide an incredible service to the patients, families and whānau who visit our hospitals each year. They give much more than a warm greeting and help to people finding their way; they offer the 'human touch', with genuine care and our value of respect – Manaaki.

Lindy Lely, Manager Volunteering, with June Weir, one of the Blue Coat

From marriage proposals to offers of dinner and ice cream, our Blue Coats have been thanked by patients in some creative ways. It was fitting to mark 15 years of Blue Coat service with a celebratory lunch at the Marion Davis Library on 25 September. The event was attended by many of the original Blue Coats from 2003 who are still volunteering.

Our volunteers are a vital team that help us to have a positive impact on our community. Our Blue Coat volunteers bring a lifetime of experience, patience, people skills, encouragement and warm smiles at a time when our patients and visitors need additional care and kindness. Their efforts to make every person feel welcomed to our organisation have helped us to provide world-class healthcare with a The Blue Coats were thanked by Gwen Tepania-Palmer, Board representative; Meg Poutasi, Chief of Strategy, Participation and Improvement; Suzanne Corcoran, Director of Participation and Experience; and Lindy Lely, Manager Volunteering.

2.2 Health sector partnerships

Long Term Investment Plan for the future of healthcare in the Northern Region

The first Northern Region Long Term Investment Plan was published in October. This is the first time the regional DHBs have worked together to develop a formal joint vision for the future of healthcare. The Plan focuses on the impact population growth will have on the healthcare system over the next 20 years.

Phase one of the plan is for remediation work required to ensure our current buildings are fit for purpose and to address the current maintenance backlog. At Auckland DHB this is helped by the $305 million investment announced this year.

The plan also identifies that the Northern Region will need approximately 1,600 extra hospital beds in the next 20 years and outlines options for increasing hospital capacity. This

includes the development of current hospital sites and the potential for building additional hospitals in the region.

This plan marks the ongoing collaboration across the region and with Government.

Introducing the Āke Āke app

In September the Āke Āke app was launched. The app, which helps with Te reo Māori pronunciation, protocol and waiata, is a first for Auckland and Waitemata DHBs. Our employees are encouraged to download the app to help when leading, or being part of discussions that involve Māori communities.

The app is available on iOS and Android.

2.3 Patients and community

2.3.1 Email enquiries

Communications manages a generic communication email box, responding to all emails and connecting people to the correct departments. For this period, 466 emails were received. Of these emails, 47 were not communications-related and where appropriate, were referred to other departments and services at Auckland DHB.

2.3.2 Patient experience

Here is just one example of the great things our patients and communities say about the care our people provide:

"I still find it hard to express all that you did for me when I was a heart surgery patient. I am now a fit and healthy man, I work two jobs and I'm enjoying life as much, if not more, than I ever have.

"I don't know if surgeons, doctors, nurses and student nurses very often think of the magical way they can change the lives of their patients, but as one of them, I can tell you that few days pass without me thinking about that and not a day passes when I am not infinitely grateful to them. A 'heartfelt' thank you for everything you did while I was with you! – E.

2.4 External and internal communications

2.4.1 External

We received 107 requests for information, interviews or for access from media organisations between 8 September and 19 October 2018. Media queries included various enquiries about the shortage of Anaesthetic Technicians, a request for comment on planned industrial action by our Clinical Perfusionists, proactive coverage of the Liver Transplant Unit's 20 year anniversary and the Northern Region's Long Term Investment Plan.

Approximately 9 per cent of the enquiries over this period sought the status of patients admitted following road accidents and other incidents, or who were of interest because of their public profile.

The DHB responded to 26 Official Information Act requests over this period.

2.4.2 Internal

- 45 news updates were published on Hippo, the DHB intranet.
- Six editions of 'Our News', the weekly email newsletter for all employees, were distributed.
- Seven 'Staying connected – Equity' sessions were held – Roadshows with CE Ailsa Claire with Chair Pat Snedden attending some of the events.
- The October/November issue of Nova was published.
- Three CEO blogs were published:
    - Mental health and the importance of looking after ourselves and each other
    - Meeting the needs of our people through the Youth Health Improvement Hub and taking part in the Rainbow Tick focus groups
    - Equity, including the recent Auckland Homeless Count

2.4.3 Events and campaigns

Recycle Week, 15-19 October

Tūhono (together) was the theme for recycle week this year, as we marked how we can take better care of our environment collectively.

We ran an exhibition stand on Level 5 at Auckland City Hospital to highlight what we are doing to reduce our waste to landfill in our clinical and non-clinical areas.

Over seven languages featured in our Recycle Week video.

Along with some of our partner organisations, we shared useful hints and tips on how to reduce your carbon footprint at work and home.

A video of top tips in different languages was produces as a creative way to help our people think about the different ways they can take care of the environment while at work.

Mental Health Awareness Week, 8-12 October

Our people work in a really busy environment doing an amazing job of looking after our patients and community. Mental Health Awareness Week provided us with a great opportunity to remind our people to look after themselves and each other.

We marked Mental Health Awareness Week with a number of events – from chair yoga, mindfulness sessions, and Zumba. There were also a wide range of resources available at information stands across our Auckland City Hospital and Greenlane sites.

The theme for Mental Health Awareness Week was 'Let nature into your workplace.' We encouraged people to nominate teams or individuals who they thought would like a little bit of nature brought to them, these people received a small plant.

Cyber Smart Week, 8-12 October

We marked Cyber Smart week by encouraging all our people to do three simple things to reduce their cyber security risks both at work and at home:

- make passwords long and strong
- think before clicking on suspicious links and attachments
- connect with care – only use secure USBs.

Auckland Transport free 2-wheeler safety check

Auckland Transport provided free check-ups of 'two wheeler' vehicles – bicycles, scooters, motorcycles and any other two wheeled vehicles people have.

There was plenty of take up for the free safety check-ups. Events like these are one of the ways we can help to promote transport alternatives to cars.

Restart a Heart Day

On Thursday 18 October we marked World Restart a Heart Day to help create awareness around how we can all help save a life. People could find out where defibrillators are located in their community and learn how to perform CPR at the Information Stand at Auckland City Hospital.

2.4.4 Social Media

Followers

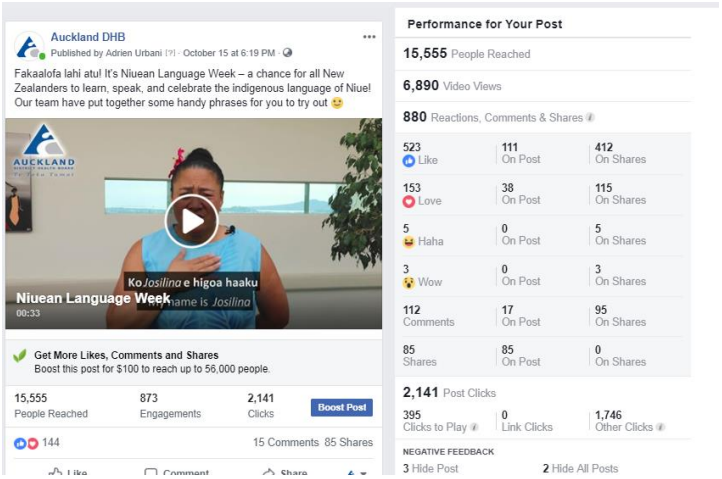
LinkedIn: 9021

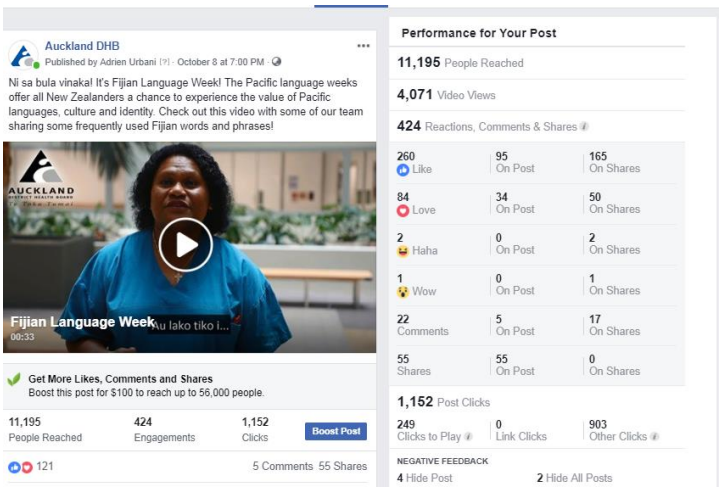
Facebook: 6845

Twitter: 5721

Instagram: 534

Top posts and statistics





Auckland DHB
Published by Adrien Urbani [?] · October 2 at 6:30 PM ·

Meet Mero, another one of our Long Service award recipients, who we are lucky to have on our team! Mero joined our team in 1996 as a Kaiatawhai at Starship Hospital, and since then has been helping to ensure that our Māori patients and whānau are cared for, supported, and heard.

In addition to supporting our patients, Mero's taken part in and supported most of our powhiri and whakatau, and blessings of our hospital grounds.
#ADHBpeople

Performance for Your Post

9,041 People Reached

884 Reactions, Comments & Shares

452 Like	186 On Post	266 On Shares
233 Love	94 On Post	139 On Shares
5 Wow	0 On Post	5 On Shares
156 Comments	85 On Post	71 On Shares
41 Shares	41 On Post	0 On Shares

1,471 Post Clicks

245 Photo Views	0 Link Clicks	1,226 Other Clicks

NEGATIVE FEEDBACK

1 Hide Post	1 Hide All Posts
0 Report as Spam	0 Unlike Page

Reported stats may be delayed from what appears on posts

Auckland DHB
Published by Adrien Urbani [?] · September 13 ·

We along with Waitemata District Health Board are thrilled to announce free te reo classes for our employees thanks to a new partnership with Te Whare Wānanga o Awanuiārangi!

Dr Te Kani Kingi, pictured here with our rangatira Dame Naida Glavish, made the announcement yesterday.

The free, on-site classes will run over the course of 18 months and include language used in everyday healthcare. Stay tuned for details!
#TeWikiOTeReoMāori

Performance for Your Post

7,083 People Reached

367 Reactions, Comments & Shares

233 Like	143 On Post	90 On Shares
60 Love	42 On Post	18 On Shares
4 Wow	3 On Post	1 On Shares
49 Comments	40 On Post	9 On Shares
21 Shares	21 On Post	0 On Shares

759 Post Clicks

85 Photo Views	0 Link Clicks	674 Other Clicks

NEGATIVE FEEDBACK

4 Hide Post	1 Hide All Posts
0 Report as Spam	0 Unlike Page

Reported stats may be delayed from what appears on posts

2.5 Our People

Allied Health Scientific and Technical Awards 2018

In October we celebrated with the diverse workforce that makes up Allied Health, Scientific and Technical – at the annual Awards evening. More than 100 nominations were received for the awards and 22 awards were presented on the evening. It was a great opportunity to hear about some of our people who are aiming high and doing some amazing things for our patients and communities.

Celebrating with our Award winners.

Long Service Awards

We are fortunate to have so many people at Auckland DHB who chose to spend a huge chunk of their careers with us. At the annual Long Service Awards in September we celebrated with some of the amazing people who reached the milestones of 20, 30 and 40 years' service at Auckland DHB. Reaching these milestones is a very special occasion, and the awards are a great opportunity to celebrate our people's dedication and commitment.

Local Heroes

There were 18 people nominated as local heroes during September. The nominations were of such a high calibre that we have two September Local Heroes.

The first September Local Hero is **Zoe Etches, Clinical Midwife Advisor**.

Zoe was nominated by a senior house officer, who had the flowing to say:

"Every shift, Zoe works tirelessly to support the midwives, nurses, and doctors on level 9 and Tamaki. Zoe is constantly available for advice, assistance, and support.

Zoe Etches with Jo Gibbs, Director Provider Services

"No task is insurmountable for her, she responds calmly and professionally to everything. From doing an ECG, to a tricky CTG, to managing a massive post-partum haemorrhage or patient who is coding, Zoe can do it all.

"It is so reassuring when I know she is on call, because I know that the patients are in safe hands. As a house officer she was so supportive to me. I know people like her are rare and precious gems to a department. Her selflessness, professionalism, competence, and skill have made her an invaluable member of level 9. Everyone I talk to agrees."

The second September Local Hero is **Matua Patrick Taylor**, here's what is nomination said:

"Matua Patrick continuously goes above and beyond the call of duty for whānau, patients, nursing and medical staff within the Department of Critical Care Medicine.

"With his calm, gentle and professional manner he is able to provide exceptional support to whānau during some of their most difficult and vulnerable times.

"He has been known to come in at all hours of the day and night to attend whānau meetings, karakia and to also provide the nursing and medical staff with immeasurable support during some very challenging times. We are very privileged to have the services of Matua Patrick within our department. We thank him for all he does for our patients, whānau and the multi-disciplinary team."

Matua Patrick Taylor with Marg Dotchin, Chief Nursing Officer

2.5.2 Recognising Diversity

Te Wiki o Te Reo Māori – Celebrating Māori Language Week

At Te Toka Tumai Auckland DHB we celebrated Te Reo Māori with the rest of Aotearoa New Zealand during Te Wiki o Te Reo Māori.

This year's theme was 'Kia ora te reo Māori', which plays on our national greeting "kia ora" and means literally, 'Let the Māori Language live.'

The week was a chance to acknowledge and celebrate the Māori language as a unique cultural taonga (treasure) for all New Zealanders, and to make sure te reo is alive and vibrant for future generations to enjoy. This national celebration also ties into our new initiative to further promote respect for and celebrate our diversity.

During the week we encouraged our people to celebrate Māori Language week by:

- ing people with kia ora in your daily kōrero (conversations)
- Learning the daily kupu (word) presented by the Ako Ako girls.
- Joining one of the te reo pronunciation and waiata workshops.

Events were well attended and were an important part of building cultural awareness and building te reo Māori skills.

Our people learning putiputi harakeke (flax weaving).

Celebrating Pasifika Language Weeks

We celebrated Tuvaluan, Fijian and Niuean Language Weeks.

Staff were encouraged to learn a new word or phrase that they can use at work with videos featuring our employees from Auckland DHB and Waitematā DHB.

Our popular Fijian language week video.

Our Niue language week video.

Rainbow Tick Focus Groups

At Auckland DHB we celebrate the diversity we have in our team and in the population we serve, and as part of this we are working towards becoming Rainbow Tick certified. The Rainbow Tick is awarded to organisations that understand, value, and welcome sexual and gender diversity.

We invited employees to share their ideas, questions and observations about diversity and inclusion at three focus groups held across our sites. The Rainbow Tick will help us measure and improve to make sure this is a great place to work for all our employees.

We're proud to recognise the diversity we have in our team and in the community we serve.

3. Performance of the Wider Health System

3.1 National Health Targets Performance Summary

	Status	Comment
Acute patient flow (ED 6 hr)		Sep 88%, Target 95%
Improved access to elective surgery (YTD)		89% to plan for the year, Target 100%
Faster cancer treatment		Sep 95%, Target 90%
Better help for smokers to quit: • Hospital patients • PHO enrolled patients • Pregnant women registered with DHB-employed midwife or lead maternity	  	Sep 93%, Target 95% Jun Qtr 92%, Target 90% Jun Qtr 92%, Target 90%
Raising healthy kids		Sep 100%, Target 95%
Increased immunisation 8 months		Sep Qtr 95%, Target 95%

Key:	Proceeding to plan		Issues being addressed		Target unlikely to be met	

4. Financial Performance

The 2017/18 year end audit is now complete and the final 2017/18 Annual Report has been presented to the Board for approval before being submitted to the Ministry of Health on 31 October 2018. There has been no change post-audit to the result previously advised to the Board at year end: a surplus of $1.012M against a budgeted breakeven position. The 2018/19 Annual Plan was completed and approved by the Board on 25 October 2018. This included a breakeven financial plan for 2018/19 and the three out-years.

The result for the year to date period ending 30 September 2018 is a deficit of $7.2M against a budgeted deficit of $925k ($6.3M unfavourable). The result is made up of a Provider arm deficit of $15M (unfavourable to budget by $8M), partially offset by a Funder Arm surplus of $7M, favourable to budget by $1M and a Governance Arm surplus of $617k, favourable to budget by $648k. The overall unfavourable position in the Provider arm is revenue driven, with revenue recognised lower than budget due to volume under delivery for electives and IDFs. Volumes delivered were impacted by the NZNO strike earlier in the year, plus ongoing capacity issues for elective surgery delivery which is also impacted by acute volumes.

4. Clinical Governance

4.1 Health Research Council awards Beaven and Liley medals

Congratulations to two Auckland DHB clinicians who were recognised by the Health Research Council of New Zealand for their outstanding research.

Beavan Medal for ICU research

Dr Colin McArthur, clinical researcher and intensive care specialist, was awarded the Beavan Medal – the highest honour from the Health Research Council – for his success in driving ICU research in New Zealand and inspiring other clinicians.

Prior to 1994 and Dr McArthur joining the Australia and New Zealand Intensive Care Society Clinical Trials Group, there was little clinical research in New Zealand ICUs.

Dr McArthur says the Medal acknowledges not just me and the many others involved, but also that intensive care research is a strong player in the clinical research space.

Beavan Medal recipient Dr Colin McArthur.

Liley Medal for fertility treatment breakthrough research

Professor Cindy Farquhar, consultant clinician at Fertility Plus and Womens Health received the prestigious Liley medal for her study into Intrauterine Insemination (IUI).

Professor Farquhar's research showed that IUI – a less invasive and cheaper alternative to IVF – was three times more effective than where couples try to conceive naturally around likely times of ovulation.

Health Research Council Chief Executive, Professor Kath McPherson, noted that Professor Farquhar's study has provided evidence in a field where less invasive, more successful, and more affordable treatment options are very much needed.

Liley Medal recipient Professor Cynthia Farquhar.

Fellowship for Clinical Director, Anil Nair

Congratulations to Dr Anil Nair, Clinical Director, Emergency Department (Adult), who is now a Fellow of the Australasian College of Health Service Management (ACHSM) and the New Zealand Institute of Health Management (NZIHM) Fellowship is awarded to people who have demonstrated to their peers that they have the knowledge, attitudes, conceptual and communication skills to be recognised as senior managers and leaders in the health and aged care sectors.

Fellowship is the highest membership category and it is recognised both nationally and internationally.

Remembering Dr Fiona Wu

Dr Fiona (Tzou Fen) Wu, Consultant Diabetologist at Auckland DHB, sadly passed away in October. Fiona was a very well regarded as a physician and colleague.

Fiona graduated from Auckland Medical School in 1992 and became a Fellow of the Royal Australasian College of Physicians, specialising in Endocrinology in 2000. In 2001, she undertook the prestigious Nuffield Medical Fellowship at the University of Oxford, obtaining a Doctor of Philosophy Degree in 2007.

Fiona returned to Auckland in 2011, to the post of Consultant Diabetologist at Auckland DHB.

Fiona was an asset to the Diabetes service providing a depth and breadth of knowledge and support to her colleagues. She was well regarded by her patients, providing up to date evidence-based medicine to optimise their outcomes.

Fiona was a loved and much respected member of the Auckland DHB team and she is sorely missed.

Health and Safety Performance Report

1.Recommendation

That the Board:

1. **Receives the Health and Safety Performance report for September 2018.**
2. **Endorses reporting of progress.**
3. **Identifies any further format or reporting changes required to the performance report.**

Prepared by: Nick Engelmann, Director Occupational Health and Safety AUCKLAND DHB
Endorsed By: Sue Waters, Chief Health Professions Officer

Glossary

BBFA	Blood and/or Body Fluid Accident
EY	Ernst and Young Limited
HSR	Health and Safety Representative
HSWA	Health and Safety at Work Act (2015)
LTI	Lost Time Injury (work injury claim)
MFO	Medical Fees Only (work injury claim)
MOS	Management Operating System
PCBU	Person Conducting a Business or Undertaking
PES	Pre-employment Health Screening
SMS	Safety Management System
SPEC	Safe Practice Effective Communication (SPEC)
SPIC	Safe Practice in the Community
YTD	Year to date
A/A	As Above

1.1 Board Strategic Alignment

Community, whanau and patient-centred model of care	*Supports Patient Safety, workplace safety, visitor safety*
Emphasis and investment on both treatment and keeping people healthy	*This report comments on organisational health information via incidents, health monitoring and leave information.*
Service integration and consolidation	*This report details mandatory workplace safety audit results and reports findings and updates to the Finance risk and Assurance committee*
Intelligence and insight	*The report provides information and insight into workplace incidents and what Auckland DHBis doing to respond to these and other workplace risks.*
Consistent evidence-informed decision-making practice	*Demonstrates Integrity associated with meeting ethical and legal obligations*
Outward focus and flexible, service orientation	*Health, safety and wellbeing risks and programmes are inherently focused on staff, patients, visitors, students and contractors. All strategic and operational work programmes and policy decisions are discussed with relevant services such as site visits and approaches to reduce risks.*
Emphasis on operational and financial sustainability	*Addresses Risk minimisation strategies adopted*

1.2. Executive Summary

August and September have again been busy months for the Occupational Health and Safety team. From a staffing perspective the team is almost at full strength, which is opportune, as the workload has increased significantly over the past six months due to increased presence and education in the workforce. In order to stop reliance on temporary nursing staff it has been decided to recruit another full time nurse.

An additional nursing resource in this area is going to have a two-fold impact. Firstly this initiative will negate the need to have relief nurses in the department, and it will allow nursing staff to conduct more occupational health initiatives, such as environmental monitoring.

Last month it was reported we were working hard to refine our data to provide the Board with an accurate, and meaningful representation of Occupational Health and Safety compliance at Auckland DHB. Many months of work has gone into this area, and there have been significant changes in this report.

The reader will note that along with the previously updated Lost Time Injury Frequency Rate (LTIFR), accepted claims and declined claims for lost time injuries will also be reported. Accurate and fair claim outcomes are a by-product of the Health and Safety team now conducting investigations for all Lost Time Injuries (LTI) that occur in the business.

To facilitate these investigations, an Incident Causation Analysis Methodology (ICAM) – Lead Investigator course has been held over two days, in which all advisors attended. ICAM investigations are now a minimum requirement for employee incidents that register as a SAC rating of 1 or 2 in addition to serious Lost Time Injuries.

The reader will also note the now declining LTIFR, previously, LTIFR was calculated on all reported LTI, regardless if an incident was deemed not applicable through investigation, or if the claim was subsequently declined. As a result, the LTIFR never decreased. To address this the following will be reported on

- The LTIFR
- The number of LTI claims vs the number of substantiated claims.

This will give the Board an accurate reflection of the positive work being completed in the Health and Safety team

On the 5th of November, DATIX incident categories are also changing to present more accurate data for this report. The concept of incident classification has been aligned with Health and Safety best practice, where an incident is now classified by what it is, not what hazards may have caused an incident. The benefit of this method of reporting is that DATIX input has been significantly sped up, and the classification of hazards is now linked back to a causation section at the conclusion of the DATIX report.

The change in incident classifications has now also allowed this report to reflect injury categories as per Australian Standard 1885.1:1990 *Workplace Injury and disease recording standard* (there is no equivalent NZ standard)
Injury types are classified as follows;

- No Treatment
- Medical Treatment Injury (Treatment by a medical provider)
- First Aid Treatment
- Lost Time Injury

- Fatality

Further to this, body injury location will also feature in this report, pinpointing trends on manual tasking injuries at Auckland DHB

The Health and Safety team has recently conducted an analysis of all Health and Safety risks at Auckland DHB and have identified a number of "Risk" areas. The identification of risk will set the foundation for a more focused safety management system in the future and also marks the refining and updating of Auckland DHB wide Health and Safety risks in the respective strategic and corporate risk registers.

Identified Risk areas are


Asbestos Management


Hot Works


Confined Spaces


Subcontractor Management


Manual Tasks (including patient handing)


Fatigue Management


Remote and isolated work (lone worker)


Hazardous Substances


Vehicles and Driving


Workplace Violence and Aggression


Working at Heights


Biological Hazards

It is proposed that from this point forward, a different risk area will be addressed each month, with commentary focusing on;

- Areas of risk
- Recent achievements
- Any applicable audit updates
- Outstanding corrective actions
- Any other items of interest

1.2.1 Statistical Snapshot

The data in this report is accurate up until the end of September 2018, this being the last complete month prior to board report completion. The following is a brief synopsis of points of interest in this report.

WORKSAFE NEW ZEALAND | MAHI HAUMARU AOTEAROA

There have been no notifiable incidents in September

There were 42 Blood and Bodily Fluid Accidents (BBFA) in September, 27 of which have been reported on DATIX. OHS Nurses are following up on those that have not been reported

LTIFR

The current accepted LTIFR this month is trending below the AUCKLAND DHB target of 10 and currently sits at 8.95

Health and Safety Performance Report – September 2018

Contents

2. Purpose of Report

This report is intended to provide information to the Board relating to the health and safety performance at Auckland DHB. Each Directorate receives a similar, focused report, containing data related to that part of the organisation. These are included in Section 9.

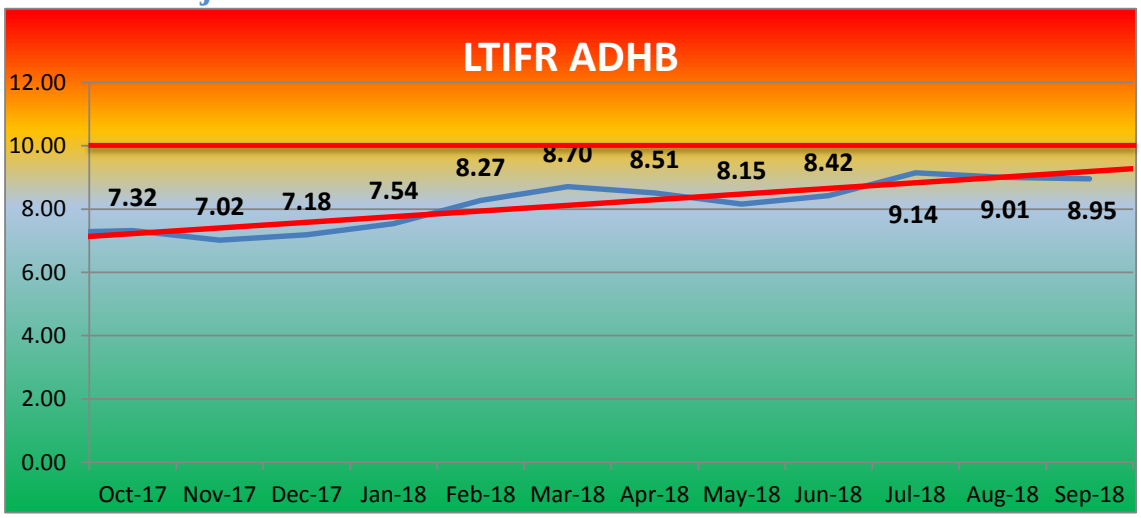
3. Health and Safety Scorecard for September 2018

In light of the Board requiring improvement and clarity on the reporting of Health and Safety, significant change has been made to lead and lag indicators to ensure best practice has been utilised. As described in the Good Governance Guide for Directors, focus is being placed on preventative lead indicators as opposed to the traditional approach of lag indicators.

3.1. Lag Indicators

Lag indicators are those indicators which measure Auckland DHBs incidents in the form of past incident statistics. They are a traditional safety metric used to indicate progress towards compliance.

Lost Time Injuries

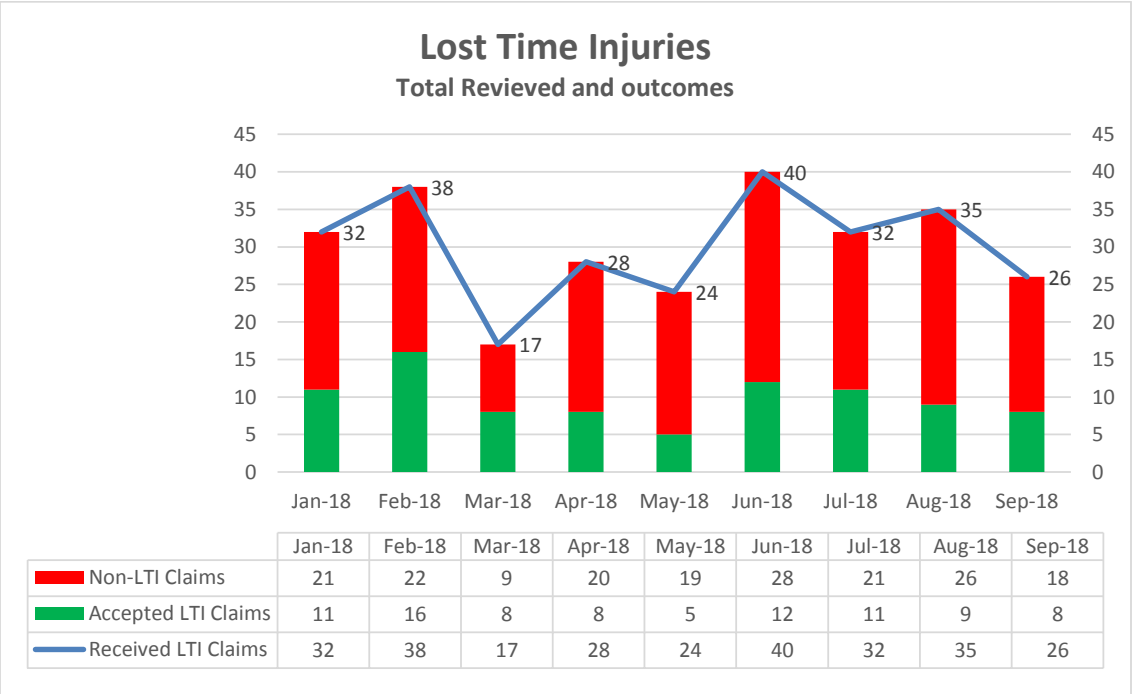


Last month it was discovered that the LTIFR was being reported on all reported incidents of Lost Time Injury, including those that were being investigated and found either not to relate to a work incident, or did not incur lost time. This has now been rectified. The team continues to work hard to further reduce the occurrence of injuries to our workers.

The graph has now been colour coded from green through to red to reflect the state of lost Time injuries and a red target line has been introduced to graphically represent the revised target of 10.

Number of Injury Claims	34	35	
Lost Time Injury Severity Rate	0.197605	2	
Reported LTI's	15	10	
Accepted LTI's	7	10	
Cost of Injury Claims (000's)	15	80	
Excess Annual leave: % of workers with excess annual leave	10.82	6	

A new metric of Accepted LTI's has been introduced to represent the investigative process, and show the positive work the Health and Safety team is undertaking to ensure that all or our injured workers have contact from us at the earliest opportunity, rehabilitation strategies are put in place and further to this, our workers are supported back to full health in a quick and efficient manner.



	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Non-LTI Claims	21	22	9	20	19	28	21	26	18
Accepted LTI Claims	11	16	8	8	5	12	11	9	8
Received LTI Claims	32	38	17	28	24	40	32	35	26

The lost time severity rate remains low and under target again this month

Incident Reporting

Reported incidents refers to any incident entered into DATIX.

Incident reporting remains strong this month with 176 employee related incidents reported over the month and 19 contractor related incidents entered.

Staff	176	200	
Contractors	19	50	

There have been no notifiable incidents in September 2018

Top three incident classifications for September 2018

The top three incident classifications for September 2018 were as following
42 Workplace Violence related incidents
42 Biological incidents (BBFA)
12 Hazardous Substances incidents

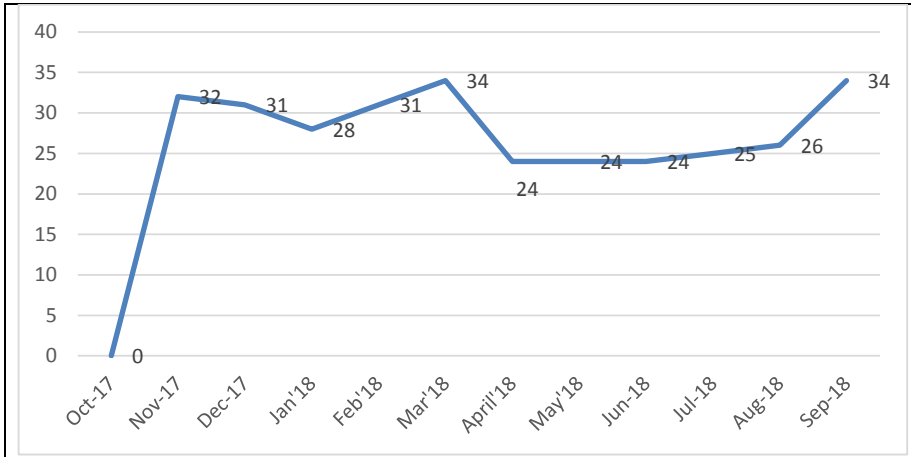
All of these incident types have been highlighted as within the risk areas for the business and work is currently being undertaken to realign and focus Health and Safety strategies and targets to better address these areas.

3.2 Lead Indicators

	Actual	Target	Trend
% Pre-employment screening before start date	99	100	
% local H&S Induction completed (YTD)	52	100	
% Health & Safety e-learning completed (YTD - Excluding RMOs & HOs- one month lag	54	100	
Number of H&S Representative Vacancies	28	25	
% H&S Representatives Trained	83	80	
% of reported H&S Incidents investigated- 14 days (one month lag)	34	80	
# of outstanding H&S Incident investigations	161	200	
Number of contractor audits completed	32	10	
Level of compliance contractor audits	90	90	
# of Hazardous Substance audits conducted	3	10	
% Hazardous Substance audits compliant	88	80	
# MAPA training completed in high risk WV areas	105	95	
Number of staff Seasonal Influenza Vaccinations (YTD) 2018	8618	7923	
Contact Tracing (events)	1	0	
Number of Staff Assessed (For Contact Trace)	3	0	

Commentary on Health and Safety Indicator exceptions

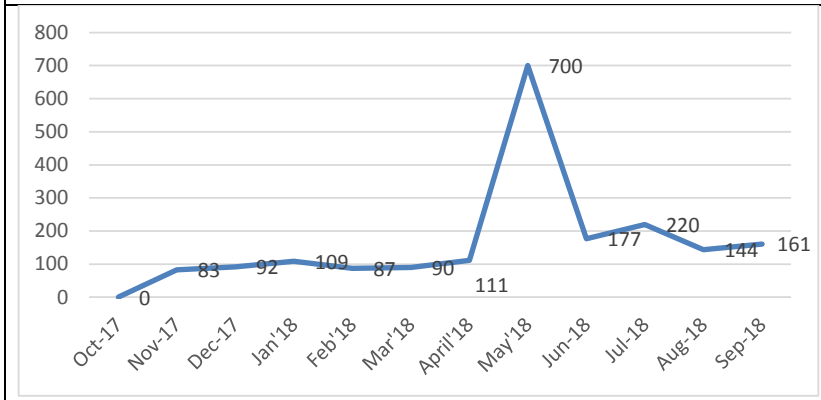
This area will reflect any dramatic changes, or changes of note in the lead and lag indicators.



% of reported H&S Incidents investigated- 14 days (one month lag)

Currently the designated window for the close out of Health and Safety incidents in DATIX is set at 14 days. We have seen over the past 6 months that this is difficult to achieve due to shift work, time, involved personnel away on leave, or for a multitude of other reasons. The Health and Safety team is actively training and engaging with the workforce on a daily basis which goes someway to explaining the increase in compliance in this area. To further increase compliance with our reporting requirements a number of initiatives are currently under way.

- Review of the current incident manual
- Continued training of our workers
- DATIX incident categories have been simplified
- The focus of initial incidents has been taken away from hazard identification, and back to identifying the outcome
- Increasing closeout timeframe from 14 days to 30 days to account for shifts and time off from work.



of outstanding H&S Incident investigations

A slight increase this month due to the addition of all outstanding property and facilities incidents this has since been reduced to only 1 outstanding in facilities.

We continue to work hard in this area to ensure full investigations for all reported matters by;

- Ensuring Daily audits of all entries
- Full investigations on all reportable incidents and Lost Time injuries
- Team recently undertook ICAM lead investigator training to further assist in the development of their investigation skills

4. Health and Safety Risks

This month we have consulted with the risk team to ensure that the risks reported on, are not duplicated elsewhere, and that they are current Health and Safety risks to the organisation. This month several sessions are planned with the teams in order to review and update all Health and Safety risks in both the corporate and strategic risk registers. Any risks that are no longer reported in this report have either been updated in the Corporate risk register or have been de-escalated back to a directorate level. Further risks can also be found in the enterprise risk report.

Note - *An initial broad-brush risk session was held between the AUCKLAND DHB Health and Safety team and Risk, to identify areas of concern for Health and Safety across all of AUCKLAND DHB. The following areas have been identified as Health and Safety risk areas*

Risk	Current status/Issues	Action	Residual Risk (consequence x likelihood)
 Asbestos Management	• Procedure covers whole of organisation • Recent external audit findings were positive	Continued systems improvement and trials of Alpha Tracker software	Medium (6) –There is always a "risk" of asbestos exposure in the current environment however it is of note that there has never been a positive air sample taken at Auckland DHB for asbestos and there are no recorded incidents of asbestos exposure on record.
 Confined Spaces	• Procedure held at a Facilities Directorate level, no Auckland DHB wide standard published	Development of a Auckland DHB wide Standard Operating Procedure	Low (3) – There are no recorded instances of confined spaces work being conducted outside of the facilities remit, however it would make sense to instigate a change to a group level procedure in order to capture all workers at Auckland DHB not just those falling under the facilities remit.
 Manual Tasks (including patient handing)	• Current Manual Tasking document is due for review as of August 2018 • Needs to align with latest WorkSafe guidelines on Manual tasking requirements	Document in final stages of review prior to being published	Moderate (8) – Currently Auckland DHB has only 1 nurse trainer responsible for initial and refresher training for all of Auckland DHB. To comply with the current WorkSafe guide – Moving and Handling in Healthcare, all new starters would require at least one training session and a two yearly refresher for all staff. Further to this there is insufficient resourcing to provide general Manual Tasking training to the greater workforce in high risk areas such as Cleaning services
 Remote and isolated work (lone worker)	• Procedure still in Draft format • No underpinning Risk assessments conducted on old documentation	1. Risk Team leading a broad brush risk assessment across all stakeholders in November, Safety team to then develop draft group level procedure 2. Collate and incorporate latest Regional Internal Audit lone worker audit findings 3. Distribute draft for comment prior to ratifying through board	Moderate (8) – Generally those areas working in lone worker situations have their own processes in place which are working. • There is currently a work stream around lone worker • An information session on lone worker is being rolled out by Health and Safety in December • Continuously monitored at the Security for Safety steering group.
 Vehicles and Driving	• There is a Hippo page referencing the Auckland DHB Motor Vehicle policy but this does not exist. • No Group Level overarching policy across all of Auckland DHB	Develop new Standard Operating Procedure at a group level as a minimum standard across the entire organisation	Moderate (8) – Generally those areas working with company vehicles have localised processes and procedures. Vehicle incidents are being recorded in DATIX, and a scope of work is underway to develop a group level Standard Operating Procedure
 Working at Heights	• Procedure held at a Facilities Directorate level, no Auckland DHB wide standard	Development of a Auckland DHB wide Standard Operating Procedure	Moderate (8) – There is no overarching policy or process in place for those outside of facilities. This is of concern for any other contractors or staff that may unwittingly be performing at heights work, although this is very rare, however best practice would dictate this risk should be elevated to a group level and apply to all workers
 Biological Hazards	• There are currently many documents held at both a Corporate and a directorate level covering different aspects of Biological hazards, e.g. BBFA's, clinical waste.	Development of a Auckland DHB wide Standard Operating Procedure, pulling together all of the current policies and procedures throughout the business	Moderate (8) – for ease of reference and use from workers throughout Auckland DHB it makes sense to have a corporate level Procedure in place setting a minimum standard for all facets of biological hazards. Individual directorates or workgroups could expand on this minimum requirement at a local level
 Hot Works	• Procedure held at a Facilities Directorate level, no Auckland DHB wide standard	Development of a Auckland DHB wide Standard Operating Procedure	Moderate (8) – There is no overarching policy or process in place for those outside of facilities. This is of concern for any other contractors or staff that may unwittingly be performing any form of hot work, although this is very rare, however

Risk	Current status/Issues	Action	Residual Risk (consequence x likelihood)
			best practice would dictate this risk should be elevated to a group level and apply to all workers (Hot works – welding, grinding, cutting of metal, etc)
 Contractor Management	• There is a Health and Safety Contractor Policy and several HR policies	Development of a Auckland DHB wide Standard Operating Procedure pulling together, and creating linkages between all documents	Moderate (8) – The subcontractor management document requires updating and it is appropriate to have this at a corporate level to ensure the same standard is applied across all contractors, regardless of where they operate in the business
 Fatigue Management	• Currently no comprehensive up to date group level procedure in place	Development of a Auckland DHB wide Standard Operating Procedure	Moderate (8) – There are currently various documents in place covering different aspects of fatigue management however no comprehensive document covering the entire business. Fatigue, Wellbeing and worker health would all fall under this area
 Hazardous Substances	• Health and Safety Policy in place and ChemWatch system in place	• Underpinning risk assessments need to be completed • Develop new Group level document • Engage with procurement to ensure that all chemicals only come through one portal into the business	Low (3) – Hazardous substances, on the whole, are well handled in the organisation. The implementation of ChemWatch has greatly improved prior practices, however a guiding procedure at a corporate level would further align process throughout the business
 Workplace Violence and Aggression	• Current project in place – finalising scoping of project	• Finalise scoping project • Undertaking of risk assessment process	Critical Risk (15) – This is classified as a critical risk as workplace violence is a frequent occurrence. There are measures and security in place, the development of this Procedure will align approach and process across the organisation whilst reflecting local requirements.

5. WorkSafe NZ Notifications – no change from last report

Notifiable Events (Staff) (previously called Serious Harm)

There were no Notifiable Events in September 2018.

6. Worker-Reported Incidents

Directorate Abbreviations for Chart 2:

AMS:	Adult Medical Services Directorate
ARPHS	Auckland Regional Public Health Service
C and B:	Cancer and Blood Services Directorate
CS:	Cardiac Services Directorate
CH:	Children's Health Services Directorate
CSS:	Clinical Support Services Directorate
CLTC:	Community and Long Term Conditions Directorate
CORP:	Corporate Services
MH:	Mental Health Services Directorate
PMS:	Patient Management Services
POS:	Perioperative Services Directorate
SS:	Surgical Services Directorate
WH:	Women's Health Services Directorate

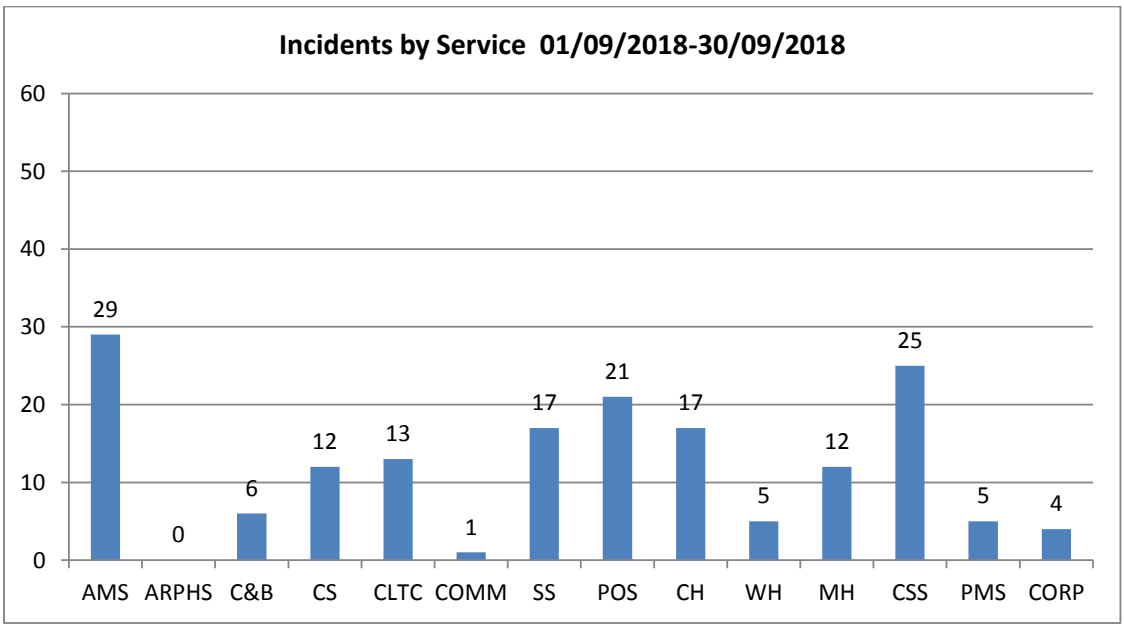


Chart 1 Incidents by Directorate: September 2018

This month there were no substantial differences from previous reports. The majority of incidents were again reported in Adult Medical, Perioperative, and Clinical Support Directorates.

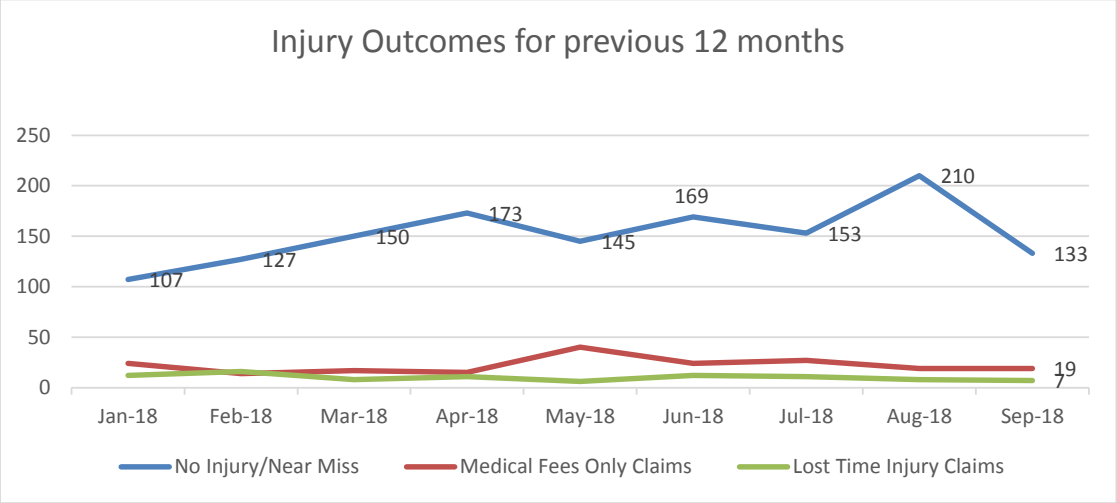
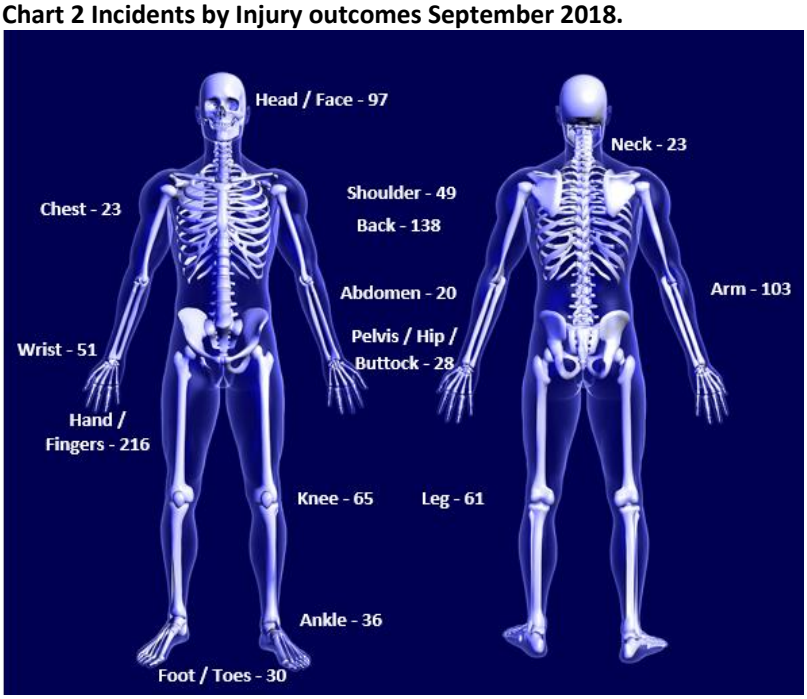


Chart 2 Incidents by Injury outcomes September 2018.



Representation of injured anatomical areas for 2018

A new method of representing what injuries our workers are sustaining. By trending in this fashion, we are able to identify recurrent problem areas and can go back through DATIX reports to further discriminate how these injuries are occurring and how to best address them. A breakdown of the main areas of concern are detailed below;

Area of Injury	Main Cause	How to address
Hand /Fingers	BBFA's – needle stick injury	Continued education around sharps protocols, and continued support through BBFA process from OHS team
Back / Shoulder	Manual Tasking Injuries	Increased training sessions around good manual tasking practice. Potentially look at increasing FTE for at least another Nurse Trainer specialising in Manual Handling.
Arms	Manual Tasking injuries	Increased training sessions around good manual tasking practice

7. Health and Safety Activities

ACC Accredited Employer Partnership Programme Audit

The Health and Safety Team has concluded the internal ACC audit process and is now liaising with ACC in order to determine the three areas of deep dive audit that now occur as part of the Accredited Employer Programme (AEP). This has taken several weeks of work from the team and we are working toward Auckland DHB reaching a tertiary level of accreditation within the AEP program

Ernst and Young Follow-Up Health and Safety Review

Ernst and Young (EY) were engaged by Auckland and Waitemata DHBs to identify gaps in the current Health and Safety policies and practice. The Health and Safety at Work Act (2015) was sufficiently different from the Bill to warrant a further audit. This was identified in the EY report, and a follow-up audit was conducted in June/ July 2017.

The following are a list of the remaining actions from this audit.

EY Recommendations and action update; High Risks (Orange), Moderate (Blue) and Improvement Idea (Black)

Risk area	EY Recommendations	AUCKLAND DHB Actions	Status
High			
Locations of community workers not always adequately accounted for.	Auckland DHB to address this risk as a high priority	Lone worker electronic tracking project team in Trial phase New Policy being redrafted	Trials have commenced for the lone worker app; expected trial completion will be at December 2018.
Moderate			
Training matrices and records are not readily	Develop a non-clinical H&S training matrices (or similar) outlining the minimum training required by workers to undertake the role safely.	Learning and Development to work	Preliminary consultation phase

Risk area	EY Recommendations	AUCKLAND DHB Actions	Status
available, and delivery methods require improvement	This information should be shared among the Directorates, especially where the roles are similar in functions, but not necessarily care. For example community workers (District Nursing and Community Midwives).	with HS team to address this issue	
Improvements required to report near misses and hazards	Implement additional worker training to educate workers about situations, including near misses that may give rise to a harmful or damaging incident, as well as how to report those incidents	Improved awareness at every Health and Safety Directorate meeting. Health and Safety Directions (circulated to all HSRs and managers) highlights the importance of near-miss reporting. Additional training has been provided on how to reports incidents on SMS (DATIX.	**Complete – ongoing training will be required, but we have seen increased compliance in this area, which will further improve as more training occurs**
Risk assessment process for community workers required improvement.	The draft Auckland DHB Lone and Community Worker policy should be revised to state that a risk assessment must, except in well-defined low risk circumstances, be performed for each and every client a community worker visits.	Broad Brush risk assessment for a Auckland DHB wide Lone Worker Policy to be held November 2018	**Work in progress**

Risk area	EY Recommendations	AUCKLAND DHB Actions	Status
Transfer of knowledge between Directorates and areas could be improved.	Provide a platform where workers and area managers, such as charge nurses, can share H&S management information with each other.	Work with Directorates and the OH&S Team in this area continues.	**Work in progress**
Quality of key H&S risk information provided to the Board requires improvement	Review and update risk reporting to the Board to better align reporting to Auckland DHB's material H&S risks	Complete as per this report	**Complete pending Board feedback**
Improvement Idea			
Maintenance and CAPEX prioritisation requires more clarity		**Complete for OHS team–** CAPEX digitisation is now being reviewed prior to roll out in 2019	CAPEX process is going digital. OHS team is happy with the new streamlined OHS approval process.

Hazardous Substances Regulations Review

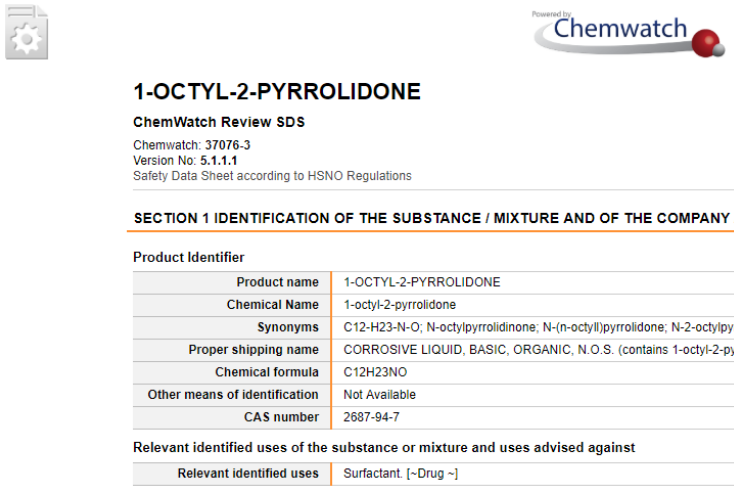
In late November Regional Internal Audit engaged Deloitte to conduct an independent review to assist in identifying how Auckland DHB hazardous substances management programme will meet the requirements of the Health and Safety at Work (Hazardous Substances) Regulations taking effect from 1 December 2017, and identify any gaps that need to be addressed.

PROJECT DETAILS			
Project title	Hazardous Substance Management		
Project Sponsor	Sue Waters		
Project Team Members	Nick Engelmann, All OHS Advisors		
Date	1/10/2018	**Version No.**	2

Actions			
Milestones	**When**	**Who**	**Status**
Set up an Approved Handler Course and offer training to areas where an Approved Handler is required	**Complete**	Garry Trotman	Complete – Team has reviewed several providers and have decided to utilise the option already being employed by LabPlus, which is of similar cost and will ensure uniformity across the entire organisation
Update inventory of chemicals used within AUCKLAND DHB	**Master Inventory complete, sorting per area aiming for 1/2/2019**	Garry Trotman	The Master Hazardous Chemical Inventory is now loaded into Chemwatch. The next step is for OHS advisors to go from site to site to ensure that all manifests reflect this and quantities are up to date.

An example of the Chemwatch interface and a zoom in on the organisational structure of AUCKLAND DHB, sorted by geographical location

Review AUCKLAND DHB's requirements and processes for ensuring safety data sheets remain current.	**Complete**	Garry Trotman	Complete – SDSs are always current within the Chemwatch system, administrators of the system are advised as soon as an update has occurred for dissemination to the respective area of the business that utilises that SDS



Powered by Chemwatch

1-OCTYL-2-PYRROLIDONE

ChemWatch Review SDS

Chemwatch Hazard Alert Code: 3

Chemwatch: **37076-3**
Version No: **5.1.1.1**
Safety Data Sheet according to HSNO Regulations

Issue Date: **04/12/2017**
Print Date: **04/10/2018**
S.GHS.NZL.EN

SECTION 1 IDENTIFICATION OF THE SUBSTANCE / MIXTURE AND OF THE COMPANY / UNDERTAKING

Product Identifier

Product name	1-OCTYL-2-PYRROLIDONE
Chemical Name	1-octyl-2-pyrrolidone
Synonyms	C12-H23-N-O; N-octylpyrrolidinone; N-(n-octyll)pyrrolidone; N-2-octylpyrrolidone; Surfadone LP-100
Proper shipping name	CORROSIVE LIQUID, BASIC, ORGANIC, N.O.S. (contains 1-octyl-2-pyrrolidone)
Chemical formula	C12H23NO
Other means of identification	Not Available
CAS number	2687-94-7

Relevant identified uses of the substance or mixture and uses advised against

Relevant identified uses	Surfactant. [~Drug ~]

Screenshot of an SDS, note the currency of the document in the top right along with the print date.

Notify Worksafe NZ that Sodium Fluoroacetate is being used onsite	**Complete**	Garry Trotman	Notification had been completed at time of receiving the chemical.

Health and Safety Maturity Assessment

Following a recommendation at the February Finance Risk and Assurance Committee meeting, Auckland DHB has been engaging with Regional Internal Audit to complete a Health and Safety Maturity Assessment. Regional Internal Audit has agreed to fund the assessment with the aim of completing it by December 2018.

7.1 Health and Safety Audit Schedule

The table below is provisional and includes currently scheduled audits.

July 2018	August 2018	September 2018	October 2018
• Hazardous Substances Audits and inventory review	• Workplace Checklist compliance review • Maturity Assessment (Regional Internal Audit)	• Annual ACC AEP Self-Assessment completion	• Annual ACC AEP Audit preparation
November 2018	**December 2018**	**January 2019**	**February 2019**
• Annual ACC AEP Audit • Maturity Assessment (Regional Internal Audit)	Nil	• Tentative –RIA Health and Safety Deep Dive 1 – Date TBA	• Tentative – RIA Health and Safety Deep Dive 2 Date TBA Health and Safety Harm to staff by patients

7.2 Managing Safely for Managers Course

The Managing Safety for Managers course is currently being reviewed and rewritten prior to the next delivery date in December. Feedback is indicating that the course is far too heavy on legislative learnings and not enough detail about the practical application of safety as a manager working at Auckland DHB. There are also plans to significantly shorten the course from an entire day to three to four hours, this will ensure greater accessibility for managers.

There will be no loss of content during this change and there will be a light load of pre-course readings to be undertaken prior to the training day.

The aim is to provide a focused training session that adds value to our Managers and doesn't distract from safety engagement and continued cultural change.

7.3 Board Health and Safety Engagement visits

The next, and final, board engagement visit for the year will be held on the 28th of November 2018, further details will be circulated prior to this date.

The last board engagement visit focused on new strategy, and tools being utilised at Auckland DHB. The board was introduced to SAFE365, a governance tool, newly acquired by the Health and Safety team to report on overall compliance at Auckland DHB, not only against our legislative responsibilities but to the higher ISO 45001:2018 –*Health and Safety Management Systems*.

During the session, board attendees were questioned in relation to their obligations in relation to Health and Safety, knowledge of ISO 31000:2018, as well as document controls, Board engagement,

and overall Director's safety knowledge. We are pleased to report that members easily surpassed the New Zealand legislative requirements.

The session has provoked many new ideas for the Safety team and we will continue to strive towards ISO 45001:2018 compliance.

7.4 Auckland DHB Health and Safety Committee

The Auckland DHB Health and Safety Committee meets six-weekly, chaired by Sue Waters, and last met on Wednesday the 3rd of October 2018. Minutes can be accessed on Hippo.

7.5 DATIX

DATIX is Auckland DHB's incident management database. To date the system has not been very intuitive and as a result workers were shying away from using the system, this feedback was gathered from our advisors who have been working daily in amongst our front line staff. In order to address this issue and the quality of data being reported in documents such as this, a full review of incident classification has been completed with new categorisations to be implemented from the first week of November 2018.

Previously, incidents were classified within three tiers of hazards, which was proving difficult for users to understand what to put into the system. We have now changed the concept around completely. From November, users will enter the "result" or "outcome" of the incident. Instead of hundreds of possible incident categorisations, the team has developed just eight.

The employee incident management guidance document is also being reviewed to align with these changes and updates, and will be available in November 2018.

Full details of the new categories can be found in Appendix 4.

7.6 Auckland DHB Moving and Handling Steering Committee

The Auckland DHB Moving and Handling Steering Committee is chaired by Brenda McKay and meets monthly. Minutes can be accessed on Hippo. Additional Graphing can be located in Appendix 1 and 2

7.7 Auckland DHB Violence and Aggression Steering Committee

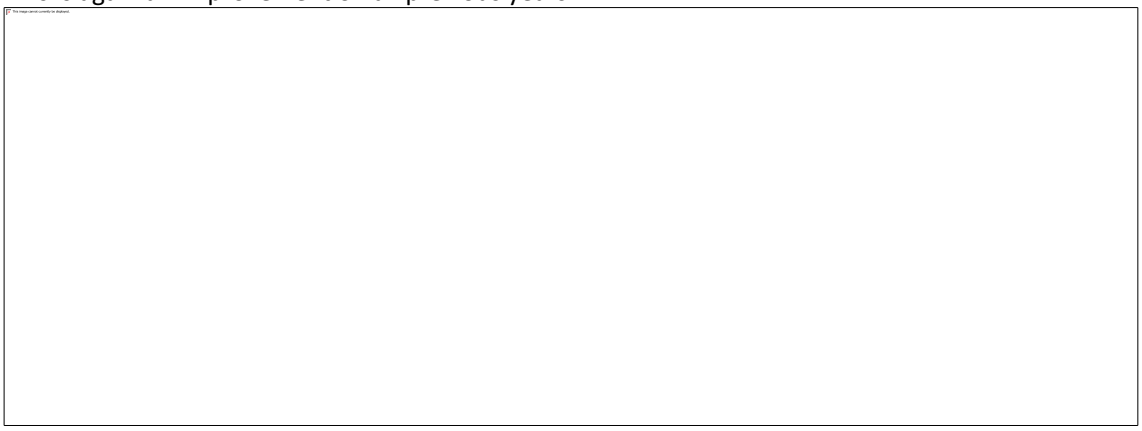
The Chairperson is Sue Waters. Work is underway to improve workplace violence prevention and responses with the clinical teams in Adult Emergency Department. An Advisor who will support the work of the Workplace Violence and Aggression Steering Committee has been hired and commenced in the month of May. Work has begun on the trial of the Management of Actual or Potential Aggression (MAPA) as a replacement for the current Code Orange De-escalation Training. A Rollout Plan for Calm Communications and Security for Safety Training is being followed-up.

7.8 Health and Safety Team

The Health and Safety team is currently recruiting for an additional Staff Nurse. The additional resource will prove invaluable during vaccination clinics and will stop the department relying on temp nursing staff on a weekly basis.

7.9 Seasonal Influenza Vaccination Uptake:

The Seasonal Influenza Vaccination Campaign is now complete. The aspirational target is set at 80% and we almost made the target this year, gaining 79%, which represents 8618 vaccinations delivered. This is again an improvement on all previous years.



7.10 6 Monthly Checklist Completions:

The HSRs do a 6 Monthly Checklist for their local areas. This occurs in February and August of each year. Currently, 82% of the Auckland DHB Directorates have been received by the Health and Safety team. The low compliance figure was noted and enquiries have been made with those areas that have not submitted a checklist. On many occasions we are finding that the list has been completed but not submitted. Advisors are currently following this up further to assist and get full compliance where possible.

In addition to this, the Health and Safety team is also making inquiries into an automated method of completing and submitting these forms in future

Issue	Action	Due Date
HS 6 monthly checklists are not consistently being completed	HS team to investigate alternate automated method of submission	31 December 2018

8. Directorate Health and Safety Reports

The reports below are provided for each Directorate for use on their MOS boards. Please contact Health and Safety for any additional detail or comments required.

-Adult Medical

-Auckland Regional Public healthAlliance

Cardiac

Children's Health

Clinical Support

Commercial Services

Community and LTC

Corporate

Mental Health

Patient Management

Perioperative

Surgical

Women's Health

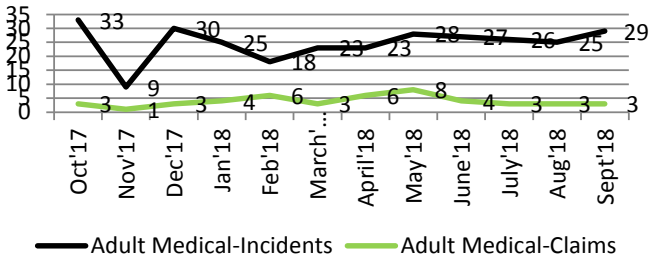
Adult Medical Services Health and Safety Report

Lagging

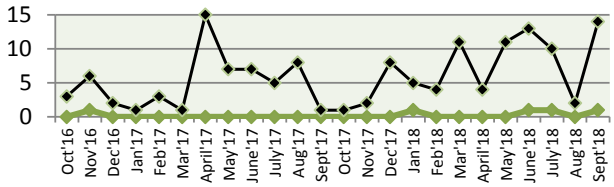
	Actual	Target	Trend
H&S Incidents	29	20	
Work Injury Claims	3	0	
Lost Time Injuries	2	0	
Notifiable Events	0	0	

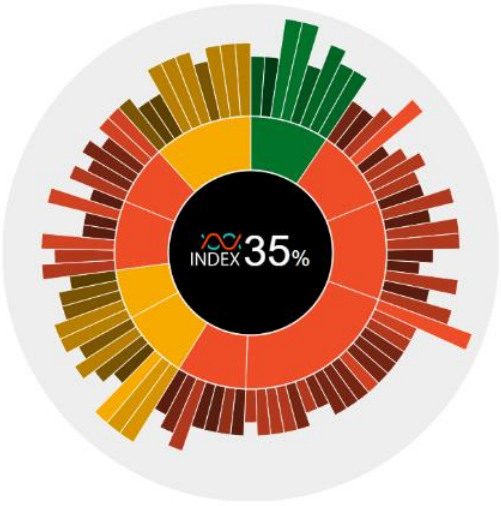
Leading

	Actual	Target	Trend
%H&S Inductions (YTD)	55	100	
H&S Rep Vacancies No.	5	2	
%H&S Rep Training	84	80	
%6 Monthly Workplace Checklist	100	80	
Outstanding DATIX Incidents	8	10	



WORKPLACE VIOLENCE AND AGGRESSION (From 2 Years Rolling)





SAFE365 Starburst Graphic

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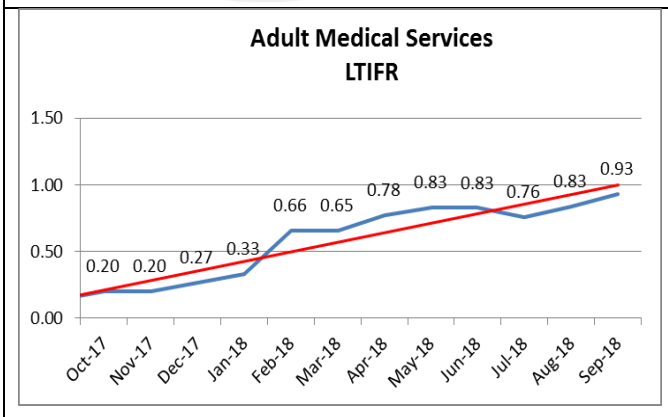
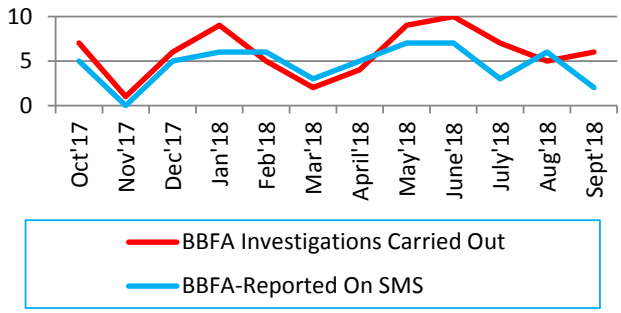


BLOOD AND BODY FLUID ACCIDENTS (From 1 Year Rolling)



ARPHS Services Health and Safety Report

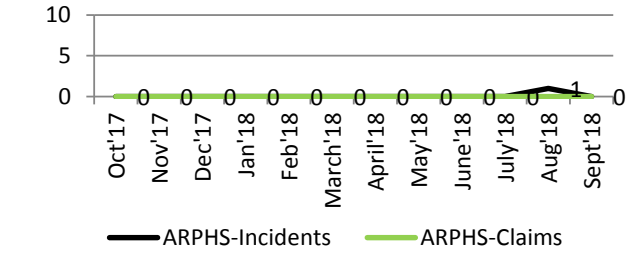
Lagging

	Actual	Target	Trend
H&S Incidents	0	20	
Work Injury Claims	0	0	
Lost Time Injuries	0	0	
Notifiable Events	0	0	

Leading

	Actual	Target	Trend
%H&S Inductions (YTD)	68	100	
H&S Rep Vacancies No.	0	2	
%H&S Rep Training	83	80	
%6 Monthly Workplace Checklist	100	80	
Outstanding DATIX Incidents	0	10	

Health and Safety Incidents and Claims for 12 months



WORKPLACE VIOLENCE AND AGGRESSION
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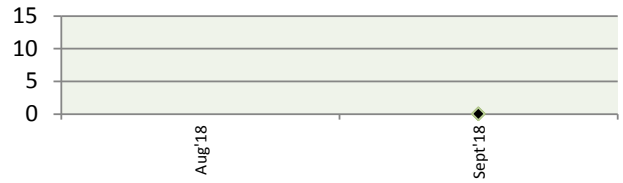

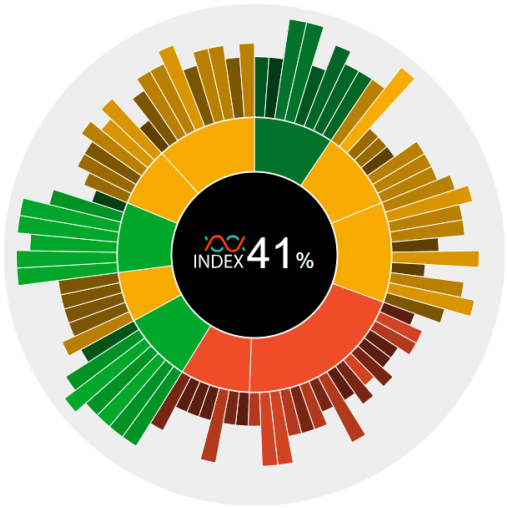

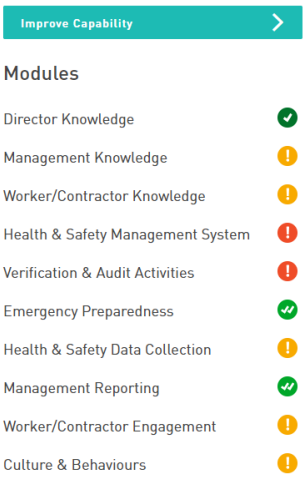

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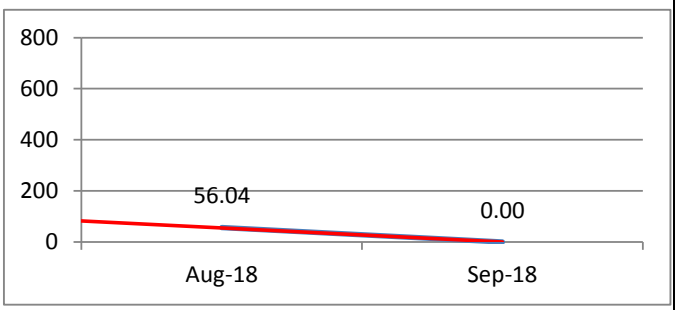
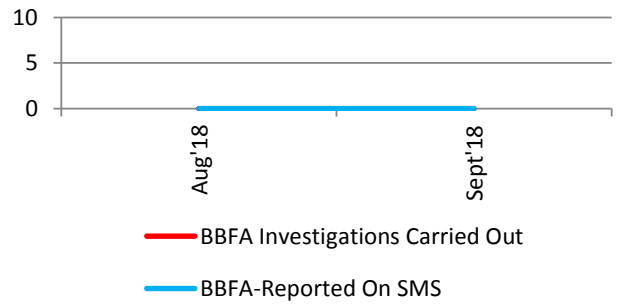
ARPHS LTIFR



BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



Cancer and Blood Services Health and Safety Report

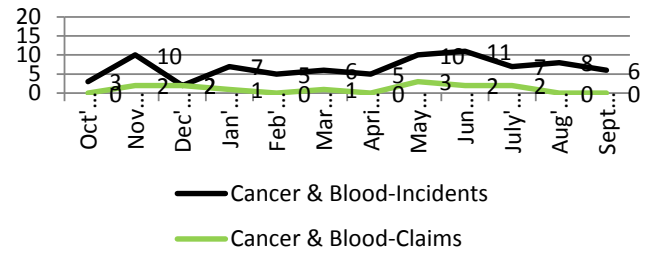
Lagging

	Actual	Target	Trend
H&S Incidents	6	20	
Work Injury Claims	0	0	
Lost Time Injuries	0	0	
Notifiable Events	0	0	

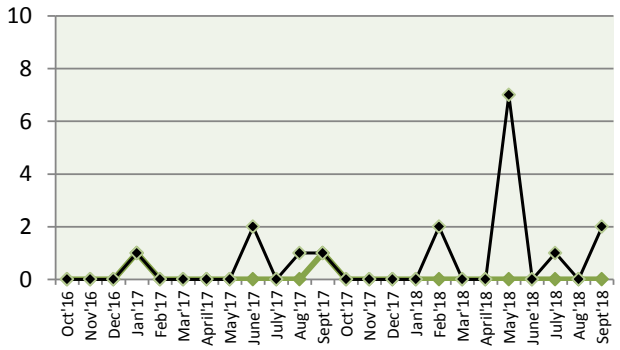
Leading

	Actual	Target	Trend
%H&S Inductions (YTD)	74	100	
H&S Rep Vacancies No.	0	2	
%H&S Rep Training	92	80	
%H&S Rep Checklist	100	80	
Outstanding DATIX Incidents	3	10	

Health and Safety Incidents and Claims for 12 months



WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



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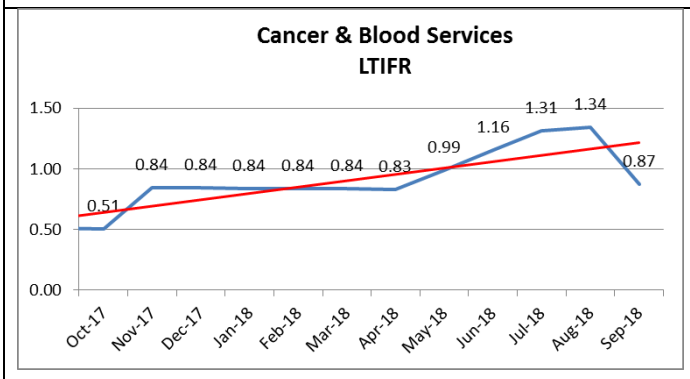
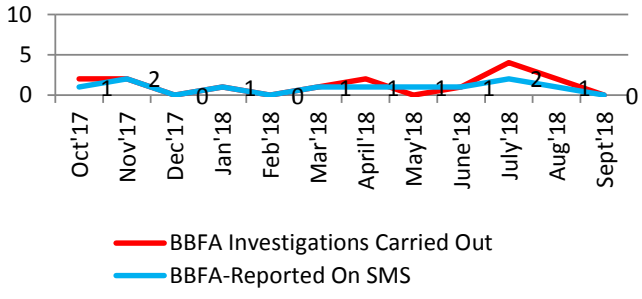


BLOOD AND BODY FLUID ACCIDENTS



Cardiac Services Health and Safety Report

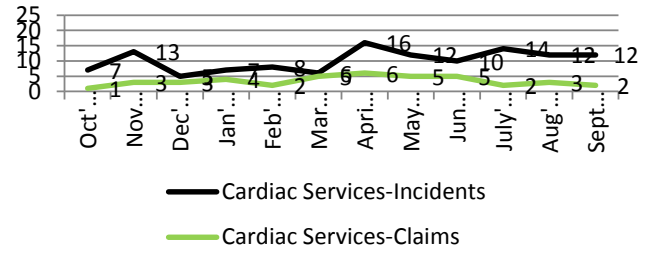
Lagging

	Actual	Target	Trend
H&S Incidents	12	20	
Work Injury Claims	2	0	
Lost Time Injuries	0	0	
Notifiable Events	0	0	

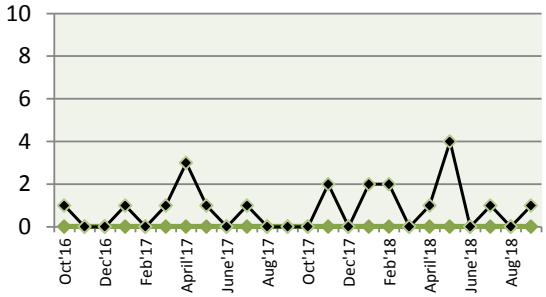
Leading

	Actual	Target	Trend
%H&S Inductions (YTD)	37	100	
H&S Rep Vacancies No.	1	2	
%H&S Rep Training	96	80	
%6 Monthly Workplace Checklist	91	80	
Outstanding DATIX Incidents	5	10	

Health and Safety Incidents and Claims for 12 months



WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



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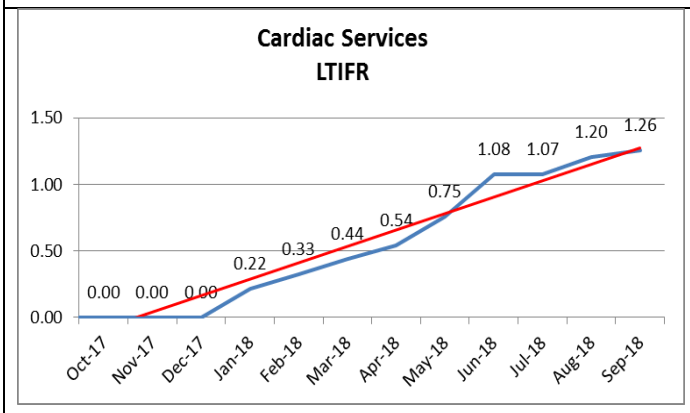
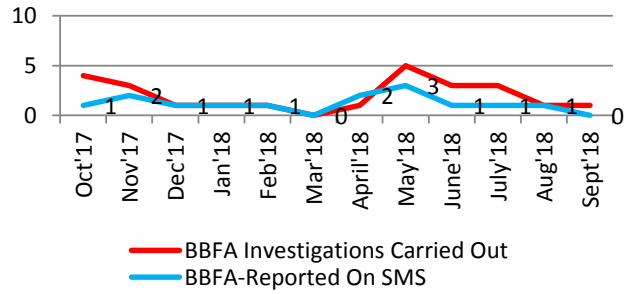
Cardiac Services
LTIFR



BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



Children's Services Health and Safety Report

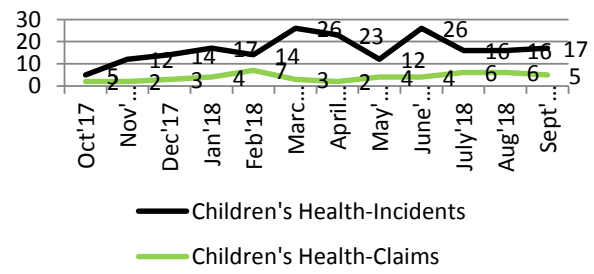
Lagging

	Actual	Target	Trend
H&S Incidents	17	20	
Work Injury Claims	5	0	
Lost Time Injuries	2	0	
Notifiable Events	0	0	

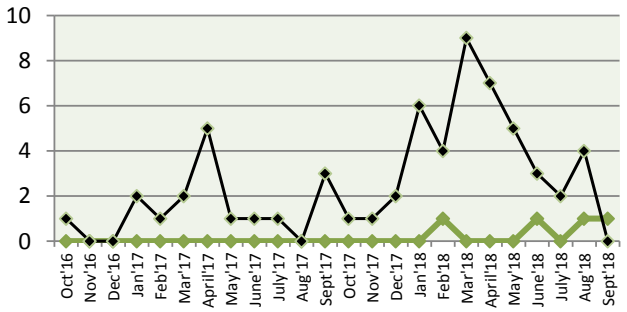
Leading

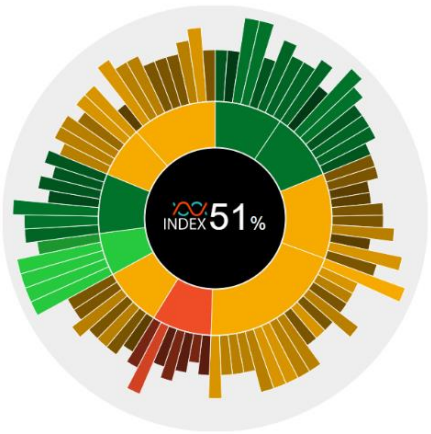
	Actual	Target	Trend
%H&S Inductions (YTD)	25	100	
H&S Rep Vacancies No.	6	2	
%H&S Rep Training	77	80	
%6 Monthly Workplace Checklist	52	80	
Outstanding DATIX Incidents	9	10	

Health and Safety Incidents and Claims for 12 months



WORKPLACE VIOLENCE AND AGGRESSION





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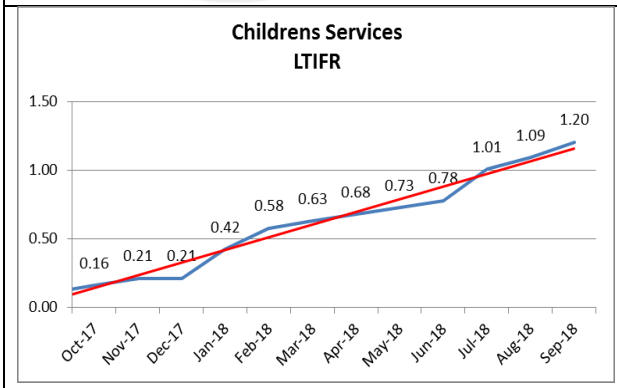
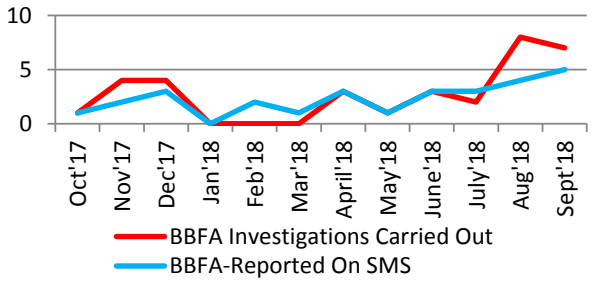
Childrens Services LTIFR



BLOOD AND BODY FLUID ACCIDENTS (From 1 Year Rolling)



Clinical Support Health and Safety Report

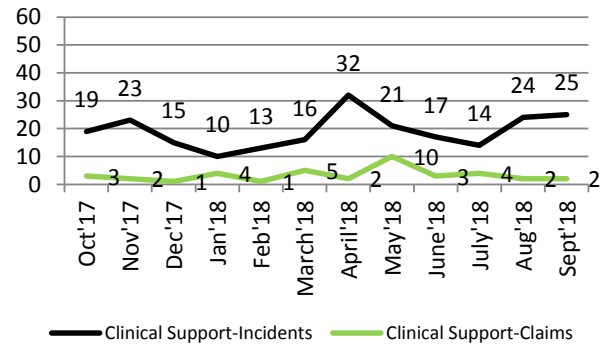
Lagging

	Actual	Target	Trend
H&S Incidents	25	20	
Work Injury Claims	2	0	
Lost Time Injuries	1	0	
Notifiable Events	0	0	

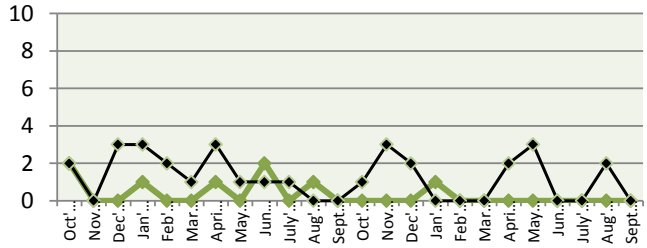
Leading

	Actual	Target	Trend
%H&S Inductions (YTD)	78	100	
H&S Rep Vacancies No.	4	2	
%H&S Rep Training	95	80	
%6 Monthly Workplace Checklist	100	80	
Outstanding DATIX Incidents	20	10	

Health and Safety Incidents and Claims for 12 months



WORKPLACE VIOLENCE AND AGGRESSION (From 2 Years Rolling)



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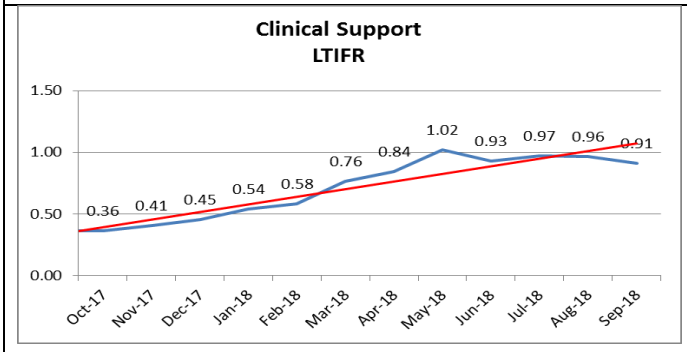

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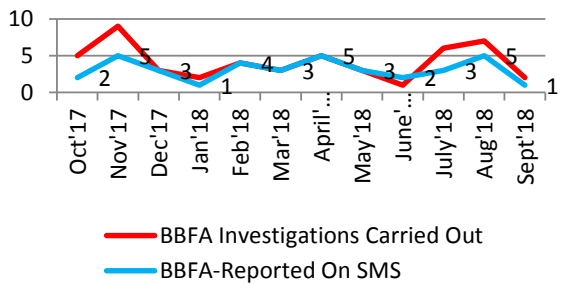


Commercial Services Health and Safety Report

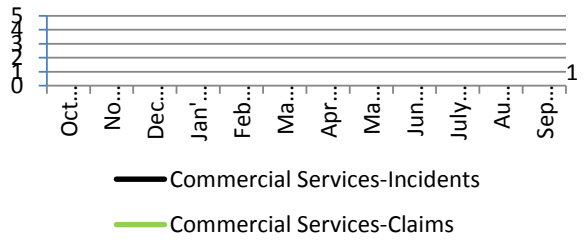
Lagging

	Actual	Target	Trend
H&S Incidents	1	20	
Work Injury Claims	0	0	
Lost Time Injuries	0	0	
Notifiable Events	0	0	

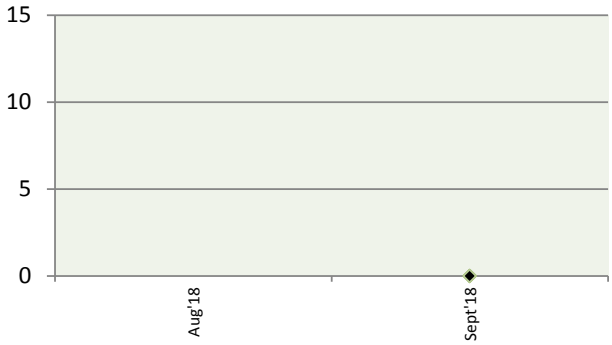
Leading

	Actual	Target	Trend
%H&S Inductions (YTD)	0	100	
H&S Rep Vacancies No.	0	2	
%H&S Rep Training	0	80	
% 6 monthly Workplace Checklist	0	80	
%PES before start date	0	100	
%H&S Incidents Follow up 14 days	RU	80	

Health and Safety Incidents and Claims for 12 months



WORKPLACE VIOLENCE AND AGGRESSION (From 2 Years Rolling)



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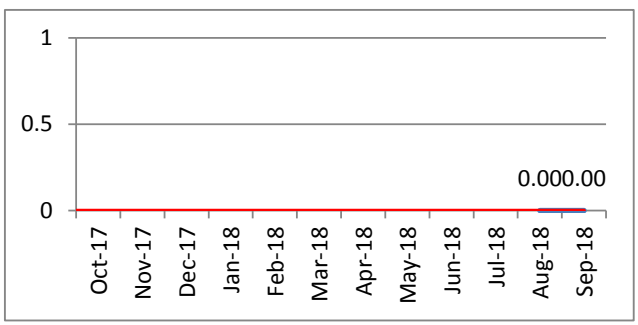
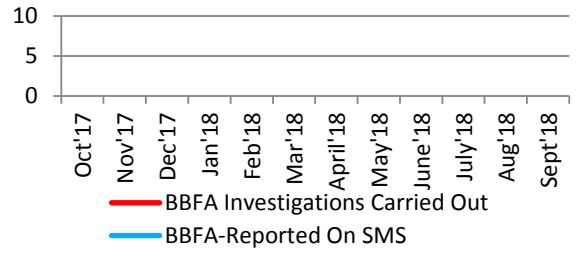


BLOOD AND BODY FLUID ACCIDENTS (From 1 Year Rolling)



Corporate Services Health and Safety Report

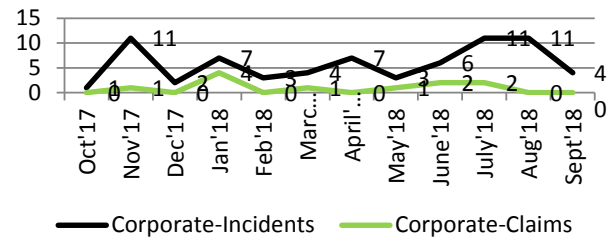
Lagging

	Actual	Target	Trend
H&S Incidents	4	20	
Work Injury Claims	0	0	
Lost Time Injuries	0	0	
Notifiable Events	0	0	

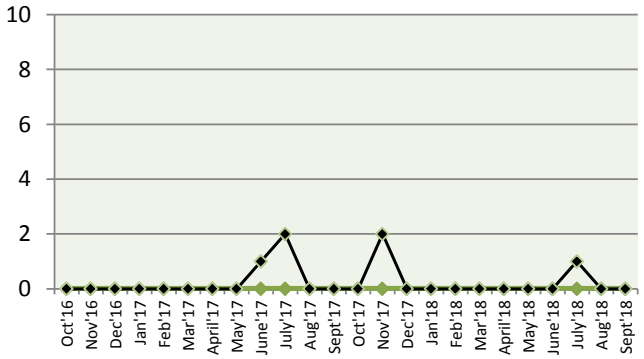
Leading

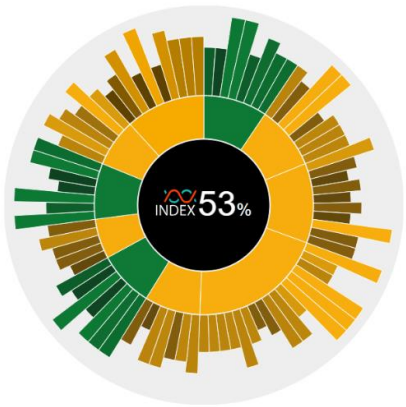
	Actual	Target	Trend
%H&S Inductions (YTD)	79	100	
H&S Rep Vacancies No.	4	2	
%H&S Rep Training	83	80	
%6 Monthly Workplace Checklist	43	80	
Outstanding DATIX Incidents	5	10	

Health and Safety Incidents and Claims for 12 months



WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)





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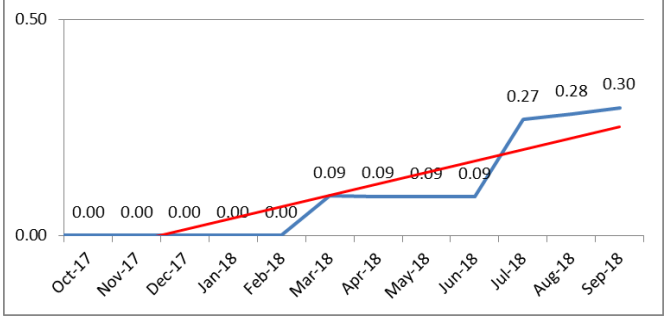
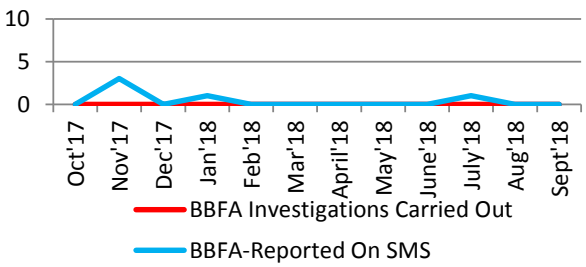
Corporate Services
LTIFR



BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



Community and Long Term Conditions Health and Safety Report

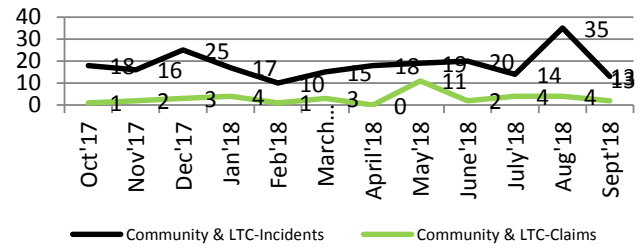
Lagging

	Actual	Target	Trend
H&S Incidents	13	20	
Work Injury Claims	2	0	
Lost Time Injuries	1	0	
Notifiable Events	0	0	

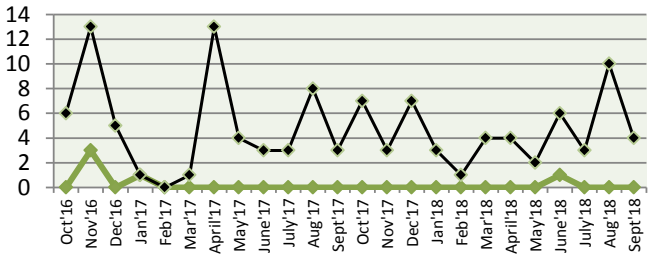
Leading

	Actual	Target	Trend
%H&S Inductions (YTD)	90	100	
H&S Rep Vacancies No.	1	2	
%H&S Rep Training	100	80	
% 6 monthly Workplace Checklist	68	80	
Outstanding DATIX Incidents	3	10	

Health and Safety Incidents and Claims for 12 months



WORKPLACE VIOLENCE AND AGGRESSION (From 2 Years Rolling)



SAFE365 Starburst Graphic (Assessment to be completed)

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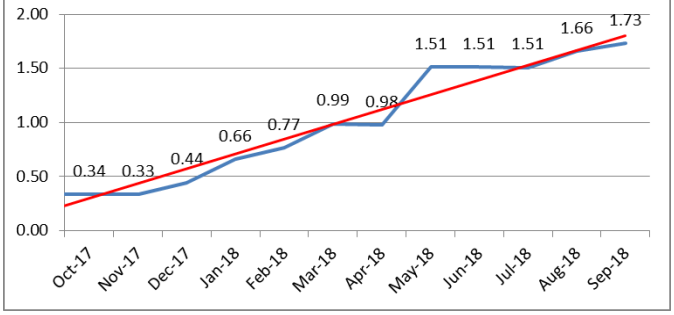
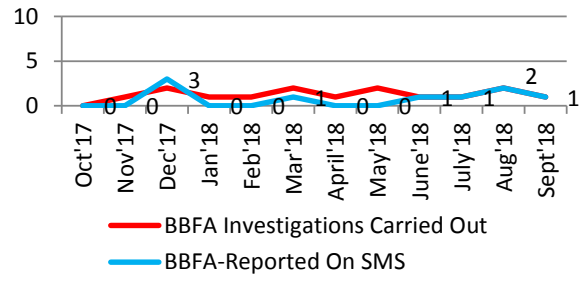
Community & LTC LTIFR



BLOOD AND BODY FLUID ACCIDENTS (From 1 Year Rolling)



Mental Health Services Health and Safety Report

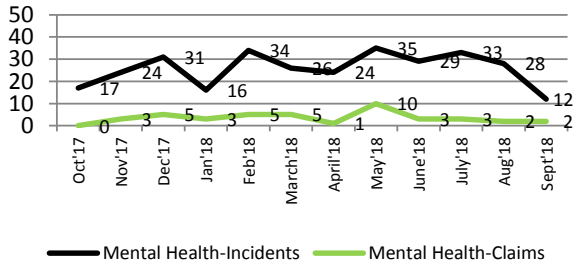
Lagging

	Actual	Target	Trend
H&S Incidents	12	20	
Work Injury Claims	2	0	
Lost Time Injuries	2	0	
Notifiable Events	0	0	

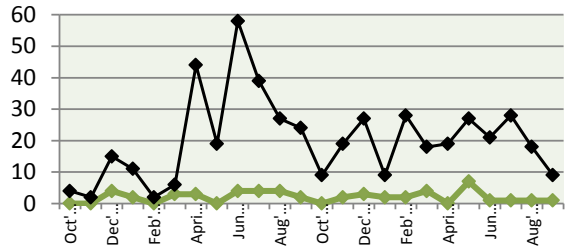
Leading

	Actual	Target	Trend
%H&S Inductions (YTD)	50	100	
H&S Rep Vacancies No.	1	2	
%H&S Rep Training	69	80	
% 6 monthly Workplace Checklist	61	80	
Outstanding DATIX Incidents	54	80	

Health and Safety Incidents and Claims for 12 months



WORKPLACE VIOLENCE AND AGGRESSION (From 2 Years Rolling)



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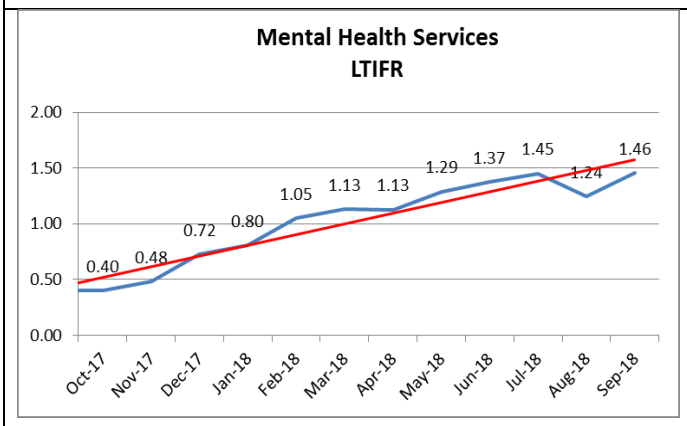
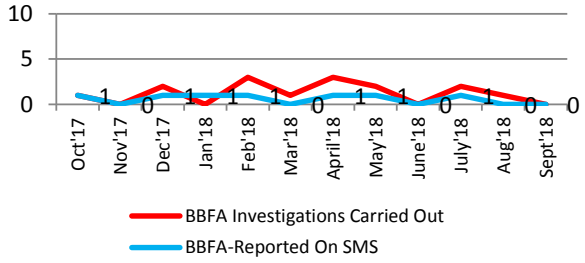
Mental Health Services LTIFR



BLOOD AND BODY FLUID ACCIDENTS (From 1 Year Rolling)



Patient Management Service Health and Safety Reports

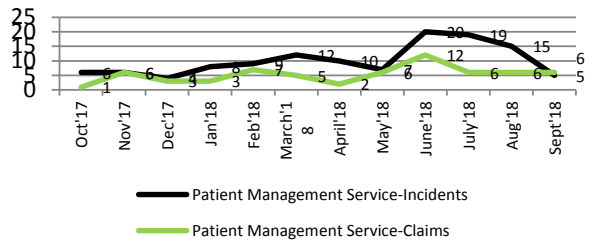
Lagging

	Actual	Target	Trend
H&S Incidents	5	20	
Work Injury Claims	6	0	
Lost Time Injuries	3	0	
Notifiable Events	0	0	

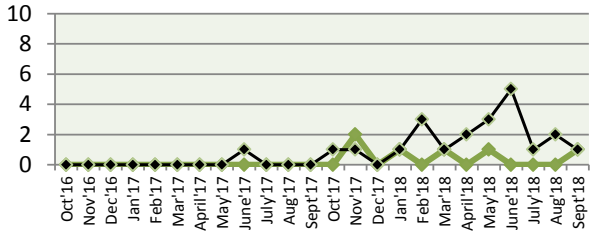
Leading

	Actual	Target	Trend
%H&S Inductions (YTD)	28	100	
H&S Rep Vacancies No.	3	2	
%H&S Rep Training	48	80	
%6 Monthly Workplace Checklist	100	80	
Outstanding Datix Incidents	5	10	

Health and Safety Incidents and Claims for 12 months



WORKPLACE VIOLENCE AND AGGRESSION



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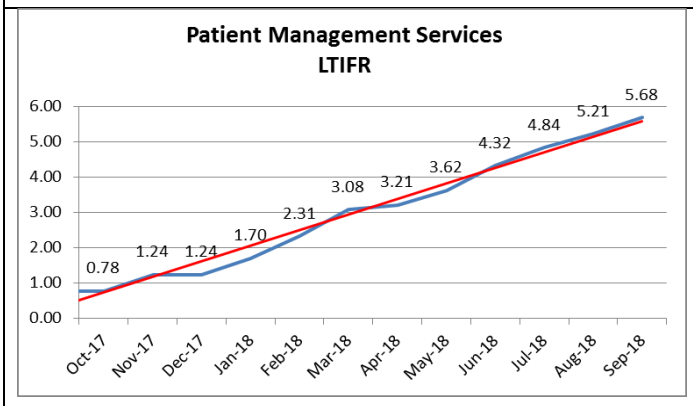
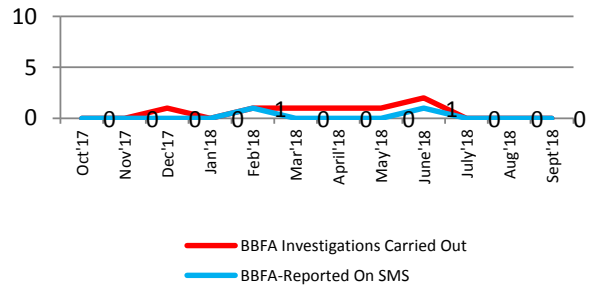


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



Perioperative Health and Safety Report

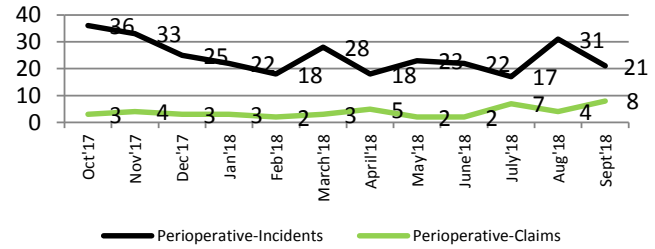
Lagging

	Actual	Target	Trend
H&S Incidents	21	20	
Work Injury Claims	8	0	
Lost Time Injuries	2	0	
Notifiable Events	0	0	

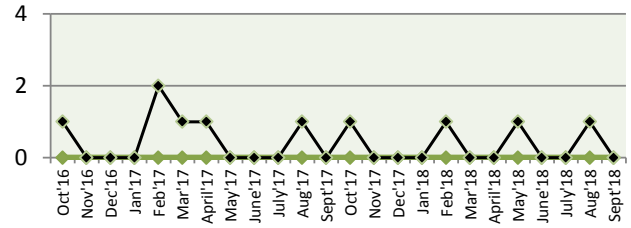
Leading

	Actual	Target	Trend
%H&S Inductions (YTD)	87	100	
H&S Rep Vacancies No.	0	2	
%H&S Rep Training	96	80	
%6 Monthly Workplace Checklist	89	80	
Outstanding DATIX incidetns	9	10	

Health and Safety Incidents and Claims for 12 months



WORKPLACE VIOLENCE AND AGGRESSION (From 2 Years Rolling)



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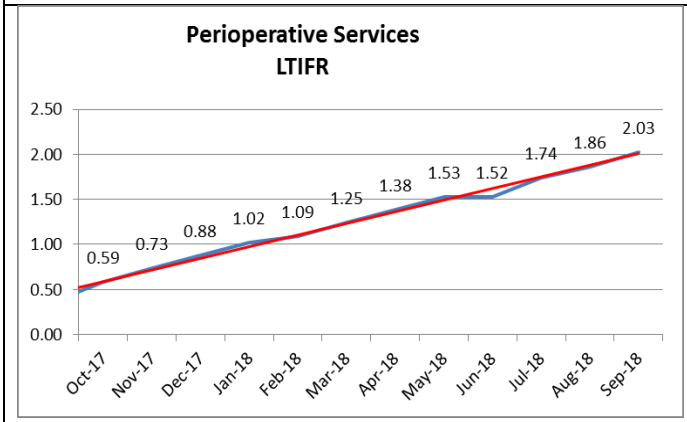
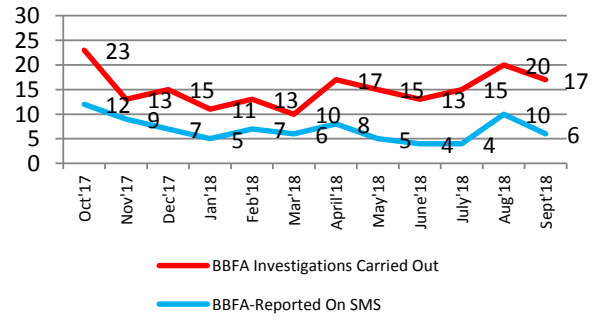
Perioperative Services LTIFR



BLOOD AND BODY FLUID ACCIDENTS (From 1 Year Rolling)



Surgical Services Health and Safety Report

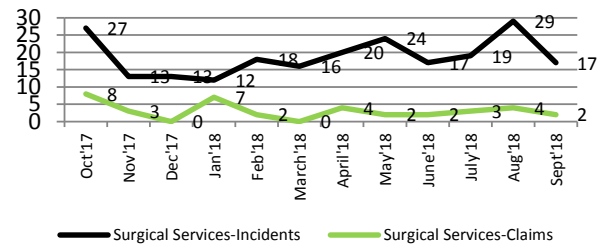
Lagging

	Actual	Target	Trend
H&S Incidents	17	20	
Work Injury Claims	2	0	
Lost Time Injuries	1	0	
Notifiable Events	0	0	

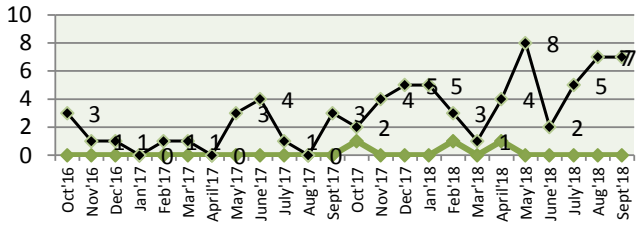
Leading

	Actual	Target	Trend
%H&S Inductions (YTD)	38	100	
H&S Rep Vacancies No.	1	2	
%H&S Rep Training	84	80	
%6 Monthly Workplace Checklist	65	80	
%H&S Incidents Follow up 14 days	10	10	

Health and Safety Incidents and Claims for 12 months



WORKPLACE VIOLENCE AND AGGRESSION



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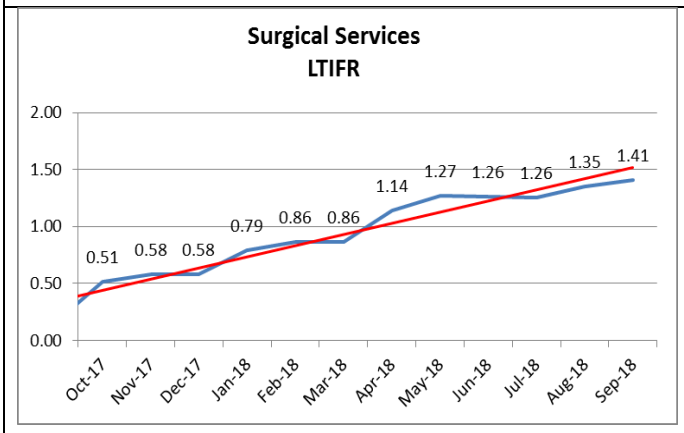
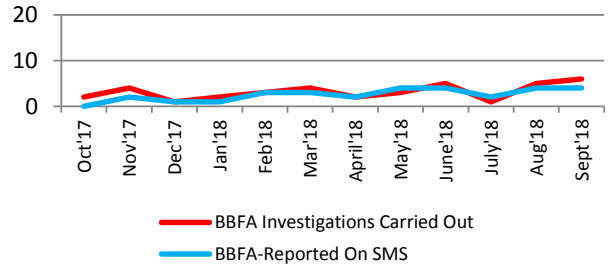


BLOOD AND BODY FLUID ACCIDENTS (From 1 Year Rolling)



Women's Health and Safety Report

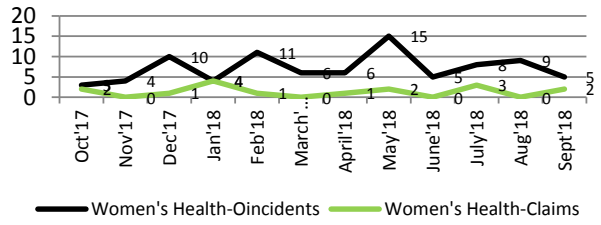
Lagging

	Actual	Target	Trend
H&S Incidents	5	20	
Work Injury Claims	2	0	
Lost Time Injuries	1	0	
Notifiable Events	0	0	

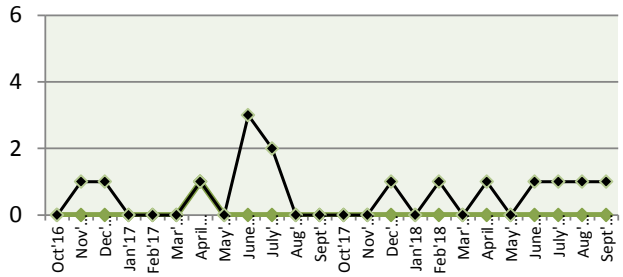
Leading

	Actual	Target	Trend
%H&S Inductions (YTD)	61	100	
H&S Rep Vacancies No.	2	2	
%H&S Rep Training	72	80	
%6 Monthly Workplace Checklist	100	80	
Outstanding DATIX Incidents	11	10	

Health and Safety Incidents and Claims for 12 months



WORKPLACE VIOLENCE AND AGGRESSION (From 2 Years Rolling)



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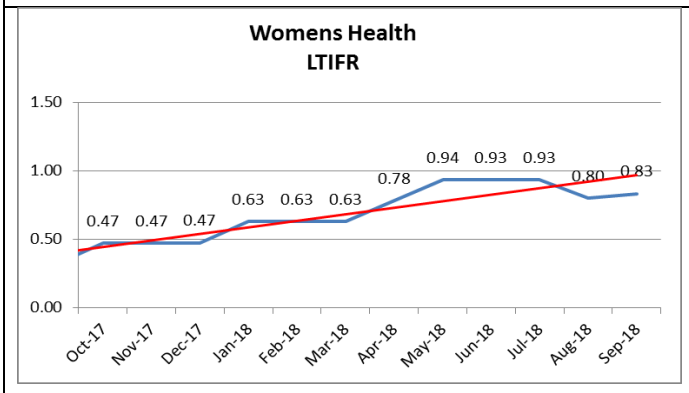
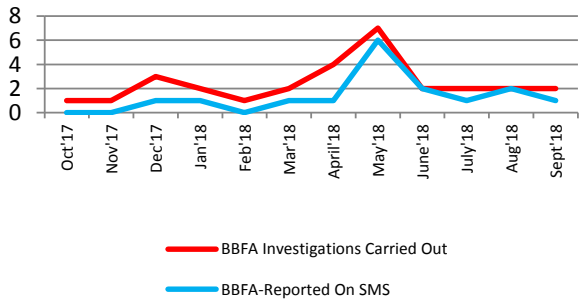
Womens Health LTIFR

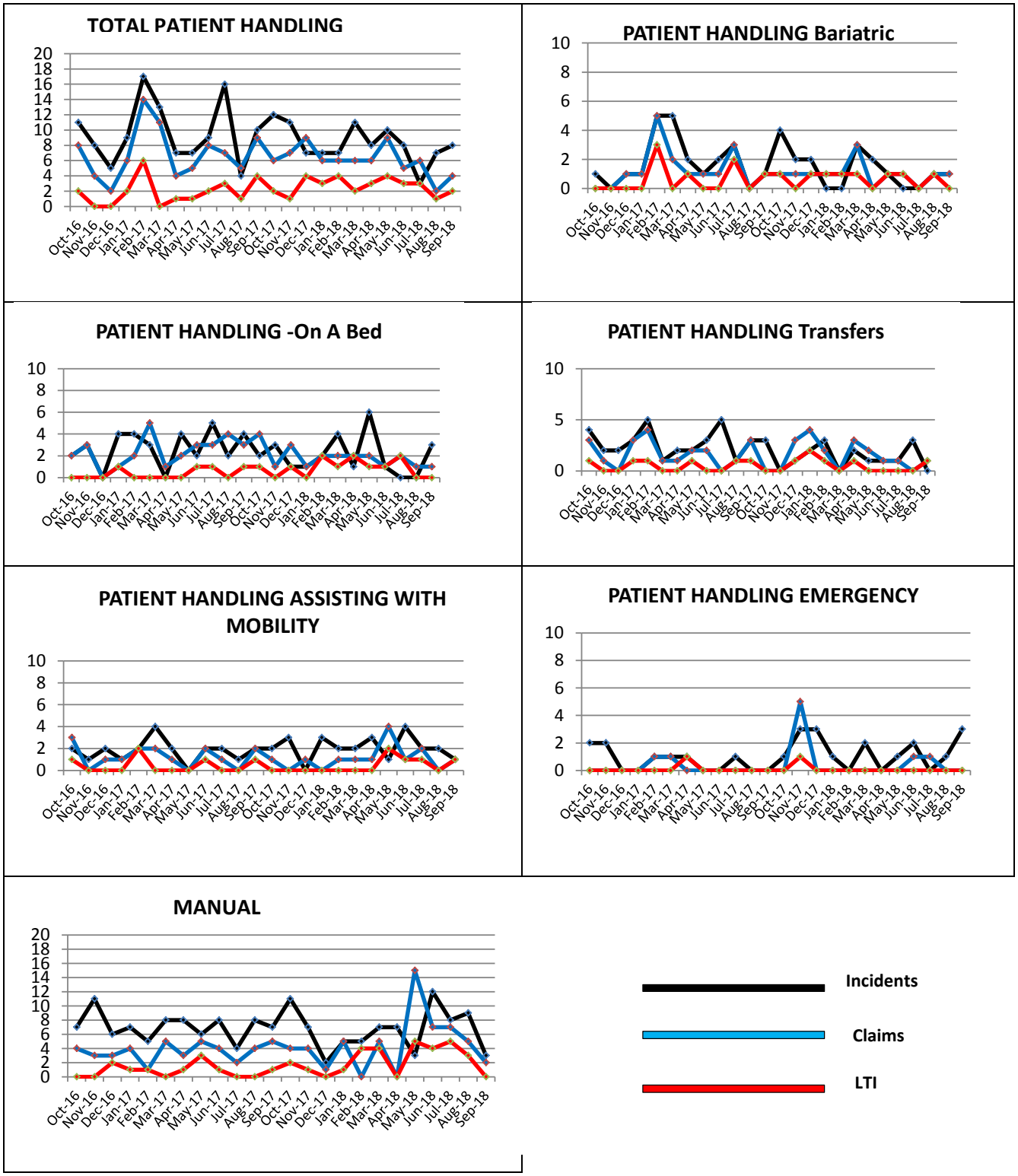


BLOOD AND BODY FLUID ACCIDENTS



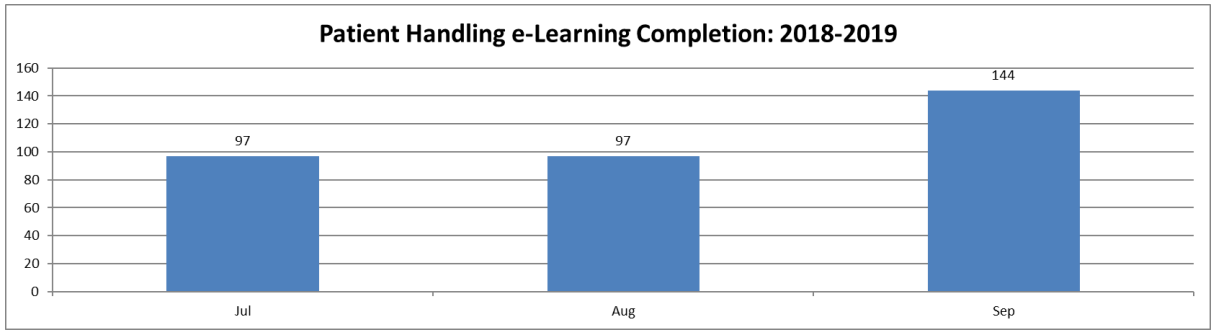
Appendix 1 - Moving and Handling

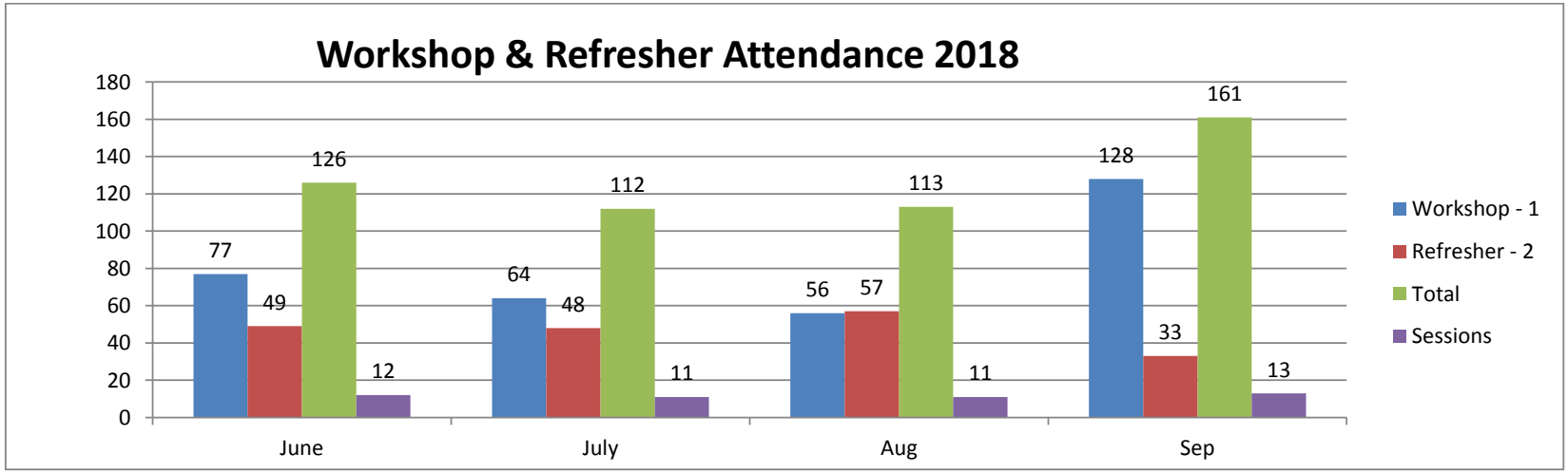
Table 5.1: Moving and Handling Injury causation



Appendix 2 - Moving and Handling

Workshops and Attendances for September 2018





Appendix 3 - Workplace Violence September 2018

AUCKLAND DHB	Workplace Violence reported			Workplace Violence CLAIMS
Directorate	September 18	%	YTD 2018	September 2018
Community & LTC	4	10%	42	0
Adult Medical	14	36%	74	1
ARPHS	0	0%	0	0
Cancer & Blood	2	5%	12	0
Cardio-Vascular	1	3%	12	0
Children's Health	0	0%	42	1
Clinical Support	0	0%	6	0
Commercial Services	0	0%	2	0
Corporate	0	0%	4	0
Mental Health	9	23%	201	1
Patient Management Services	1	3%	19	1
Perioperative	0	0%	3	0
Surgery	7	18%	41	0
Women's Health	1	3%	7	0
Total AUCKLAND DHB	39		465	4

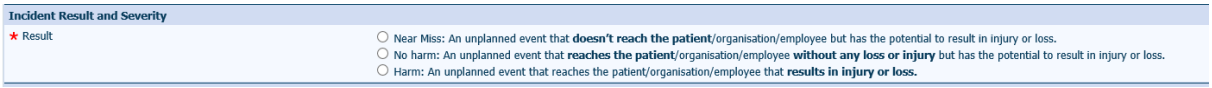
AUCKLAND DHB	Code Orange			
	September	%	YTD	%
ACH	114	80%	300	81%
Starship	19	13%	51	14%
Women's	0	0%	3	1%
GCC	1	1%	5	1%
Support Bldg.	9	6%	11	3%
Total AUCKLAND DHB	143		370	

A Code Orange call is activated by staff whenever they feel that their safety or that of others is compromised and their own methods to resolve the issue have not worked. A Code Orange Team comprises of Clinical Nurse Manager, Psychiatry Liaison and Security. Other personnel are utilised as required. All other team members and staff associated with the challenging behaviour/situation, follow the direction of the CNM to ensure management of the situation is effectively co-ordinated.

Appendix 4 - New DATIX Employee Incident Categories

Tier 1	Tier 2
Hazardous Substances	Liquids (Spills, Contaminations)
	Other Hazardous Substances (Spills, Contaminations)
	Asbestos related incident
Property / Equipment Damage	Damage under $1000
	Damage $1k-$10k
	Damage $10k-$50k
	Damage$50k-$100k
	Damage $100k+
Near Miss Any unplanned incident that occures at the workplace which, although not resulting in any injury, disease, or damage, had the potential to do so – AS 1885.1:1990	
Occupational Health (BBFA/Sharps/Hand Gel)	BBFA
	Sharps (other than BBFA)
	Hand Gel
	Chemical Exposure
Ergonomic (Includes Manual/Patient Handling)	Manual Handling
	Patient Handling
	Other Ergonomic
Workplace Violence	Critical Incident
	Staff to Staff Aggression
	Physical Contact: Patient to Staff
	Verbal: Patient to Staff
	Physical threat (no contact): Patient to Staff
	Physical Contact: Visitor/whanau to staff
	Verbal: Visitor/whanau to staff
	Physical threat (no contact): Staff to Patient
	Physical Contact: Staff to Patient
	Verbal: Staff to Patient
	Animal Attack
	Calming / Restraint process
Workplace Injury An injury which occurs but does not fit into any othe above categories. For example tripping up a flight of stairs, bumping a shin on a piece of furniture	Selection of appropriate Injury Severity option as below
Other Any incident which does not fall into any other category. Incident will be reviewed and reclassified by an OHS Advisor with consultation with the reporting person.	We have purposefully left the "Other" category for the short term in order to ensure that every incident can be adequately covered.

Removal of Incident Result and Severity option



Replacing with Injury Severity Option compliant with AS1885.1:1990

- **No Treatment**
  An injury in the workplace that requires no first aid treatment. Example – a slight strain that resolves without first aid intervention
- **First Aid**
  An injury requiring first aid treatment only
- **Treatment by a Health Provider (MTI)**
  An injury requiring treatment from a Health provider or the Emergency Department (ED)
- **Lost Time Injury**
  Any injury resulting in at least one full day off work following the day of the incident.
- **Fatality**
  Loss of a life or multiple lives.

Appendix 5 Definitions

Definitions for Monthly Performance Scorecard

Lost Time Injury Frequency Rate	LTIFR refers to the number of lost time injuries occurring in a workplace per one million man-hours worked. An LTIFR of seven, for example, shows that seven lost time injuries occur on a jobsite every one million man-hours worked. The formula gives a picture of how safe a workplace is for its workers. To further ensure that we see a trend in the LTIFR, this formula is applied over a 12-month period, this way we can see a trend and eventually, the impact of initiatives on the LTIFR.
Lost time injuries (LTI)	Includes all on-the-job injuries that require a person to stay away from work more than 24 hours, or which result in death or permanent disability. This definition comes from the Australian standard 1885.1– 1990 Workplace Injury and Disease Recording Standard.
Pre- Employment Health Screening	Process of medical screening to ensure that prospective employees are fit for their assigned role at Auckland DHB

Risk Matrix

Table 1 - Consequence Score (severity levels) **Impact on the safety of staff, patients, or public (physical/psychological harm)**				
1 Negligible	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
Minimal injury requiring no/ minimal intervention or treatment	Minor injury or illness, requiring minor intervention	Moderate injury requiring professional intervention	Major injury leading to long-term incapacity/ disability	Multiple permanent injuries or incident leading to death
No time off work	Requiring time off work for less than 3 days	Requiring time off work for 4-14 days	Requiring time off work for more than 14 days	
		Notifiable Event	Notifiable Event	Notifiable Event

Table 2 - Likelihood Score – What is the likelihood of the consequence occurring (re-occurring) / How often might it / does it happen			
Likelihood	**Incidence**	**Chance**	**Narrative**
1 - Rare	**3 Yearly**	**5%**	**Will occur only in exceptional circumstances**
2 - Unlikely	**Yearly**	**25%**	**May occur at some time**
3 - Possible	**Six-Monthly**	**50%**	**Will occur at some time**
4 - Likely	**Monthly**	**75%**	**Is likely to occur in most circumstances**
5 - Almost Certain	**Weekly**	**90%**	**Is certain to occur, possibly frequently**

Likelihood	**Consequence**				
	1 Negligible	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
5 - Almost Certain	**5**	**10**	**15**	**20**	**25**
4 - Likely	**4**	**8**	**12**	**16**	**20**
3 - Possible	**3**	**6**	**9**	**12**	**15**
2 - Unlikely	**2**	**4**	**6**	**8**	**10**
1 - Rare	**1**	**2**	**3**	**4**	**5**

Risk Score and Grade	**1 – 3 Low Risk**	**4 - 6 Medium Risk**	**8 – 12 High Risk**	**15 – 25 Critical Risk**

Human Resources Report

Recommendation

That the Board:

1. **Receives the Auckland DHB Human Resources report for November 2018.**
2. **Notes the progress towards achieving the Auckland DHB People Strategy commitments.**

Prepared by: Fiona Michel (Chief Human Resources Officer)
Endorsed by: Ailsa Claire (Chief Executive)

Glossary

Acronym/term	Definition
HR	Human Resources
MDP	Management Development Programme
NZNO	New Zealand Nurses Organisation
OD	Organisational Development
PSA	Public Service Association
SMO	Senior Medical Officer

1. Executive Summary

The purpose of this report is to provide the Board an update on the progress made towards delivering the Auckland DHB People Strategy. Our 2016-2019 People Strategy provides a pathway for working together so that we can all continue to do our life's best work for our patients, our whānau and our communities. The Auckland DHB People Strategy continues to deliver change through five programmes of work to help us all role model a happy, healthy, high-performing community by:

1. Accelerating capability and skills
2. Making it easier to work here
3. Building constructive relationships
4. Delivering on our promises
5. Ensuring a quality start

Progress on the workstreams that sit within these five programmes of work are as follows.

2. Progress/Achievements/Activity

Accelerating capability and skills

Management development programme

Training programme module development is progressing according to plan. We have a possible opportunity to accelerate further progress through collaboration with Canterbury DHB who are seeking to complete a similar piece of work. We have agreed to explore collaboration on the existing Management Development Programme (MDP), with Canterbury DHB adding financial resources into

our programme, enabling acceleration and/or extension of the MDP and use by both organisations. First conversation has taken place and they are reviewing the offering procured by Auckland.

Mentoring

The coordination of a consistent approach to mentoring across the organisation will begin in Q3. The programme will feature specific streams of mentoring to meet the needs of our Māori and Pacific employees.

Change framework

It has been clarified the Change work will focus on role modelling exemplary change practice through large organisational initiatives, including Just and Safety Culture and the building of capability around change through the wider Human Resources (HR) team's support for their directorates.

Making it easier to work here

Leader upgrade

The first of two upgrades to our Payroll system is scheduled to go live early October 2018. All upgrades on Leader and Kiosk are due to be complete by July 2019. This is a requirement prior to moving to Leave Manager which is a 6-12 month upgrade and is required to ensure compliance.

HR Services work programme

The implementation of online employee files is on track for go live in October 2018. This means we will begin to house all personnel records online, rather than using physical paper records. The reconfiguration of Workforce Central is underway which should see an increase in customer satisfaction and a reduction in manual work. Mobile technology is also in pilot to enable timesheets to be approved by smart phone, which will also be valued by our workforce.

Workforce data

We have a central recording system in place for performance and development conversations as required by the Hospital Certification Audit in 2017. Performance Conversation Workshops are being held for managers which include use of the performance recording tool. We are currently tracking manager participation in these workshops. In addition, our Organisational Development (OD) Practice Leader- Capability, is attending Leadership Team Meetings to reinforce the expectation of managers to utilise the Performance Management Tool.

Building constructive relationships

Together programme

This programme of work is on track, on time and on budget. Following a successful discovery phase enagaging a range of professions, roles and people to identify what behaviours are needed to live our values, the design of culture tools and resources for use throughout the organisation is now underway.

Employee survey

This initiative is on track to open Auckland DHB's second survey in November 2018. We are using the same provider, enabling good benchmarking with our 2016 survey and with healthcare providers globally. Manager (training) roadshows begin in October 2018 to prepare people leaders and their teams to participate in the survey and follow-on action planning.

Just and safety culture

Just and Safety Culture project initiation activities have commenced with the Steering Committee membership confirmed, terms of reference and meeting approach agreed to. A business case is to be drafted in order to secure organisation support, budget and a Request for Proposal approach.

Delivering on our promises

Belonging/recruitment and retention

Rainbow focus groups are currently underway as one of our final activities towards Rainbow Tick certification.

There is a change of OD Practice Leader for this diversity and inclusion (Belonging) portfolio due to the incumbent leaving. Recruitment for the role is underway.

Speak Up programme

Speak Up working group membership numbers have recently been increased to address capacity and work programme requirements. A campaign is also currently being scoped to attract new supporters, numbers of which we would like to increase to >200.

Development of a manager's coaching framework is underway to refresh and support current materials that will continue to ensure effective response to Speak Up submissions.

A confidential system option is being explored for collection of all Speak Up submissions in one location, which would help ensure a consistent response with well managed care plans for our people.

Wellbeing

The Wellbeing Programme Steering Committee has been refreshed and re-launched and includes Executive, Senior Medical Officer (SMO), Nursing, Allied Health, Union and external representation. The Programme is focusing on increasing collaboration, cooperation and a joined-up approach across the organisation to issues of wellbeing.

Remuneration Strategy

To Thrive programme initiatives are well underway for the Cleaning, Waste Orderly and Orderly services pilot group. Since To Thrive was launched in June 2018, interest is expanding to other employee groups across Auckland DHB.

SMO Workbook tool development and the programme of work leading towards implementation continues with the Vendor, healthAlliance and other stakeholders.

2020-2025 People Strategy

A draft plan for co-designing the next iteration of the People Strategy has been written to enable delivery by June 2019.

Holidays Act review

A meeting to conclude the terms of reference and framework with Ministry of Business, Innovation and Employment, Council of Trade Unions and DHB representatives is scheduled for November 2018. Nationally, there are ongoing conversations about system level implications of the Holidays Act. Auckland DHB has provided resourcing support to the national process.

Pay equity

Pay Equity claims for all DHBs are being managed at a national level. Seven regional or national pay equity claims have been received by DHBs from the Public Service Association (PSA), Midwifery Employee Representation and Advisory Services and New Zealand Nurses Organisation (NZNO) unions, covering 170 occupations across administration and clerical, nursing, midwifery and allied health workforces. Auckland DHB has provided resourcing support to the national process.

The Employment Relations Strategy Group has endorsed a national approach where multiple pay equity claims cover the same workforces. This strategy will require different unions to combine their claims and work together.

The first pay equity claim to be assessed is the PSA Administration and Clerical claim. The PSA have highly resourced their pay equity campaign and bargaining team. They are active on several DHB sites and are promoting that pay increases of up to 45% are likely as a result of the pay equity claim.

The PSA have requested an effective date for their pay equity claim. The inclusion of an effective date for the NZNO claim was an outcome of the Independent Panel Process.

In September 2018 Auckland DHB represented large DHBs as a pilot site for the pay equity Work Assessment tool, requiring 40 PSA member employees to be interviewed about the content of their roles. Although resource intensive, this information gathering process was well received by the PSA and supported Technical Advisory Services to progress the claim.

Ensuring a quality start

Recruitment strategy

A paper reflecting outcomes from the Recruitment Review undertaken with key stakeholder groups earlier in 2018 has been discussed. It recommends an improved in-house model of recruitment, and an initial tranche of funding has been provided to begin to enhance the capability and capacity of the recruitment service.

3. Conclusion

This report has provided the Board with an update on the progress made towards delivering the Auckland DHB People Strategy objectives; in particular the workstreams that sit within the five programmes of work. Further progress reports will be submitted to the Board at upcoming meetings.

Financial Performance Report – Three Months Ending September 2018

Recommendation

That the Board receive this Financial Report for the three months ending September 2018

Prepared by: Rosalie Percival, Chief Financial Officer
Date: 30 October 2018

1. Executive Summary

The audit for the year ending 30 June 2018 was completed in October 2018 by Audit New Zealand and the audited Annual Report was approved by the Board via circular resolution by 30 October 2018. There were no changes to the reported result of a $1M surplus against a budgeted breakeven result.

The final 2018/19 Annual Plan and budget was approved by the Board via circular resolution on 26 October 2018. The 2018/19 budget is for a breakeven result.

Performance for the month of September 2018 against budget shows a net surplus of $2M which was unfavourable by $2.4M to the budgeted surplus of $4.4M.

Performance for the year to date (YTD) shows a net deficit of $7M which was unfavourable by $6M to the budgeted deficit of $0.9M. The overall YTD net deficit unfavourable variance is made up as follows:

Result by Division	**YTD (three months ending 30 Sept-18)**		
	Actual	**Budget**	**Variance**
Funder	7,138	6,000	1,138 F
Provider	(14,961)	(6,894)	8,068 U
Governance	617	(31)	648 F
Net Surplus / (Deficit)	**(7,207)**	**(925)**	**6,282 U**

- The favourable Funder arm result is primarily due to favourable revenue from MOH contracts and lower than budgeted demand driven expenditure across health of older people and primary health organisations.
- The unfavourable Provider arm result is primarily revenue driven, with revenue less than budget by $9.6M. This is mainly driven by a liability provision for under-delivery of electives and IDF volumes.
- The favourable Governance result is mainly due to less expenditure than budgeted for outsourced funder services and infrastructure costs (mainly IT and Professional fees).

2. Summary Result and Financial Commentary for September 2018

$000s	Month (Sept-18)			YTD (three months ending 30 Sept-18)		
	Actual	Budget	Variance	Actual	Budget	Variance
Income						
Government and Crown Agency	130,312	128,294	2,018 F	386,768	385,412	1,356 F
Non-Government and Crown Agency	8,244	7,854	390 F	24,249	23,417	832 F
Inter- District Flows	54,190	54,075	116 F	162,562	162,224	338 F
Inter-Provider and Internal Revenue	(958)	1,579	2,537 U	(5,915)	4,736	10,652 U
Total Income	**191,789**	**191,801**	**12 U**	**567,663**	**575,789**	**8,126 U**
Expenditure						
Personnel	77,521	80,661	3,141 F	242,824	254,602	11,778 F
Outsourced Personnel	2,528	1,167	1,361 U	7,305	3,529	3,776 U
Outsourced Clinical Services	3,311	2,824	487 U	8,637	8,610	27 U
Outsourced Other Services	6,325	6,174	150 U	19,098	18,523	575 U
Clinical Supplies	24,970	23,701	1,269 U	75,970	72,996	2,974 U
Funder Payments - NGOs and IDF Outflows	57,064	55,824	1,240 U	167,770	167,472	298 U
Infrastructure & Non-Clinical Supplies	18,013	17,023	991 U	53,266	50,981	2,285 U
Total Expenditure	**189,732**	**187,374**	**2,358 U**	**574,870**	**576,714**	**1,843 F**
Net Surplus / (Deficit)	**2,057**	**4,427**	**2,370 U**	**(7,207)**	**(925)**	**6,282 U**

Result by Division	Month (Sept-18)			YTD (three months ending 30 Sept-18)		
	Actual	Budget	Variance	Actual	Budget	Variance
Funder	1,378	2,000	622 U	7,138	6,000	1,138 F
Provider	476	2,422	1,946 U	(14,961)	(6,894)	8,068 U
Governance	203	5	198 F	617	(31)	648 F
Net Surplus / (Deficit)	**2,057**	**4,427**	**2,370 U**	**(7,207)**	**(925)**	**6,282 U**

Commentary on DHB Consolidated Financial Performance

Month Result - Major variances to budget on a line by line basis are described below:

Revenue is unfavourable to budget by $12k and mainly driven by:

- $2M (21%) favourable Government and Crown Agency revenue, largely due to higher than budgeted ACC Income and other Government sourced funds received in the month.
- $2.5M (-160.7%) unfavourable Inter-Provider and Internal revenue, reflecting a provision for IDF wash-up, due to year to date IDF volumes below contract.

Expenditure is unfavourable to budget by $2.4M (-1.3%) mainly driven by:

- $1.8M (3.8%) favourable combined Personnel/Outsourced staff costs mainly in Medical and Nursing staff costs. FTEs are overall close to budget.
- The remaining variance is due to unfavourable movements across all other expenditure categories.

Year to Date Result - Major variances to budget on a line by line basis are described below.

Total Revenue is unfavourable to budget by $8M (-1.4%), mainly driven by:

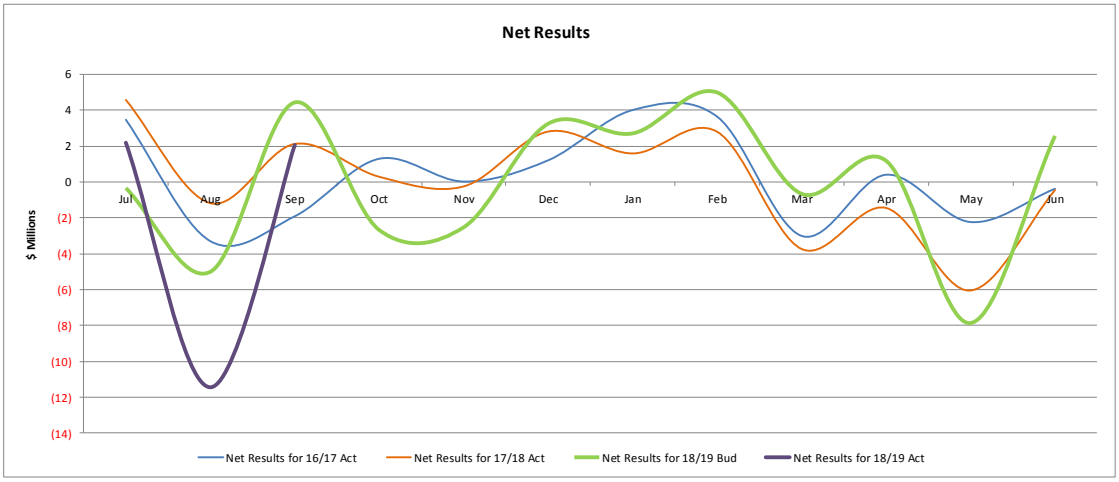
- $1.4M (0.4%) favourable variance in Government and Crown Agency revenue, due to lower MOH side contract income for both the Funder ($5M) and Provider ($3M). These are mostly in line with services delivered.
- $11M (-225%) unfavourable Inter-Provider and Internal revenue, mainly reflecting a $9.2M provision for IDF wash-up. The provision is in line with YTD IDF and elective volumes under-delivery.

Total expenditure is $1.8M (0.3%) favourable, mainly driven by:

- $8M (3.1%) favourable variance in Personnel/Outsourced Personnel costs - this movement reflects FTEs below budget by 55 FTE (0.60%) and one off favourable variance for MECA implementation costs.
- $3M (-4.1%) unfavourable variance in Clinical Services mainly due to clinical supplies savings not realised; $0.6M unfavourable in Ophthalmology due to new drug approved recently by Pharmac ; $0.5M unfavourable in Radiology due to volume and cost of interventional radiology procedures over budget; and $0.5M unfavourable in Paediatric Haematology and Oncology due to unusually high volumes for this service resulting in high pharmaceutical costs.
- $2.3M (-4.5%) unfavourable variance in Infrastructure and Non Clinical supplies YTD expenditure is mainly due to the following: $1.6M unfavourable repairs and maintenance reflecting high infrastructure maintenance costs and $0.6M unfavourable bad and doubtful debts in line with favourable non resident income to date.

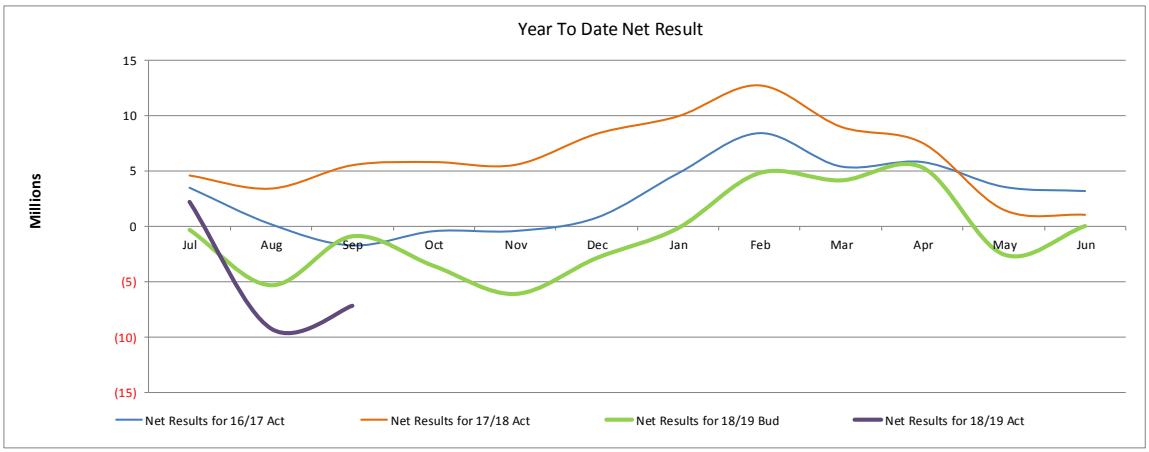
3. Performance Graphs

Figure 1: Consolidated Net Result (Month)



$ millions	July	August	Spetember	October	November	December	January	February	March	April	May	June	Total
Net Results for 16/17 Act	3.462	(3.302)	(1.914)	1.290	0.017	1.203	4.004	3.636	(3.010)	0.398	(2.238)	(0.384)	2.871
Net Results for 17/18 Act	4.569	(1.187)	2.114	0.283	(0.252)	2.806	1.585	2.793	(3.739)	(1.453)	(6.051)	(0.456)	1.012
Net Results for 18/19 Bud	(0.342)	(5.010)	4.427	(2.683)	(2.530)	3.244	2.703	4.982	(0.666)	1.175	(7.867)	2.566	(0.000)
Net Results for 18/19 Act	2.183	(11.446)	2.057										(7.207)

Figure 2: Consolidated Net Result (Cumulative YTD)



$'millions	July	August	September	October	November	December	January	February	March	April	May	June
Net Results for 16/17 Act	3.462	0.159	(1.755)	(0.465)	(0.448)	0.755	4.759	8.394	5.385	5.783	3.545	3.162
Net Results for 17/18 Act	4.569	3.382	5.497	5.779	5.527	8.333	9.919	12.712	8.972	7.520	1.468	1.012
Net Results for 18/19 Bud	(0.342)	(5.352)	(0.925)	(3.608)	(6.137)	(2.893)	(0.190)	4.791	4.125	5.300	(2.566)	(0.000)
Net Results for 18/19 Act	2.183	(9.263)	(7.207)									
Variance to Budget 18/19	2.525	3.912	6.282									

4. Financial Sustainability

Auckland DHB has generated significant savings over the past few years despite the savings becoming more difficult to find and deliver. To improve savings delivery capability, the DHB has implemented a Financial Sustainability Program to ensure continuous identification, assessment (risk and achievability), implementation and monitoring of savings initiatives.

The plan for 2018/19 is to deliver total benefits of $11.5M, with benefits to be generated within the Provider Arm. The benefits have been phased according to expected delivery. For year to date, benefits of $817k have been achieved against the phased target of $1M, resulting in a $228k adverse variance to plan.

September 2018 Summary Position

2018/19 Provider Financial Sustainability	YTD Actual $000	YTD Target $000	YTD Variance $000	Full Year Forecast $000	Full Year Target $000	Full Year Variance $000
Revenue Growth	271	188	83	3,250	3,250	0
Procurement & Supply Chain	252	457	-205	3,513	3,513	0
Loss Making Services	0	106	-106	2,118	2,118	0
Cost Containment	0	0	0	60	60	0
Sustainability Initiatives	0	0	0	200	200	0
Models of Care	0	0	0	500	500	0
Patient Flow	8	10	-2	40	40	0
Outpatients	286	284	2	1,832	1,832	0
Total	817	1,045	-228	11,513	11,513	0

Commentary on Performance by Workstream:

- **Revenue Growth [YTD $83k F] -** This workstream covers a range of initiatives including data quality work focusing on ensuring all activity is captured and appropriately funded, and reviewing funding for national services.

- **Procurement & Supply Chain [YTD $205k U] -** This initiative relates to healthAlliance, Pharmac, MBIE and DHB led procurement and supply chain savings. The initiatives include efficiencies in stock management, product rationalisation and procurement savings. HealthAlliance savings of $252k are reported against a budget of $457k.

- **Loss Making Services [YTD $106k U] -** Eleven services have been identified and prioritised for review. To date reviews have been completed for Bone Marrow Transplant Unit, Cardiology, Vascular, Neurosurgery, ORL, Orthopaedics, General Surgery and Cardiothoracic. The reviews have highlighted opportunities for improved volume and revenue capture as well as possible cost containment. Work on realising the identified opportunities will continue throughout the year. The year to date unfavourable variance is for Haematology savings not yet realised.

- **Cost Containment -** Benefits from the recently implemented FCM Online Travel Approvals system – phased to commence October 2018.

- **Sustainability Initiatives -** Targets yet to be confirmed.

- **Models of Care -** Benefits for COPD phase 2 to commence November 2018. Other opportunities in this area are being investigated.

- **Patient Flow [YTD $2k U] -** This reflects the benefits achieved year to date for the Discharge Planning project.

- **Outpatients [YTD $2k F] -** The Outpatient Production planning programme went live in May 2018 and has delivered benefits in this financial year of $286k through increasing clinic session utilisation. The programme is on target as at Quarter one.

5. Financial Position

5.1 Statement of Financial Position as at 30 September 2018

$'000	30-Sep-18			31-Aug-18	Variance	30-Jun-18	Variance
	Actual	Budget	Variance	Actual	Last Month	Actual	Last Year
Public Equity	881,298	881,298	0F	881,298	0F	881,298	0F
Reserves							
Revaluation Reserve	515,639	515,639	0F	515,639	0F	515,639	0F
Accumulated Deficits from Prior Year's	(456,995)	(457,007)	12F	(456,995)	0F	(458,009)	1,014F
Current Surplus/(Deficit)	(7,206)	(925)	6,281U	(9,263)	2,057F	1,014	8,220U
	51,438	57,707	6,270U	49,381	2,057F	58,644	7,206U
Total Equity	**932,736**	**939,005**	**6,270U**	**930,679**	**2,057F**	**939,942**	**7,206U**
Non Current Assets							
Fixed Assets							
Land	321,582	321,582	0F	321,582	0F	321,582	0F
Buildings	578,093	580,481	2,388U	578,914	821U	581,987	3,894U
Plant & Equipment	85,975	89,359	3,383U	86,876	901U	87,854	1,879U
Work in Progress	36,769	39,076	2,307U	33,229	3,540F	30,418	6,351F
Total PPE	1,022,420	1,030,498	8,078U	1,020,602	1,818F	1,021,841	579F
Investments							
- Health Alliance	64,525	63,742	784F	64,062	463F	63,452	1,074F
- HZHPL	11,053	9,646	1,407F	9,646	1,407F	9,646	1,407F
- ADHB Term Deposits > 12 months	2,317	-	2,317F	2,318	2U	1,818	498F
- Other Investments	538	538	0F	538	0F	538	0F
	78,433	73,926	4,507F	76,564	1,868F	75,454	2,979F
Intangible Assets	1,350	1,252	97F	1,300	50F	1,251	98F
Trust Funds	13,774	15,308	1,535U	13,749	25F	13,490	284F
	93,556	90,486	3,070F	91,614	1,943F	90,195	3,361F
Total Non Current Assets	**1,115,977**	**1,120,984**	**5,008U**	**1,112,216**	**3,760F**	**1,112,037**	**3,940F**
Current Assets							
Cash & Short Term Deposits	114,454	108,136	6,317F	100,168	14,286F	97,106	17,348F
Trust Deposits > 3months	14,291	15,792	1,502U	16,292	2,002U	15,792	1,502U
ADHB Term Deposits > 3 months	30,000	30,000	0F	30,000	0F	30,000	0F
Debtors	26,982	32,222	5,240U	35,019	8,038U	32,222	5,240U
Accrued Income	64,547	60,344	4,204F	63,238	1,310F	60,344	4,204F
Prepayments	5,771	1,225	4,545F	8,110	2,339U	1,225	4,545F
Inventory	14,176	13,853	323F	14,435	259U	13,853	323F
Total Current Assets	**270,220**	**261,572**	**8,648F**	**267,262**	**2,958F**	**250,542**	**19,678F**
Current Liabilities							
Borrowing	(559)	(2,164)	1,605F	(595)	36F	(666)	107F
Trade & Other Creditors, Provisions	(182,984)	(166,632)	16,352U	(176,628)	6,355U	(152,718)	30,266U
Employee Entitlements	(208,193)	(206,046)	2,147U	(209,847)	1,654F	(208,503)	309F
Funds Held in Trust	(1,275)	(1,275)	0F	(1,275)	0U	(1,275)	0U
Total Current Liabilities	**(393,011)**	**(376,117)**	**16,894U**	**(388,344)**	**4,666U**	**(363,161)**	**29,850U**
Working Capital	**(122,792)**	**(114,545)**	**8,247U**	**(121,083)**	**1,708U**	**(112,620)**	**10,172U**
Non Current Liabilities							
Borrowings	(4,355)	(10,013)	5,658F	(4,360)	5F	(4,510)	155F
Employee Entitlements	(56,094)	(57,421)	1,327F	(56,094)	0F	(54,965)	1,129U
Total Non Current Liabilities	**(60,449)**	**(67,434)**	**6,985F**	**(60,455)**	**5F**	**(59,475)**	**974U**
Net Assets	**932,736**	**939,005**	**6,270U**	**930,679**	**2,057F**	**939,942**	**7,206U**

Commentary

The major variances to budget are summarised as:

Property, Plant and Equipment:
The variance reflects capital expenditure tracking below budget. Budgeted capital spend is based on timing of implementation of capital projects as advised by services which may vary due to timing of capital approval, procurement and implementation timeframes.

Cash and Short Term Deposits:
The higher than budgeted balance mainly reflects the impact of the delay in the capital program on cash, lower than budgeted payments to providers / suppliers and favourable timing of debtors budgeted revenue received.

Debtors and Accrued Income:
Debtors and Accrued income in total is lower than budgeted levels mainly driven by timing of receipts from MOH. The timing is reflected in the higher than budgeted cash on hand balance.

Borrowings:
Borrowings balance is below budget by $5.7M mainly driven by the timing of planned financing lease arrangements.

Trade and Other Creditors, Provisions:

Is made up of:	**$000's**
Trade Creditors (including accruals)	167,149
Income in Advance	15,418
Provisions (Litigation)	417
Total	182,984

5.2 Statement of Cash flows (Month September 2018)

$000's	30-Sep-18			YTD (three months ending 30 Sept-18)		
	Actual	Budget	Variance	Actual	Budget	Variance
Operations						
Revenue Received	194,831	191,347	3,484F	566,242	574,427	8,185U
Payments						
Personnel	(79,175)	(80,661)	1,487F	(242,004)	(254,602)	12,598F
Suppliers	(43,900)	(42,308)	1,592U	(130,878)	(128,898)	1,979U
Capital Charge	0	0	0F	-	0	0F
Payments to other DHBs and Providers	(53,248)	(55,744)	2,497F	(163,952)	(166,959)	3,007F
GST	(2,695)	0	2,695U	(516)	0	516U
	(179,016)	(178,713)	303U	(537,350)	(550,460)	13,110F
Net Operating Cash flows	**15,815**	**12,633**	**3,181F**	**28,892**	**23,967**	**4,925F**
Investing						
Interest Income	456	454	2F	1,333	1,362	28U
Sale of Assets	0	0	0F	45	0	45F
Purchase Fixed Assets	(2,050)	(6,796)	4,746F	(11,127)	(20,389)	9,264F
Investments and restricted trust funds	130	0	130F	(1,481)	0	1,481U
Net Investing Cash flows	**(1,465)**	**(6,343)**	**4,878F**	**(11,230)**	**(19,028)**	**7,799F**
Financing						
Interest paid	0	(100)	100F	(30)	(300)	270F
New loans raised	0	0	0F	-	6,903	6,903U
Loans repaid	(62)	(80)	18F	(283)	(513)	230F
Other Equity Movement	0	0	0F	-	0	0F
Net Financing Cash flows	**(62)**	**(180)**	**118F**	**(313)**	**6,090**	**6,404U**
Total Net Cash flows	**14,288**	**6,111**	**8,176F**	**17,349**	**11,030**	**6,317F**
Opening Cash	100,168	102,024	1,858U	97,106	97,106	0F
Total Net Cash flows	14,288	6,111	8,176F	17,349	11,030	6,317F
Closing Cash	**114,454**	**108,136**	**6,317F**	**114,454**	**108,136**	**6,317F**
ADHB Cash				111,723	106,390	5,333F
A+ Trust Cash				2,397	1,414	983F
A+ Trust Deposits - Short Term < 3 mths & restricted fund				334	332	2F
				114,454	**108,136**	**6,317F**
ADHB - Short Term > 3 months				30,000	30,000	0F
A+ Trust Deposits - Short Term > 3 months				14,291	15,792	1,502U
ADHB Deposits - Long Term				-	-	0F
A+ Trust Deposits - Long Term				16,090	15,308	782F
Total Cash & Deposits				**174,835**	**169,237**	**5,598F**

Planning Funding and Outcomes Update

Recommendation

That the Board note the key activities within the Planning, Funding and Outcomes Unit since the last update provided on 26 September 2018.

6.2

Prepared by: Wendy Bennett (Manager Planning and Health Intelligence), Joanne Brown (Funding and Development Manager Hospitals), Tim Wood (Funding and Development Manager Primary Care), Kate Sladden (Funding and Development Manager Health of Older People), Ruth Bijl (Funding and Development Manager Women, Children and Youth), Trish Palmer (Funding and Development Manager Mental Health and Addictions), Shayne Wijohn (Manager Māori Health Gain), Lita Foliaki (Manager Pacific Health Gain), Raj Singh (Project Manager Asian, Migrant and Refugee Health Gain)
Endorsed by: Dr Debbie Holdsworth (Director, Funding), Dr Karen Bartholomew (Director, Health Outcomes)

Glossary

ACC	-	Accident Compensation Commission
ARC	-	Aged Residential Care
ARPHS	-	Auckland Regional Public Health Service
CELT	-	Commissioning Executive Leadership Team
CCL	-	Cardiac Catheter Laboratory
CfYH	-	Centre for Youth Health
CLP	-	Community Learning Programme
CSC	-	Community Services Card
CVICU	-	Cardiovascular Intensive Care Unit
DHB	-	District Health Board
DSLA	-	Diabetes Service Level Alliance Team
ECMO	-	Extracorporeal Membrane Oxygenation
EP	-	Electrophysiology
ESPI	-	Elective Services Performance Indicators
ETHC	-	East Tamaki Health Care
FCT	-	Faster Cancer Treatment
FFtF	-	Fit for the Future
HBHF	-	Healthy Babies Healthy Futures
HCSS	-	Home and Community Support Services
HIPs	-	Health Improvement Practitioners
HPV	-	Human Papilloma Virus
HVAZ	-	Healthy Village Action Zones
IDF	-	Inter District Flows
MaCSA	-	Maternal and Child Services Alliance
MoH	-	Ministry of Health
NCHIP	-	National Child Health Information Platform
NCSP	-	National Cervical Screening Programme
NGO	-	Non-Governmental Organisation
OIS	-	Outreach Immunisation Service
PHAP	-	Pacific Health Action Plan
PHO	-	Primary Health Organisation
PVS	-	Price Volume Schedule
SLM	-	System Level Measures
YTD	-	Year to Date

1 Summary

This report updates the Auckland District Health Board (DHB) on Planning and Funding and Outcomes activities and areas of priority, since its last meeting on 26 September 2018.

2 Planning

2.1 Annual Plan

The final draft of the Annual Plan is due for submission to the Ministry of Health (MoH) on 1 November 2018. This will be sent via email to Board members for circular resolution approval prior to submission. Updates and amendments in line with Ministry feedback have been incorporated, alongside updated financial content.

2.2 Annual Report

The 2017/18 Annual Report is due for completion by 31 October. A draft has been submitted to the Ministry for Ministerial review. The final draft was presented to the Finance, Risk and Assurance Committee Meeting on 17 October and subsequently to Board members via email with letters of representation for final approval through circular resolution.

2.3 System Level Measures (SLM) Improvement Plans

Implementation of activities in the 2018/19 SLM Improvement Plan is ongoing. The Q4 2017/18 SLM report is included under separate cover.

2.4 Cancer Equity Planning

Analyses of cancer data to support the regional cancer work programme is currently being undertaken – considering mortality, registrations, cancer survival rates, screening rates and timeliness of treatment.

3 Primary Care

3.1 Auckland Waitemata Alliance

The Chairs for Auckland and Waitemata DHBs, Pat Snedden and Judy McGregor, met with the Alliance Leadership Team to present and discuss priorities and focus. The discussion focused on equity and a shift to a rights based approach, as opposed to a deficit approach to health. Further the leadership team was challenged to not necessarily accept closing the gap is sufficient and questioning if the current level of outcome/performance is acceptable and or desirable. Thus, in addition to closing the gaps the leadership team may need to also improve overall performance and outcomes achievement.

3.2 Implementation of new Primary Care Initiatives from 1 December 2018

From 1 December 2018, several changes will take place to provide people with greater access to primary care. The changes are part of Budget 2018 and include:

- Extending access to low-cost general practice visits to all Community Services Card (CSC) holders. This includes injury-related visits Accident Compensation Commission (ACC). The changes provide additional subsidies to enable general practices to charge patients no more than $18.50 for enrolled adults and $12.50 for enrolled youth aged 14-17 for a standard day time nurse or GP consultation. Dependents of people with a CSC will also be able to access low-cost visits

- Extending CSC eligibility to all people receiving the accommodation supplement or who are tenants in social housing
- Extending zero-fee general practice visits and exemption from the standard prescription co-payment charge (usually $5 per item) on subsidised prescription items for children under the age of 14. This includes after-hours services and injury-related visits (ACC).

The funding team, in collaboration with the Ministry of Health and PHOs, are working through the implementation process. General practices' are able to opt-in and choose a 1 December 2018 or 1 January 2019 implementation date for the CSC holders aspect. For the extension to zero-fee for under 14s general practices' can decide to opt-out, however it is anticipated this is very unlikely.

3.3 Primary Care Emergency Preparedness Forum

On 23 Oct 2018 a primary care emergency preparedness forum is occurring. This is an opportunity to explore the current level of preparedness and what can be improved upon.

The forum aims to develop guidance for the northern region on emergency preparedness expectations for primary care. To enable this, the forum will:

- Clarify the existing emergency preparedness requirements in the PHO Services Agreement, After Hours and Community Pharmacy contracts.
- Confirm DHB expectations of providers and their work programme to meet the requirements and seeking feedback to better understand the implications.
- Identify examples of best practice that could assist and support overall improved preparedness.

A common sense emergency preparedness guidance document is planned to be produced following this event.

4 Health of Older People

4.1 Age Residential Care (ARC)

Transitional funding for ARC providers with a material pay equity deficit is continuing for 2018/19. As pay equity funding is included in the bed day price it is based on averages, meaning some providers are disadvantaged whilst others are better off. Therefore, providers who have a pay equity deficit greater than 1.5% of their eligible support workers' wage costs pre 30 June 2017 are able to apply for transitional funding. Seven Auckland DHB facilities have applied for transitional funding; we will work with them using the ARC Analysis Tool to determine if there is a material deficit. The MoH has a $3,000,000 capped transition fund. Funding to providers will be pro-rated to stay within this limit if necessary.

Submissions for the review of the National Age Related Residential Care (ARRC) Agreement (A21) are due at the end of October 2018. It is reasonable to expect there may be changes to the ARRC Agreement as a result of the ARC Funding Model Review (currently underway, initial report due in December 2018). These are unlikely to come into effect for 1 July 2019. From engagement to date, the areas of focus for the Funding Model Review are:

- a more refined case mix approach
- accommodation payment/financing arrangements
- mechanisms for procuring and funding primary care, pharmacy and allied health for ARC residents
- funding settings relating to short-stay and long-stay care

- mechanisms to support appropriate access to ARC for rural populations.

When considering issues for the annual review we've been asked to be mindful of issues that have been captured within the Funding Model Review engagement process.

4.2 Home and Community Support Services (HCSS)

A review of the cost model for the Auckland DHB HCSS casemix is underway. The University of Auckland (Department of Accounting & Finance) developed the original cost model using an activity-based costing approach and are undertaking the review. An initial workshop has been held with providers, and templates agreed for data collection (to be completed by the end of October 2018). Aspects covered by the review are: assumptions and, practices and policies built into the model; amendments required due to the introduction of in between travel, guaranteed hours and pay equity; and changes required due to changes in the model of care. This review is not to renegotiate the price but, changes could be relativities between case mix categories.

5 Women, Children & Youth

5.1 Immunisation

Health Target

The Immunisation Health Target was met in Quarter 1, with 95% of babies fully vaccinated by eight months of age. Pacific results are particularly pleasing at 97%. The equity gap for Māori however has widened again, with coverage back at 86%.

HealthWEST signed the NIR/Outreach Immunisation Service (OIS) contract for the 18/19 Financial Year in its original form, despite their request to negotiate term, funding and specifications. Discussions have now been held with HealthWEST to signal the intention to implement the National Child Health Information Platform (NCHIP) in early 2019, acknowledging there will be implications for the NIR service and that formal consultation with stakeholders will be undertaken this calendar year. Information from other DHBs continues to be gathered, including through site visits to Canterbury, Waikato and Counties Manukau.

Agreements for the Plunket-DHB immunisation collaboration are going through the contract sign off process. The collaboration will start this month. The first cohort of babies to offer this service to is being identified, applying learnings from the Canterbury tracking mechanism. Communication processes to avoid duplication of contact are being worked through with key stakeholders.

Development of an assertive contact algorithm is progressing, data has now been analysed and the algorithm developed. This is currently being written up, after which it will be tested with the OIS for implementation.

Analysis of new-born enrolment has been finalised for discussion with PHOs. A strategy for babies not enrolled with a GP will be developed, particularly with a focus for OIS to help guide the family to a practice for on-going primary care.

An active anti-immunisation campaign is running in the month of October. It was pleasing to see the strong public and health response supporting immunisation. 140 complaints to the Adverting Standards Authority in 48 hours resulted in an anti-immunisation billboard on the Southern Motorway being removed.

Mumps catch up programme
The school based MMR vaccine catch up programme has now been completed across both Auckland and Waitemata (Counties Manukau did not run a school based programme). The offer to ten low decile/high Pacific schools was accepted in nine schools. Results will be provided next report.

5.2 NCHIP
The project team is progressing the design phase to implement the National Child Health Information Platform (NCHIP) in the Northern region DHBs. NCHIP will provide a point-of-care view of each child's progress through the 29 health milestones from 0 to 6 years of age. This month, Memorandums of Understanding were agreed in principle with Plunket and the Ministry of Education to obtain contact details for children who are lost-to-service. Discussion with the Ministry of Social Development is scheduled next week.

5.3 Youth Health
The Ministry of Health has confirmed funding for an increase in health services into decile 4 secondary schools. Auckland DHB has developed and implemented enhanced school based health services inclusive of full time nursing resources embedded in the school community and proportionate to the size and complexity of the school role. Provision of nursing services in all Alternative Education, Teen Parent Units and decile 1- 3 schools has been a requirement for a number of years. Auckland DHB has funded additional services with visiting General Practitioners, and visiting Clinical Psychologists. There is additional nursing and general practitioner leadership across the programme. The result is delivery of high quality, youth friendly, comprehensive primary care services in school settings. These minimise disruption from learning, and maximise both health and educational attainment.

With the extension to decile 4 schools, Auckland DHB has three additional schools we are required to provide services in, one of which (Mt Roskill Grammar) we had already established services. Selwyn College and Avondale College have been approached regarding the establishment of enhanced school based health services and are keen to have services in place for the start of the 2019 calendar year. In total, this will mean services are delivered to 12 mainstream secondary schools to around 12,500 students.

5.4 Transgender Healthcare
The Planning, Funding and Outcomes (PFO) team hosted a project focused on improving access to gender affirming healthcare for transgender peoples for the northern region DHBs. The main body of work is nearing completion and moving into business as usual activities. Highlights from the project include development of health pathways, provider education, development of clinical guidelines, establishment of services for youth (provided by the Centre for Youth Health (CfYH)) and improved specificity regarding services provided by Auckland Regional Sexual Health Services (ARSHS). The work has been supported throughout by a strong Clinical and Consumer Advisory Group.

As the work moves to business as usual, the Advisory Group will be replaced by a Clinical Governance Group led jointly by CfYH and ARSHS. The group will continue to have consumer representation. The group is expected to consider and address issues such as equity of access, quality and consumer satisfaction with services. Planning and Funding representative from both Counties Manukau Health and Planning, Funding and Outcomes will continue to have input. One piece of work has yet to be completed, namely establishing a peer support service. A tendering process will be undertaken to contract an NGO provider/s to manage the service. It is expected to have a significant voluntary component for delivery. The intent is to enter into an agreement from 1 July 2019, following the tendering process.

5.5 Maternity Services

Changes have been made to maternity services at Auckland City Hospital. This may result in an increase in post-natal transfers to Birthcare, within the scope of their existing contract. Birthcare has consistently expressed a desire for increased post-natal transfers and have confirmed that they have capacity to provide care to more women. Eligibility for a postnatal transfer as specified in the contract has been discussed with Auckland City Hospital senior midwifery staff and management. The impact of changes will be monitored.

5.6 Maternal and Infant Well-being Assessment and Proto-typing of an Intensive Wrap Around Service

Auckland DHB Commissioning Executive Leadership Team (CELT) approved seed funding for development of an electronic tool to support routine enquiry across a range of domains. Pregnant women and new mothers should routinely be asked about a range of psycho-social factors known to negatively impact on mothers' and babies' health and well-being. Factors include such domains as family violence and depression. However, information obtained as part of the Maternal and Child Services Alliance (MaCSA) show that women are not routinely asked, and that there is no standardisation. Complexity is increased with a range of professional groups involved throughout the pregnancy including GPs, midwives, obstetricians and Well Child Tamariki Ora nurses. An electronic tool will help address this. A set of validated questions has been drafted for finalisation and inclusion into an electronic tool. Responses to questions on the tool will support clinicians to identify appropriate pathways to services, and highlight unmet need.

In considering this approach, it was recognised a group of women need to be guided through this in a more supported manner and rapidly engaged in more intensive services. This includes women who are eligible for maternal mental health or Community Alcohol and Drugs Pregnancy and Parenting Services. Evidence also shows that young pregnant women (under 20 years of age) and some other groups of women may need more intensive services to achieve the best outcomes. Auckland DHB CELT has approved proto-typing an intensive wrap-around service for those not eligible for the secondary mental health and Alcohol and Other Drug services. This would start as soon as the pregnancy was confirmed (ideally in the first trimester) and continue until at least the child's second birthday. Women's Health and Child Health leadership have endorsed this approach which will be co-designed and have a strong equity focus.

While there are a number of international models that will be considered, New Zealand's specific cultural context needs to shape the service design. A similar service is also being piloted in Counties Manukau and learnings will be taken from their experiences. An evaluation will be built into the proto-type from the outset.

6 Māori Health Gain

6.1 Māori Health Pipeline Projects

The Māori health pipeline is currently progressing proposal development in five areas:

- Lung cancer screening: Health Research Council proposal did not succeed and new funding streams are being investigated
- Kapa haka pulmonary rehab: Scoping and establishment of a steering group is underway. Draft terms of reference have been developed and will be discussed at an initial scoping meeting
- Northern region breast screening data match ('500 Māori women campaign'): Proposal to offer screening to Māori women enrolled with a PHO across the region. All project approvals are now complete including Ministry of Health approvals, privacy, Māori data sovereignty, PHO and regional data approvals. The second project meeting was held with all three breast

screening Lead Providers. Agreement was reached for detail of a systematic process for implementation, monitoring and evaluation

- PHO/Māori provider data match: All Waitemata DHB and Auckland DHB Māori providers have agreed to participate in the data match to quantify the group of people enrolled in a Māori provider but not with a PHO. Discussions with Counties Manukau Maori providers are ongoing. PHO and other relevant permissions have been obtained, including the Metro Auckland Data Stewards. MACGF will be informed at its next meeting. This project is split into a phase one data match analysis and phase two of co-designing an offer of service
- Cervical screening high grade lesions: Project documentation has been drafted and internal discussions are progressing regarding funding, clinical oversight and audit requirements. Discussions regarding the most appropriate risk register are ongoing between Auckland and Waitemata DHB
- Adult weight management: Scoping is underway for a Diabetes physician led pre-bariatric weight loss programme to support weight loss for people in the bariatric surgery pipeline.

6.2 Maori Immunisations Co-design Project

Auckland and Waitemata District Health Boards, in collaboration with the community are currently reviewing existing Maori focussed immunisation promotional material. On October 3 a survey was initiated to obtain community feedback on a number of different poster designs we have mocked up. The survey is particularly targeted at people of Maori decent to help improve Maori child immunisation rates and outcomes for tamariki Maori. The survey closed on 19 October, initial feedback shows:

- Participants liked the Maori whanau at a marae
- Poster needs to target key audience
- Poster needs to reflect a real situation
- Bright colours and good simple language preferable

7 Pacific Health Gain

7.1 PHAP Priority 1 – Children are safe and well and families are free of violence

The following is the 2018 – 2019 Quarter 1 results of the Healthy Babies Healthy Futures (HBHF) programme, in relation to the different elements of the programme. Performance against Pacific targets are identified, as well as performance for the rest of the programme (delivered to Māori, Chinese and South Asian populations). The service is provided by West Fono, targeting Pacific women/parents, HealthWEST, targeting Māori women/parents, Chinese New Settlers Services Trust, targeting Chinese and Asian mother/parents and The Asian Network Inc. targeting Indian and South Asian mothers/parents.

7.1.1 Community Learning Programme (CLP)

The Community Learning component of HBHF consists of six modules, delivered in a face-to-face setting to pregnant women or parents of children aged 2 years and under. The modules are:

1. Being healthy for your baby
2. Making healthy food choices
3. Practical food preparation of healthy meals
4. Reading food labels
5. Shopping smarter
6. Keeping active

Number of CLP groups facilitated (18/19 Q1)

	ACTUAL	TARGET	PERFORMANCE

PASIFIKA	3	3	100%
HBHF	16	12	133%

Number of mothers enrolled in the CLP (18/19 Q1)

	ACTUAL	TARGET	PERFORMANCE
PASIFIKA	44	30	147%
HBHF	249	120	207%

Some Communities do most of their work over this quarter.

7.1.2 TextMATCH Service

The TextMATCH component of the HBHF service is provided by the National Institute of Health Innovation (NIHI), University of Auckland and consists of text messages being sent to pregnant women and parents of children aged two and under. The messages provide information to encourage healthy and safe lifestyle choices. It also encourages those not well linked to health services to access appropriate antenatal, postnatal and infant healthcare.

People enrolled to TextMATCH (18/19 Q1)

	ACTUAL	TARGET	PERFORMANCE
PASIFIKA	74	69	107%
HBHF	232	276	84%

Feedback from mothers

- A te reo service user says *"I enjoy receiving your text messages. Some are repetitive. Would like broader info."*
- Pasifika mums are saying:
  - *yes thanks for messages it is really help me everyday*
  - *Its awesome.. I like the messages.. keep sending em..xo*
  - *Like to say thank you for your wonderful text messages* ☺☺
- A south Asian mother commented *"Thank you so much! They are very helpful. plz continue sending me the messages . Cheers."*

Feedback Scores

- When asked how useful did 25 participants find TextMATCH. Participants on average rated the service 4.6 out of 5.

7.1.3 Engaging Mothers to talk health and create a plan for better nutrition and increase physical activity

This component of the HBHF service requires the service provider to engage in a conversation with pregnant women and mothers of young children, with the objective of understanding their health goals, needs and the barriers to achieving and meeting these. A"SMARTER plan for change" is then completed together.

Mothers engaged in a healthy conversation (18/19 Q1)

	ACTUAL	TARGET	PERFORMANCE
PASIFIKA	59	60	99%
HBHF	310	240	129%

7.1.4 Promoting HBHF to eligible mothers in the community

HBHF providers are required to promote the service in the communities they are responsible for and work with organisations that engage with pregnant mothers and children to also promote the

service. This component is measured by the number of *promotional forms* that are signed by eligible mothers.

Completed promotion forms by eligible mothers for quarter 1 2018 – 2019

	ACTUAL	TARGET	PERFORMANCE
PASIFIKA	95	90	105%
HBHF	422	360	117%

The HBHF Ministry of Health Manager continues to endorse this programme for the performance and outcomes achieved for the community.

7.2 PHAP Priority 2 – Pacific People are smoke-free

As part of developing a training programme for smoke-free champions in Healthy Village Action Zones (HVAZ) and Enua Ola churches and communities, a survey of 200 members of these churches and communities was undertaken. The majority of survey respondents were women (131), of Samoan ethnicity (125). 73 were current smokers. Three main themes emerged from the response to the question why *Pacific* people smoke, and these are addiction, stress relief and peer pressure. For people who had smoked but have stopped, the two main reasons for stopping were concern about their health and their family and the cost of smoking. Consequently, their response as to what would motivate them to stop smoking were health of their family, including improving the health of their children, being good role models for their children and financial benefits for their families. Church and religious reasons can be appealing as reasons for some people.

Providing health messages and education were the least likely method to encourage people to stop smoking. As to possible methods to assist Pacific people to stop smoking, respondents were provided with a list of possible methods and were asked to rate each on a scale of 'not helpful' to 'very helpful'. Group support or "quitting together" was the top preference.

In response to a question on effective of methods to encourage Pacific people to stop smoking, the four top preferences were:

i. Having smoke-free support at church, youth, sport or community group.
ii. Information from church leaders.
iii. Information from community leaders and smoke-free champions with mana.
iv. Information provided to children at Sunday School.

In relation to the training for church/community smoke-free champions, the survey results suggest the following:

- Information needs to be tailored to guide smoke free-champions and church and community leaders so that they increase their effectiveness in their support of people to stop smoking, specifically in their sphere of influence.
- Further information of the harmful effects of smoking and specifically the harm of second hand smoking on children and family members.
- Strengthen the importance and impact of smoke-free environments on both smokers and non-smokers.
- Enable members of the smokers' community to be appropriately supportive i.e. negative comments to smokers may not be helpful.
- Strong focus on the impact on family finances.
- Identify the triggers and behavioural substitutes for smoking.
- Explore whether friendly competition between groups of smokers, with support within the church/community.
- Explore opportunities to provide stop smoking support in the context of social activities.

- Promote access to stop smoking services and NRT.

Two training dates for HVAZ have been set, 50 smoke-free champions will be trained.

The results of this survey further confirms observations that we have of Pacific people in general, in that in terms of behaviour change, the support of a group of people known to them within a community that matters to them is the preferred approach.

The current system largely relies on clients being referred as individuals to a provider not known to the client. The engagement that results from this process is low.

This work is being done collaboratively by the smoke free programme manager, the Pacific Team in the DHBs, with the co-ordinators of the HVAZ and Enua Ola programmes and the health committees of the churches and community groups.

Our current Pacific Health Action Plan 2016 – 2020 has smoke-free environments as its second priority. We would like to offer stop-smoke support within the church environment as the next step.

7.3 Priority 3 – Pacific people are active and eat healthy

The 14 community members from HVAZ & Enua Ola programmes undertaking the Personal Trainer Level 4 NZIS training have completed Module 3. They are currently working with individual clients, providing nutrition and physical activity education as well as supporting them to adopt what they are learning. This training will place these 14 students in a good position to be further trained to be health coaches for both groups and individuals. Their Pacific language and cultural skills will enable them to work with Pacific people with diabetes at individual, family and group contexts.

7.4 Priority 4 – Pacific People access medical and other help early

An inaugural full day workforce development workshop was held for parish community nurses, fanau ola nurses, HVAZ and Enua Ola co-ordinators and managers. West Fono, Tongan Health Society, AH+ PHO and Procare were represented. The workshop resulted from a review of the parish community nursing service. A Steering Group was established to oversee the review and to oversee the implementation of the recommendations of the review. The Steering Group includes Waitemata DHB Director of Nursing, Dr Jocelyn Peach, Director of Nursing Primary Care, Jean McQueen, Pacific Nursing Director Abel Smith, AH+ and Procare nurse leaders and other DHB personnel. The workshop was led by Abel Smith and Celeste Gillmer, Team Leader for the Primary Health Care Nursing Development Team at Waitemata DHB.

A number of recommendations resulted from the workshop and these will be implemented in the coming year. The workshop will be held quarterly.

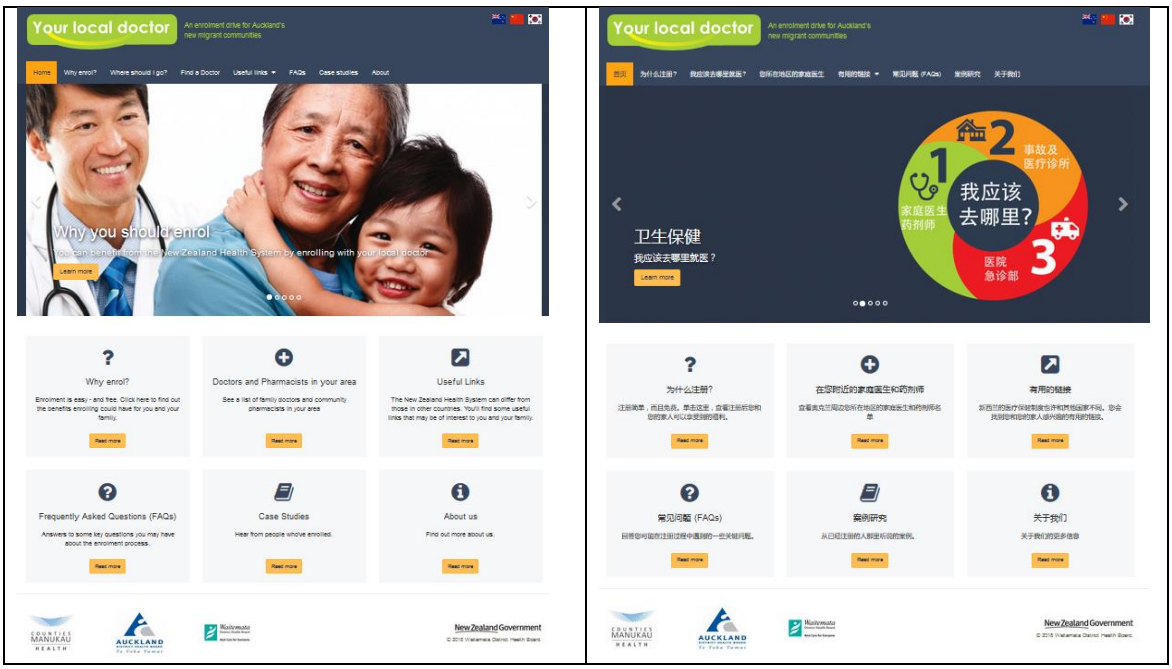
8 Asian, Migrant and Refugee Health Gain

8.1 Increase Access and Utilisation to Health Services

Indicators:

- Increase by 2% the proportion of Asians who enrol with a PHO to meet 71% target by 30 June, 2018 (current rate 70% as at Q1 2018/19).
- 80% of eligible Asian women will have completed a cervical sample by 2020 (current rate 51.7% as at June 2018).

We have updated the 'your local doctor' website (www.yourlocaldoctor.co.nz) with assistance from healthAlliance. The refurbished website has a fresh modern look and feel to it, is more user friendly across various media platforms than the previous version. We will continue to promote the website among stakeholders and settlement partners. It is promoted as a dedicated one-stop resource website that has information available in a range of formats, e.g. video podcasts, factsheets, brochures and web links with the aims to increase awareness of the New Zealand health & disability system among new migrants. The website is available in English, Simplified Chinese and Korean.



9 Hospitals

9.1 Cancer target

Auckland DHB has continued to achieve the 62-day Faster Cancer Treatment (FCT) indicator and at end of September 2018 was 93.9%. A six month interim arrangement is in place to use private provider Radiotherapy capacity in response to internal capacity constraints relating to workforce and reduced linear accelerator capacity associated with planned machine replacement. For the month of September, 12 women were referred for outsourced radiotherapy treatment.

9.2 Auckland DHB Surgical Health Target

The 2018/19 surgical Health Target discharge position for the Auckland DHB population at the end of August was 85.5% of planned volumes, including adult Orthopaedic volumes. Preliminary results for September, noting that coding is not 100% complete for the month, is 81% discharge plan. Based on the reported performance YTD there is expected to be a significant revenue shortfall in both MOH additional elective funding and IDF funding, and this has been separately reported to the Audit, Risk and Finance subcommittee.

9.3 ESPI Compliance

General - ESPI performance for August has not recovered following the July nurses strike and the provider reported acute demand of August.

The DHB was ESPI2 moderately non-compliant for July, with General Surgery accounting for most of the breach. The DHB was also non-compliant for ESPI5 with Adult Orthopaedics, and Paediatric Surgery being the non-compliant services. ESPI8 is now being monitored for 2018/19, and Auckland DHB was moderately non-compliant at 93.9% for August, with General Surgery and Vascular the main areas of breaches. Work has been progressing in General Surgery to ensure the appropriate Clinical Prioritisation tools are being implemented correctly to ensure compliance going forward and progress to date has been favourable.

Orthopaedics – the Orthopaedic service continues to focus on booking the longest waiting patients with more of the internal and external capacity being used for longer waiting patients. Quarter 1 saw 131 patients receiving surgery through the outsourced pathway compared with 80 patients in the same period last year. The Orthopaedic outsourcing YTD is slightly ahead of plan; however there is a capacity shortfall within the Auckland DHB provider of approximately 350 discharges. Based on the YTD plan requirements the provider is tracking at 66% of the adult Orthopaedic discharge requirement.

9.4 2018/19 Auckland DHB provider performance

It is too early to reliably forecast the IDF position however analysis YTD shows no material change in acute demand for all populations when compared with last year and elective delivery is less than for the same period last year.

9.5 Regional Cardiology service demand

Auckland DHB Cardiology service has implemented new capacity to address the backlog of 35 patients and provide capacity for a sustainable increase of 30 procedures per annum. Winter pressures in the form of increased acute demand, a cluster of transplants and high Extracorporeal Membrane Oxygenation (ECMO) volumes are impacting on the scheduling of elective Cardiac surgery capacity as a result of pressure on Cardiovascular Intensive Care Unit (CVICU) bed capacity. This has resulted in a sustained increase in the number of patients waiting for Cardiac surgery, however the right regional clinical processes are in place to ensure patients are prioritised appropriately and generally maximum waiting times for priority patient groups are not being breached.

9.6 2018/19 Auckland DHB Provider Planning

The funder has identified additional external capacity on a facility-only arrangement basis to support delivery of elective services and the provider leadership teams are considering a range of options to improve access to elective services.

9.7 2018/19 IDF Arrangements

Formal adjustments to Waitemata DHB forecasts are being considered with the intention of updating the provider PVS for the November reporting period onwards. The revised Waitemata DHB plan reallocates existing funding to services with increased demand such as stroke services, renal transplant services and Electrophysiology (EP) services.

9.8 2019/20 IDF Planning

2019/20 IDF volume forecasts have been developed over the last three months and are in the process of being finalised in time for the MOH 31 October deadline. Regional discussions are underway presently regarding the application of an appropriate price uplift for services that are not subject to automatic national price adjustments e.g. Mental Health provider services.

9.9 Policy Priority areas

Colonoscopy Indicators

The Auckland DHB provider successfully achieved the urgent and surveillance colonoscopy (80.33%) indicators, but did not achieve the non-urgent (priority 2) indicator (66.48%) in September 2018 after

achieving the indicator in August after a sustained period of non-compliance. The service continues to implement a range of measures to achieve sustainable improvement and simultaneous compliance with all indicators.

Radiology Indicators
Auckland DHB performance in outpatient CT and MRI indicators continues to improve. The provider has had to take on MRI volumes for Counties Manukau DHB patients whose waiting times for local MRI were staring to impact on the timeliness of treatment services and this is expected to be required on an on-going basis.

9.10 National Services

Auckland DHB has been working with the MOH National services team to review the approach to national consideration and prioritisation of the clinical need for increased investment in national services delivered by Auckland DHB. The historical approach has not enabled a population focussed, clinical led discussion regarding the relative merits of national service proposals. Auckland DHB has submitted proposals for increased investment from 2019/20 in the national services for Adult Congenital Heart disease and Cardiac Inherited Diseases and the MOH has advised at this time that they cannot substantively respond to the proposals at this time pending further investigation and clarification of the future prioritisation process.

9.11 Regional Service Review Programme

Cardiac Catheter Laboratory (CCL) services – Counties Manukau Health is proceeding with the presentation of their local business case for an additional CCL (effective 2023) and Northland is proceeding with implementation planning for a local CCL (with a provisional start date of 2019). Auckland DHB will need to update the stranded cost analysis completed in February 2018 and the updated financial impact analysis will inform a two year regional agreement to fund stranded costs that are unable to be managed through redistribution of resources.

Hospital Advisory Committee Meeting 17 October 2018 – Draft Unconfirmed Minutes

Prepared by: Madeleine Willis, Board and Committee Manager

Recommendation

That the unconfirmed minutes from the Hospital Advisory Committee meeting held on 17 October 2018 be received.

Minutes
Hospital Advisory Committee Meeting
17 October 2018

Minutes of the Hospital Advisory Committee meeting held on Wednesday, 17 October 2018 in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton commencing at 1.30pm

Committee Members Present	**Auckland DHB Executive Leadership Team Present**	
Judith Bassett (Chair)	Ailsa Claire	Chief Executive Officer
Jo Agnew	Margaret Dotchin	Chief Nursing Officer
Michelle Atkinson	Joanne Gibbs	Director Provider Services
Doug Armstrong	Fiona Michel	Chief Human Resources Officer
Gwen Tepania-Palmer	Rosalie Percival	Chief Financial Officer
	Meg Poutasi	Chief of Strategy, Participation and Improvement
	Shayne Tong	Chief of Informatics
	Sue Waters	Chief Health Professions Officer
	Dr Margaret Wilsher	Chief Medical Officer
	Auckland DHB Senior Staff Present	
	Tara Argent	Interim General Manager Women's Health
	Dr John Beca	Director Surgical, Child Health
	Jo Brown	Funding and Development Manager Hospitals
	Ian Costello	Director of Clinical Support Services
	Suzanne Corcoran	Director Participation and Insight
	Dr Mark Edwards	Director Cardiovascular Services
	Dr Lalit Kalra	Acting Director Community & Long Term Conditions
	(Other staff members who attend for a particular item are named at the start of the minute for that item)	

1. APOLOGIES

The apologies of Board Members Pat Snedden (Board Chair) and Lee Mathias be received.

The apology of Executive Leadership Team member Sue Waters, for late arrival, be received.

The apologies of senior staff members, Vanessa Beavis and Peter van der Weijer be received.

2. REGISTER AND CONFLICTS OF INTEREST

There were no new interests to record. There were no conflicts of interest with any item on the open agenda.

3. CONFIRMATION OF MINUTES 12 September 2018 (Pages 8 - 22)

Resolution: Moved Gwen Tepania-Palmer / Seconded Jo Agnew

That the minutes of the Hospital Advisory Committee meeting held on 5 September 2018

be confirmed as a true and accurate record.

Carried

4. ACTION POINTS (Pages 23 - 25)

All actions were either complete or in progress.

5. PERFORMANCE REPORTS

5.1 Provider Arm Operational Performance – Executive Summary (Pages 26 - 30)

Joanne Gibbs, Director Provider Services asked that the reports be taken as read, briefly highlighting key points:

- The Provider Arm continues to experience on-going demand for its services which is stretching its capacity to deliver. The situation is exacerbated by the continued pressure felt within key workforces such as Anaesthetic Technicians and Midwifery and the requirement to catch up on elective work which had to be cancelled during the nurse's strike. A careful eye was also now being kept on the cardiac wait list where a huge effort was being made by the Cardiac Surgery team to reduce numbers.
- There had been an upsurge in transplant work for the month with seven heart/lung operations performed which utilised theatre and clinician time.
- There would be a change in the woman's health leadership team with the departure of Tara Argent (Interim General Manager Woman's Health) in November. Recruitment is underway for this position and the appointment of a new Director commencing in January 2019.
  Thanks were extended to Tara Argent for her efforts in Women's Health and in supporting Peter Van de Weijer leading the service during difficult times and for her support throughout the nurse's industrial action.

5.2 Provider Arm Scorecard (Pages 31)

Resolution:

That the Hospital Advisory Committee receives the Provider Arm Operational Performance – Executive Summary for October 2018.

Carried

5.3 Clinical Support Directorate (Pages 33 - 40)

Ian Costello, Director Clinical Support Services asked that the report be taken as read, briefly highlighting the following key points:

- The commitment by the Radiology team to continue to reduce its list while the MRI scanner was down through working extended hours was acknowledged and commended. The Chair passed on the Committee's thanks to the team

- There had been a successful recruitment campaign for Medical Radiation Therapists enabling the team to be fully recruited within the next two to three months
- The Ministry of Health are extending the transition timeline to implement full Human Papillomavirus (HPV) primary screening in place of the current cervical screening programme. The change involves rising the starting age for cervical screening from 20 to 25 years as the first phase.
- Solutions to support a safer Anatomical Pathology work environment continues to be advanced with a business case for the histology cut-room expansion being submitted.

Matters covered in response to questions included:

- A more systemic approach to the management of complaints had been introduced with the implementation of a complaints action plan database. The "lessons learnt" from this could be included in future Directorate reports.

5.4 Women's Health Directorate (Pages 41 - 47)

Jo Gibbs introduced Lisa Middleburg who had joined the directorate on a six month secondment.

Tara Argent, Interim General Manager Women's Health asked that the report be taken as read briefly highlighting the following key points.

- The Long- Acting Reversible Contraceptive Block Service pilot has commenced. This provides a drop in clinic in Glen Innes and is tied in with the vaccinator role. This is free to all women. Wrap around services are being investigated and conversation is being had with the Epsom Day Clinic.

Matters covered in response to questions included:

- Gwen congratulated the Directorate for work that has been done to date and Judith Bassett applauded an excellent initiative, which provided women with more control over health outcomes.

5.5 Child Health Directorate (Pages 48 - 59)

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

- Elective surgery continues to be a central focus for the service
- There has been a significant increase in acute activity across Starship with high levels of occupancy. The significant and sustained efforts by clinical teams in all areas including wards, intensive care, emergency department, community and theatre teams were recognised.
- Good regional collaboration around the neonatal unit was reported. Appropriate movement of babies in and out of the unit was being experienced, The Ministry are looking at models of care to standardise this around the country.

Matters covered in response to questions included:

- It was advised that overall staff morale was good, although the winter months were always a more challenging time
- Staff turnover is a concern in a small number of services however, this is being addressed and information gained in the next staff engagement survey will assist in developing strategies to deal with it.
- It was noted that specialist recruitment had also made an impact.

5.6 Perioperative Services Directorate (Pages 60 - 66)

Duncan Bliss, General Manager Perioperative Services asked that the report be taken as read, highlighting the following key points:

- Drawing attention to the favourable financial result YTD for the directorate
- Considerable work, since the last staff engagement survey results were released, has been undertaken aimed at addressing culture issues within the service and developing a stable workforce.
- On-going recruitment continues to ensure full staffing of operating suites. The challenge in recruiting for the Anaesthetic Technician workforce is being addressed by a search being carried out in the UK for candidates for these positions. The internal training program will also assist in mitigating shortages within the next 6 -12 months.

The Chair acknowledged that the staffing capacity issue was proving to be a major challenge.

Matters covered in response to questions included:

- Advice was given that the Perioperative Service is currently seeing a reduction in the number of staff leaving due to unhappiness with the workplace. The efforts expended in creating a more stable workforce were now becoming evident
- Jo Agnew asked if there was a project that reports on vacant theatres due to staff shortages. It was advised that data has shown that trends have worsened over last few weeks resulting in reduced sessions

5.7 Cancer and Blood Directorate (Pages 67 - 73)

Richard Sullivan, Director Cancer and Blood asked that the report be taken as read, highlighting the following key issues and achievements:

- Advised of the appointment of Cheryl Orange to the position of Allied Health Director, Adult Medical, Cancer and Blood and Professional Leader Occupational Therapy. Cheryl will be commencing in December
- The installation of the second new linear accelerator occurred in October the LINAC clinic commenced on 15th October.
- The implementation of Medirota (roster tool for medical staff) has gone very well.

Matters covered in response to questions included:

- Trendcare has been successfully completed in Ward 64; Motutapu has yet to be

commenced.

- Progression of the training required to support the local delivery of chemotherapy and the capacity to be able to manage expectations of the other DHBs has been piloted. The next phase of the local delivery model will commence on 1st November.

[Secretarial Note: Item 5.7 scorecard was duplicated in the pack, correct scorecard was tabled for the committee]

5.8 Mental Health Directorate (Pages 74 - 84)

Anna Schofield, Director Mental Health and Addictions asked that the report be taken as read, briefly highlighting key points:

- The adult mental service is experiencing the usual seasonal high (September – January) demand for inpatient and community based services
- The series of workshop undertaken to assist with the development of a 3 year Mental Health Action Plan have been completed. The data is currently being analysed
- Continued work around the Adult acute flow will enable the smooth the processes of admission and / or discharge
- A full review of the options including the Taylor Centre remaining in its current location is being undertaken.

Matters covered in response to questions included:

- Michelle Atkinson asked whether the exponentially increasing acuity in patient units, would at some point affect measures. Anna advised that Te Whetu Tawera has always had a longer stay time, and there is the on-going challenge around good quality housing in Auckland, ensuring people are discharged to the right places. People need choice in where they receive their care, providing a range of options and being clear that what people are able to move as soon as possible.

Gwen Tepania-Palmer commended Anna and her team on their hard work on behalf of the Committee.

- In response to a question from Gwen Tepania-Palmer as to what plans were in place to deal with the increase demand over the Christmas / New Year; Anna confirmed that they had the following in place: contracted additional beds, planned acute team working with people post discharge and making sure people have whānau / family to go to and the right social connections throughout this time.

- Anna advised that it was difficult to determine the impact of the Regional Youth Forensic services review and how it ties in with the Mental Health review. It has been challenging to obtain data on what is a key vulnerable group.

- Judith Bassett noted that the Directorate was actively working with the Central City Collective and asked whether this involved additional commitment from Anna and

the team. She was advised that this is a medium to longer term piece of with positive outcomes associated with it.

5.9 Adult Medical Directorate (Pages 85 - 89)

Dr Barry Snow, Director Adult Medical asked that the report be taken as read, briefly highlighting key points:

- Barry advised that Cheryl Orange will join the team in December
- The colonoscopy surveillance target has been met. The next challenge is around bowel screening, it is heartening to note though that currently Auckland DHB has the shortest wait list tail in the country.
- While the service is struggling with acute flow, there have been no escalations in SACS although there has been an escalation in complaints relating to wait time.
- There is a growing concern around staff indicators with turnover and accumulation of annual leave rising which shows signs that staff are both under pressure and unable to take time off work and or are looking for alternative employment
- The Regional Out of Hours Stroke Hyperacute Service successfully commenced on 3rd September

5.10 Community and Long Term Conditions Directorate (Pages 91 - 97)

Dr Lalit Kalra, Acting Director Community and Long Term Conditions asked that the report be taken as read, briefly highlighting key points:

- The programme of work to better support services for the frail older person is tracking well. Two streams of work are underway around specialist geriatric management of frail older people throughout Level 2; and avoiding unnecessary hospital presentation of frail older people.
- The recruitment and retention of Allied Health staff is a major concern, and work is being carried out with the Clinical Support directorate to implement a new graduate recruitment strategy for both Physiotherapy and Occupational Therapy.
- There is growing concern around the length of stay increase to 21 days. The key highlight is the 7 day services for specialist palliative care, with specialist nurses now available to support patients and provide advice 7 days a week.

Matters covered in response to questions included:

- Gwen Tepania-Palmer passed on the congratulations and thanks of the Committee to the team who were recently granted Full Accreditation by the Royal Australasian College of Physicians Faculty of Rehabilitation Medicine subcommittee, noting the positive feedback received about the training programme.

5.11 Surgical Services Directorate (Pages 98 - 107)

Mr Arend Merrie, Director Surgical Services asked that the report be taken as read, briefly

highlighting key points:

- The directorate priorities had been set around pillars of quality
  - Culture of safety
  - Timely and effective
  - Equitable and inclusive access
  - Efficient and financially sustainable pathways
  - Our people are happy, healthy and high performing

  Progress against these can be found in the action plan on pages 110-112 in the agenda.

- Winter pressure along with the recovery from the nurses strike and the Anaesthetic technician shortages, is providing challenges in delivering required volumes which can be seen in the financial position for the month
- There has been further improvement of Day of Surgery Admission rates due to successful implementation across the services in bringing patients in on day of surgery
- There has been a continued improvement in Ophthalmology waiting time, Radio New Zealand undertook an interview in Ward 77, which turned out to be an excellent piece on modern day nursing which was tremendous for the Ward and the directorate
- A preliminary piece of work is underway to move some elective surgical work from ACH to GLCH, for implementation this year

There were no questions

5.12 Cardiovascular Directorate (Pages 108 - 115)

Samantha Titchener, Acting Director for Cardiovascular Services asked that the report be taken as read, briefly highlighting key points:

- Progress has been made on improving transport options for Northland DHB patients accessing the ACH cardiology service; family/whānau patient information pamphlets have been updated and work has commenced on discharge planning pathways to promote Northland DHB patients returning to work post procedure.

- Work continues to be carried out around critical care capacity, addressing CVICU high staff turnover with initiatives in place intent on keeping staff well with regular debriefs after critical events, provision of EAP, service and teaching sessions on resilience – "Surviving and Thriving" programme

5.13 Commercial Services (Pages 116 - 123)

Kieron Millar, Acting General Manger Commercial Services asked that the report be taken as read briefly highlighting key points.

- healthAlliance (hA) FPSC have reported annualised savings as set out on page 117 of the agenda. Opex of $1.05M made up of budgeted savings of $793K and unbudgeted savings of $255K and $1.79M in non-budgetary Capex
- The supply chain continues to have issues with moderate stock outages. A root cause

analysis in some areas indicated min-max levels were inadequate and have now been adjusted

- The product returns trial has been positive with 72 PO lines being processed and retuned for a credit value of 21.7K
- Auckland DHB has been selected as a finalist for the 2018 Sustainable Business Network awards in four categories. The categories being: Going Circular (Recycling), Efficiency Champion (Energy), Millennials on a Mission (ARPHS Sidd Mehta) and Hardwired for Social Good (Tāmaki Mental Health and Wellbeing Initiative). The winners will be announced at a special awards ceremony on 22 November 2018.

Matters covered in response to questions included:

- In response to question asked by Judith Bassett, Kieron confirmed that there was a 5% increase in meals delivered in August 90,000 meals a month to patients). The service continues to work closely with Compass to ensure both quality and service is achieved

5.14 Patient Management Services (Pages 124 - 130)

Alex Pimm, Director Patient Management Services asked that the report be taken as read, briefly highlighting key points:

- That today was National Thank you Cleaners Day. Alex attended a morning tea with 130 of Auckland DHB cleaners to thank them for their effort
- The Integrated Operations Centre relocation is progressing well, this includes working with Shayne Tong's team on the development and use of dashboard and live information to inform processes and ways of working and the design of the new facility

Matters covered in response to questions included:

- The Transition Lounge transformation project has been launched. This project aims to look at current and future needs for the hospital for the Transition Lounge and the design around that. This project will also take the responsibility for developing the revised business case to present for approval within this financial year. The location of the Transition Lounge will not be changed. There is a need to look at the opening hours of the lounge as it is not a 24/7 service currently

Gwen Tepania-Palmer acknowledged the work of the cleaning staff and passed on thanks on behalf of the Committee

5.15 Provider Arm Financial Performance Report (Pages 131 - 141)

Rosalie Percival Chief Financial Officer asked that the report be taken as read, briefly highlighting key points:

- The Provider Arm result for the year to date is $8.2M unfavourable.
- Revenue that has not been earned for electives has impacted financial performance; this is a continued trend throughout September and requires urgent redress

Resolution: Moved Gwen Tepania-Palmer / Seconded Doug Armstrong

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

Carried

6. INFORMATION REPORTS (Pages 142 – 146)

To Thrive – Programme to Support Lower Income Workers – Update (Pages 142 - 146)

Fiona Michel, Chief Human Resources Officer asked that the report be taken as read.

The paper was well received and it was commented that it was good to see other DHBs also wishing to pick up the initiative.

Fiona Michel commented that the Board and Committees would be updated regularly on progress. The initiative and interest in it is assisting in developing useful external relationships

It was noted that the initiative was low cost / high impact and could be seen as a "virtuous social cycle".

Resolution: Moved Michelle Atkinson / Seconded Gwen Tepania-Palmer

That the Hospital Advisory Committee receives the To Thrive – Programme to support lower income workers: Update report.

Carried

[Secretarial Note: Item 7.2 was considered next.]

7. DISCUSSION PAPERS

Jo Gibbs, Director Provider Services introduced the following discussion paper

7.1 Supporting the DNA Strategy: Outpatients Programme Activity (Pages 147 - 161)

Ian Costello, Director of Clinical Support Services and Ian d'Young, Outpatients Programme Manager , Adult Health Services asked that the report be taken as read, briefly highlighting key points:

The Outpatients strategic programme has been launched at Auckland DHB, within which are a number of activities that support the DNA strategy.

The Programme consists of two work streams - Current state work stream, reviewing how current models and processes can be improved, and a transformation work stream developing new models of care

A number of small scale proof of concept studies are underway to ensure patients feel their appointment is of value and to provide better access, choice and equity in our approach to outpatient care. Whilst too early to draw firm conclusions, early indications suggest patients value the new models of care.

Ian to present findings to HAC once the proof of concept studies are completed.

Resolution: Moved Jo Agnew / Seconded Gwen Tepania-Palmer

That the Hospital Advisory Committee receives the Supporting the DNA Strategy: Outpatients Programme Activity report for October 2018.

Carried

[Secretarial Note: Item 8 was considered next.]

7.2 WNB – Starship Child Health (Pages 162 – 169)

Michael Shepherd, Medical Director, Child Health Directorate introduced the report, advising that children who are "Was Not Brought" (WNB) are likely to have worse health outcomes and often worsening inequity. Children who have high incidence of WNB are also known to be at high risk of broader care and protection issues. It is also noted that high WNB rates result in inefficient healthcare delivery.

The current state of WNB in child health has been described in a range of different ways. It is noted that less than half of patients who WNB are in the Auckland DHB catchment zone. This creates a more complicated problem.

The graphs in the agenda show that there is a significant inequity in WNB rate in Maori, Pacific and children in low socio-economic status areas. There has been some progress across these areas but not as much as would be liked. This demonstrates the complexity of the problem. Actions currently being taken are outlined on page 165 on the agenda.

Resolution: Moved Jo Agnew / Seconded Gwen Tepania-Palmer

That the Hospital Advisory Committee receives the Was Not Brought – Starship Child Health report for October 2018.

Carried

[Secretarial Note: Item 7.1 was considered next.]

8. RESOLUTION TO EXCLUDE THE PUBLIC (Pages 170 - 173)

Resolution: Moved Jo Agnew / Seconded Michelle Atkinson

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

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
1. Apologies	As per that stated in the open agenda.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

2. Register and Conflict of Interests	As per that stated in the open agenda.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3. Confirmation of Confidential Minutes 5 September 2018	**Confirmation of Minutes** As per the resolution(s) from the open section of the minutes of the above meeting, in terms of the New Zealand Public Health and Disability Act [NZPH&D Act 2000]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4. Confidential Action Points	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.1 Presentation – CDU 90 Day Review	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	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 Draft HAC Forward Work Programme 2018/2019	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.1 Transplant	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982

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

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

Carried

The meeting closed at 4.35pm.

Signed as a true and correct record of the Hospital Advisory Committee meeting held on Wednesday, 17 October 2018

Chair: _____ Date: _____

Judith Bassett

Disability Advisory Support Committee Membership

Recommendation:

It is recommended that the Board:

1. **Approve the appointment of Joanne Agnew (Joint Chair), Gwen Tepania-Palmer, Robyn Northey and Michelle Atkinson as the Auckland DHB representatives on the regional Disability Support Advisory Committee.**
2. **Note that Waitemata DHB will be considering their appointments at their 14 November 2018 Board meeting.**
3. **Note that outside appointments may only be considered following completion of Board Member appointments and an assessment of experience and skill level of that regional committee membership by the chairperson-designate, together with the Chief Executives of the metro Auckland DHBs.**

Prepared by: Marlene Skelton (Corporate Business Manager)
Endorsed by: Pat Snedden (Board Chairman)

Glossary

DiSAC - Disability Support Advisory Committee
DHB - District Health Board

Purpose

This paper proposes the appointment of Auckland DHB members to the regional District Health Boards, Disability Advisory Support Committee and notes the proposed membership to be considered by Waitemata DHB. The proposed Counties Manukau DHB membership is unknown at this time.

Background

On 28 February 2018 the Board passed the following resolutions in relation to the Disability Advisory Support Committee:

1. *Agree that a single disability support advisory committee (DiSAC) with the terms of reference set out in Appendix 1 to this paper be established to advise them on disability issues, as required by the New Zealand Public Health and Disability Act 2000.*

2. *Note that, subject to Recommendation 1 being agreed, the CEOs of the metro Auckland DHBs have agreed that, to support the work of a single DiSAC, the Chief Executive of Counties Manukau DHB will assume a strategic leadership role for disability issues for the metro Auckland DHBs.*

3. *Invite the chairpersons of the Boards of Auckland, Counties Manukau and Waitemata DHBs to make appointments to the proposed DiSAC in accordance with the process set out in this paper.*

In terms of resolution one above, the Minister of Health, on 6 September 2018, granted approval for a regional Disability Advisory Support Committee to be formed.

In term of resolution three above the Board Chair on 26 September 2018, delegated authority to Gwen Tepania-Palmer and Joanne Agnew to agree Auckland DHB membership and make contact with the Board Chairs of both Waitemata and Counties Manukau DHBs asking them to do the same.

Establishment

On 28 February 2018 the Board also agreed that the following process would be used to establish the proposed regional DiSAC:

1. *The chairpersons of the metro Auckland DHB Boards will discuss and decide on a chairperson for DiSAC*
2. *Together with the chairperson-designate for DiSAC, the chairpersons of the metro Auckland DHB Boards will discuss and decide on the appointment of Board members to DiSAC, as outlined in the terms of reference outlined above, taking into account the balance of skills, experience, knowledge and diversity to enable DiSAC to carry out its functions*
3. *The chairperson-designate, together with the Chief Executives of the metro Auckland DHBs, will consider what appointed members are needed to complement the skills and experience of Board members and make recommendations to the chairpersons of the metro Auckland DHB Boards who will discuss and decide on what appointments will be made, if any. This consideration should include appropriate consultation with mana whenua*
4. *Upon all appointments being made, the two current DiSACs will be disestablished.*

In terms of resolution one above it was decided that the regional committee would be jointly chaired by Collen Brown of Counties Manukau DHB and Joanne Agnew of Auckland DHB.

The next step in the process is for each regional DHB to appoint the allocated number of Board members to the Committee.

Appointment considerations

The terms of reference provide for a membership of:

- Up to four Board members from each of the three metro Auckland DHBs
- Appointed members as may be required to complement the skills and experience of Board members.

As noted, Section 35 of the Act requires Disability Support Advisory Committees to have Māori representation. The terms of reference require that at least three members of the proposed DiSAC shall be Māori. These members may be appointed specifically or come from within the complement of existing Board members.

Proposal

It is proposed that the Auckland DHB membership shall comprise:

Joanne Agnew (Joint Chair)
Gwen Tepania-Palmer (may be considered as one of the three required Maori representatives)
Robyn Northey
Michelle Atkinson

Waitemata DHB has advised that they will be membership at their 14 November 2018 Board meeting.

Counties Manukau DHB have Board meetings on 31 October 2018 or 12 December 2018 at which they could endorse their membership to the regional Disability Advisory Support Committee.

Outside Appointees
The issue of "outside appointees" to the committee needs to be dealt with following endorsement of board membership. At that time the requirements of the terms of reference, firstly, in relation to the level of Maori representation and secondly, the required experience and skill level within the committee, needs to be considered by the chairperson-designate, together with the Chief Executives of the metro Auckland DHBs in order to make appointments.

The joint Auckland Waitemata DiSAC made it clear at their last meeting that:

"…developing effective connections with key stakeholder organisations and leveraging on their knowledge, advice and learnings would be imperative to enabling the Disability Support Advisory Committee to provide high quality advice to the Boards. Engaging with disability agencies and stakeholders to collectively resolve issues would assist in achieving outcomes that increased access to healthcare services and improved health outcomes for disabled people."

This was also later discussed at Board level at the Board meeting of 15 August 2018 where the following was recorded.

> *"In terms of consumer representation, the Board does not want isolated individuals on the committee but does require those that represent and can speak for a full segment of the community."*

The Board wishes this taken into consideration when outside appointments are being promoted.

Amendment to Committee Membership and Outside Appointments

Recommendation:

That the Board

1. **Approve the appointment of the Board Deputy Chair as a voting member to the Board, Finance, Risk and Assurance Committee and the Human Resources Sub-Committee.**
2. **Approve the ex officio membership of Margaret Wilsher and Gwen Tepania-Palmer as Auckland DHB representatives on the Auckland Health Foundation Board.**

Prepared by: Marlene Skelton (Corporate Business Manager)
Endorsed by: Pat Snedden (Board Chairman)

Glossary

HAC	- Hospital Advisory Committee
FRA	- Finance, Risk and Assurance Committee

Purpose

This paper proposes the appointment of the new Deputy Board Chair to committees of the Board and addresses a request by the Auckland Health Foundation for Auckland DHB representation on their Board.

Deputy Board Chair

Lope Ginnen was appointed as Deputy Board Chair of Auckland DHB on 19 October 2018, replacing James Le Fevre who resigned from the position on 24 January 2018.

The Board now need to endorse the Deputy Board Chairs appointment to the Board and nominated committees.

It is proposed that the following appointments be made:

Board - Member

Finance, Risk and Assurance Committee (FRAC) - Member

Human Resources Sub-Committee - Member

Auckland DHB Representation on the Auckland Health Foundation Board

The Chair of the Auckland Health Foundation, Andrew Barclay has had discussion with the Board Chair in relation to the appointment of two suitable nominees from Auckland DHB in the form of ex officio members to sit on the Foundation's Board. It has been agreed that the nominees put forward would be Margaret Wilsher and Gwen Tepania-Palmer. This decision now needs to be ratified by the Board.

Diversity and Inclusion – Deep Dive

Recommendation

That the Board:

1. **Receives the Diversity and Inclusion – Deep Dive report for November 2018.**
2. **Notes the status and progress of the Diversity and Inclusion plan.**

Prepared by: Kim Herrick (OD Practice Leader), Sarah McLeod (OD Practice Leader)
Endorsed by: Fiona Michel (Chief Human Resources Officer)

Glossary

Acronym/term	Definition
EVP	Employee Value Proposition
MALT	Māori Alliance Leadership Team
MDP	Management Development Programme
PALT	Pacific Alliance Leadership Team

1. Executive Summary

The purpose of this paper is to take a deeper look at the concept of diversity and inclusion at Auckland DHB, given the changing makeup of Auckland. The development of more inclusive culture at Auckland DHB will ensure attraction and retention of talent, increased engagement and productivity. In addition, it provides employees the opportunity to do their "life's best work". The 'Together' culture project highlighted what employees need to make Auckland DHB a great place to work including the opportunity for employees to be themselves, and provide an "accessible and approachable environment".

2. Introduction/Background

Diversity and Inclusion has multiple definitions. The definitions that resonate with the aspirations of Auckland DHB are in the following table:

Term	Definition
Diversity	"Who you are, and recognising the value you bring to work'"
Inclusion	"The degree to which people feel unique and recognised for their differences as well as feeling a sense of belonging based on sharing common attributes and goals with their peers"
Rainbow	Rainbow is a term that embraces the diversity of sexual orientations, gender, and sex identities. It is inclusive of, but not exclusive to lesbian, gay, bisexual, transgender, transsexual, intersex, takatāpui, tāhine, whakawahine, vakasalewalewa, fakaleiti, tangata ira tane, tóngzhì, mahu, palopa, fa'afafine, akavaine, fakafifine, queer, questioning, asexual, genderqueer, pansexual, gender diverse and gender fluid.

Disability	"People who have a physical, intellectual or sensory disability (or a combination of these) which is likely to continue for at least 6 months; and limits their ability to function independently, to the extent that on-going support is required." It is important to also remember people who have mental health issues and invisible disabilities like epilepsy, diabetes, Chronic Fatigue and other impairments that have no visible supports – no cane, wheelchair or working dog, etc.
Discrimination	"Discrimination occurs when a person is treated unfairly or less favourably than another person in the same or similar circumstances. It is a breach of the Human Rights Amendment Act 2016"
Bias	"Bias is a preference for one thing over another, and is part of being human; biases help us make decisions every day. Sometimes bias (conscious and unconscious) can impact the quality of decision making, reflecting our preferences and experiences"

3. Diversity and Inclusion work linked to our People Strategy

Auckland DHB People Strategy and our Employee Value Proposition (EVP) promises to provide clarity on the activities and programmes to be implemented in the DHB over the next 3 years. The Big Five actions prioritised in the people strategy are key to building better engagement across our organisation. They are: Accelerating capability and skill; Making it easier to work here; Building constructive relationships; Delivering on our promises and Ensuring a quality start.

Accelerating capability and skill

- Clear understanding of the expectations of managers, whānau, leaders and employees
- Raising awareness of ways to address conscious and unconscious bias to tackle inequities at work

Making it easier to work here

- Creating a sense of belonging through inclusive policies, processes and procedures

Building constructive relationships

- Promoting respect for diversity
- Building colleague empathy

Delivering on our promises

- Recruiting, developing and retaining more Māori and Pacific, disabled and rainbow employees to reflect the make up in our community
- Planning ahead to ensure our future workforce is sustainable

Ensuring a quality start

- Clarifying what Auckland DHB stands for and the behaviours we expect of each other for new employees and existing employees transitioning into new roles

4. Business case for Diversity and Inclusion

What are the benefits of a diverse and inclusive workforce?

1. Socio-economic benefits of employing minorities into the wider community
2. Improved health literacy for minority groups
3. Stronger cultural competency/inclusive leadership and improved patient safety
4. Higher quality care and safety of patients, staff and community
5. Inclusive organisational culture
6. Diversity of thought and innovation
7. Stronger employee engagement linked to improved patient experience
8. Ensuring our Māori and Pacific workforce are more representative, improving patient experience and health outcomes for our Māori and Pacific communities

5. Auckland DHB approach to Diversity and Inclusion

As a value based organisation, we need to embrace the Diversity and Inclusion principles.

Auckland District Health Board

Diversity and Inclusion link to our Values

Diversity and Inclusion principles are aligned to our values.

Auckland DHB values	Diversity and Inclusion Principles
Welcome ***Haere Mai*** We see you, we welcome you as a person	Encourage people to be themselves and speak up about what is important to them
Respect ***Manaaki*** We respect, nurture and care for each other	Understand you and your needs. Encourage people to listen and learn from each other. Respect other cultures and build staff engagement
Together ***Tūhono*** We are a high performing team	High performance is about working together to develop greater diversity of thought, creativity and innovation
Aim High ***Angamua*** We aspire to excellence and the safest care	Everyone is unique and we need to leverage everyone's potential and strengths to provide the highest quality health care

Diversity & Inclusion @ Auckland DHB – strategy on a page

Auckland District Health Board

THE WHY : Diversity Dividend

- Diversity of thought drives creativity & innovation
- Creating a sense of inclusion and belonging that we fully unlock the potential of our **people, patients, partners, whānau and suppliers.**
- Greater diversity and inclusion will enable us to forge stronger relationships and anticipate patient needs to deliver high quality healthcare
- A diverse workforce will lead to improved public health by increasing access to care for underserved populations and increasing opportunities for these populations to see practitioners with whom they share a common culture
- To build trust and respect we need to be mindful of 'patients unique fears, rationalisations and biases' to work towards equitable care for all patients

THE WHAT: Diversity and Inclusion

- To seek to **belong** is a hard wired instinct that binds us all together.
- Diversity is broader than ethnicity or gender. It is made up of visible and invisible attributes which create our identity.
- Diversity is an opportunity, not a problem.
- Inclusion is not tolerance, it is unconditional acceptance.
- Without inclusion, diversity is impossible.

THE HOW: Built in, not bolted on

- It is not about ticking a box. Diversity, Inclusion & Belonging is not a one off programme, it's a mind-set that is built in to all that we do and our People Strategy.
- It requires collaboration, empathy, a learning mind set and role modelling our values.
- Full support from Executive Team and Leaders

Healthy communities | **World-class healthcare** | **Achieve together** | Kia kotahi te Oranga mo te iti me te Rahi o Te Ao

AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

Current state/Progress and Activities to move to the new world

Reinforcers – Systems, Policy and Procedure

- All eligible Māori and Pacific candidates automatically shortlisted for roles
- New graduate Nursing recruitment has developed the cultural advocate model on all its interview panels. The advocates are Māori or Pacific senior nurses
- Māori Workforce Champions provide Māori mentoring, support and advocacy for Māori employees
- Mentoring/pastoral care for Māori and Pacific employees
- Disability strategy aligned with Waitematā DHB

Leadership – Culture Shaping Actions - Role modelling, Rewards and Recognition and Learning

- Executive Leadership Team supporting Te Wiki o te Reo Māori (Māori Language Week) through attending seminars, te reo and waiata workshops and kia ora video competition entries across metro Auckland DHBs
- Rainbow Tick workshops, Rainbow e Learning module and certification
- Accessibility Tick certification
- Supporting Auckland University of Technology and TupuToa internships to create pathways into Auckland DHB for Māori and Pacific

- Signed Youth Employment Pledge to show our commitment to attracting, employing and developing 16 -24 years old, especially Māori and Pacific
- Cultural Awareness training through Bicultural Tikanga in Practice and Treaty of Waitangi workshops, and CALD (Culturally and Linguistically Diverse) range of development options
- Matariki Speaker series across metro Auckland DHBs to share key leadership stories and insights into Māori culture

Community – People, patients, partners, whānau and suppliers

- Patient data to make informed decisions
- Key relationships with Work and Income, Limited Volunteer Services Programme (Ministry of Defence), Medical Council, Northern Regional Alliance (NRA), Mauri Ora Associates
- Partnership with Te Rūnanga o Ngāti Whātua to deliver the Rangatahi programme
- Partnerships with University of Auckland, Manukau Institute of Technology, Auckland University of Technology, Unitec, Whitireia New Zealand to develop a diverse pipeline of talent into Auckland DHB
- Emerging relationship with the Ministry of Education

Talent – Workforce

- Values based recruitment has been introduced to new graduate nursing through a systematic revision of the recruitment tool to provide a more culturally sensitive recruitment process
- Recruitment through diverse sources to attract a rich diversity of talent e.g. Job Fairs, Social media campaigns
- Accelerate diverse talent pool through States Services Commission Leadership and Talent model
- 4.7% of Auckland DHB workforce identifies as Māori and 8.7% identifies as Pacific. We have a metro Auckland Māori Alliance Leadership Team (MALT) working to improve our metrics. A Pacific Alliance Leadership Team (PALT) has also recently been activated

Future State

Reinforcers – Systems, Policy and Procedures

- Diversity and Inclusion lens across all phases of the employee life cycle (e.g. attraction, recruitment, selection, on boarding, performance reviews, education, exiting etc.) by systematically reducing the impact of bias by embedding values based recruitment and whānau guidelines across all directorates
- Focus on the patient life cycle to improve service
- Using Human Centred Design to create a greater 'Pull' for Māori and Pacific, disabled and rainbow job candidates to join the metro Auckland DHBs

Leadership – Culture shaping actions - Role modelling, Rewards and Recognition and Learning

- Build on the together themes to make Auckland DHB a great place to work (e.g. employees being themselves, accessible and approachable environment)
- Cultural ambassadors in all Directorates to role model inclusive behaviours and create a more inclusive mind-set and cultural change

- Employee/Affinity groups to develop a greater sense of belonging for minority groups (e.g. Māori and Pacific groups, Disability and Rainbow) using business led and Human Resources enabled strategy
- Māori Leadership Development Framework integrated into Leadership Development programmes
- Targeted communications plan to engage with diverse communities
- Māori staff hui to strengthen our engagement of the Māori workforce, specifically youth

Community – People, patients, partners, whānau and suppliers

- Stronger relationships with secondary schools and tertiary educational providers to increase the supply of a diverse job candidates to Auckland DHB
- Provide a more compelling EVP to our community partners to attract diverse talent
- Share stories on leaders in our Auckland DHB communities that highlight our values

Talent – Workforce

- Strong brand and reputation for attracting, recruiting, developing and retaining minority groups including disabled people
- Implemented States Services Commission Leadership and Talent framework with a diversity and inclusion lens
- Effective tracking of youth and other communities groups within our workforce
- Targeted and engaging communications to attract a more diverse talent pool into clinical and non-clinical roles at Auckland DHB
- Career paths from non-regulated roles into regulated roles (e.g. Health Care Assistant to Nursing etc.) to support the Youth Employment Pledge
- Auckland DHB Scholarships to attract more Māori and Pacific to study towards a healthcare career
- Embrace a culture that calls out bias and actively mitigates (keep culture visible through observable behaviours through our performance development process)
- Exceed Auckland DHB workforce Māori and Pacific targets

6. Conclusion

Our rapidly changing make up of Auckland propels the need to build a more diverse workforce and inclusive culture at Auckland DHB. The diversity and inclusion work has helped us build awareness amongst our people by encouraging an inclusive mind set, in particular increasing our Māori and Pacific workforce.

The next phase of work will focus on “building in, rather than bolting on” inclusion principles into everyday conversations, practices and processes to create a culture of belonging. Working closely with the insights from the Together project will help us develop a workplace where employees can be themselves and reach their potential.

We are grateful to have the support and endorsement of the Board and senior leadership to keep the momentum up to deliver our strategy.

Northern Region Māori Workforce Employment in Priority Occupations - Quarter Ended 30 June 2018

Please refer to the reverse side (notes page) for definitions, population projection source, occupation group and ethnicity classifications.

Source: HWIP data extracts as of 27 August 2018

Northern Regional Alliance
He Hononga o te Raki

Report Observations:

Junior Doctors: Across the region, there is a net decrease (10▼) in the number of Māori junior doctors employed this quarter. The 78 employed in the current quarter (Jun-18) is less than the 88 in the previous quarter (Mar-18) but comparable with the 80 employed Dec-17. NDHB has no net change for the last 3 quarters. Note: the number of Māori senior medical doctors increased this quarter from 45 to 49 regionally.

Nurses: Across the region, there is a net decrease (28▼) in the number of Māori nurses employed this quarter. The 553 employed in the current quarter (Jun-18) is less than the 581 in the previous quarter (Mar-18) but higher than the 528 employed Dec-17. It's worth noting that the increase from one year ago is still substantial 553 (Jun-18) vs 434 (Jun-17).

Midwives: There has been a continuing upward trend for the number and percentage of Māori midwives employed. There are 41 (7.6%) employed in the current quarter (Jun-18) compared with 37 (7.2%) in Mar-18 compared with 27 (5.6%) a year ago in Jun-17.

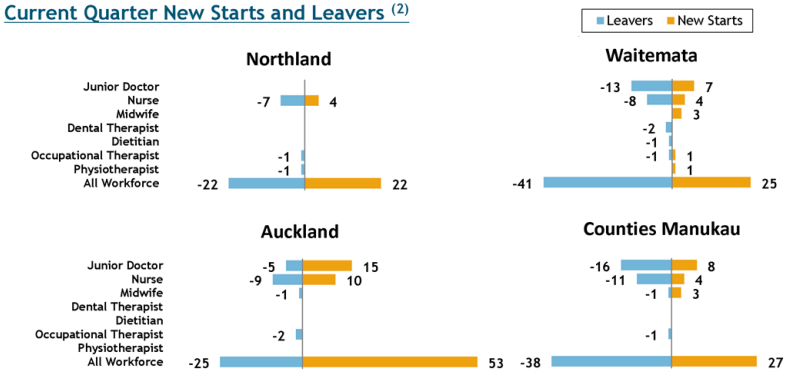
Dental therapists: Whilst there has been a net decrease in the number of Māori dental therapists employed this quarter there has been an increase in the percentage employed to 13.7% (Jun-18) from 13.0% (Mar-18) due to an overall net reduction in the total number of dental therapists employed from 207 (Jun-18) to 182 (Mar-18) . This maintains the percentage of Māori employed for dental therapist over the 11.6% 2025 regional target and neither NDHB nor WDHB need any extra for their individual targets.

Current Quarter Snapshot - % Māori Employed

Workforce Group	Northland	Waitemata	Auckland	Counties Manukau
Junior Doctor	6.3%	4.2%	6.0%	5.2%
Nurse	15.4%	4.2%	4.0%	5.3%
Midwife	8.5%	7.5%	4.6%	10.1%
[1]Dental Therapist	33.3%	10.8%	N/A	N/A
Dietitian	0.0%	10.9%	1.8%	2.3%
Occupational Therapist	7.0%	5.1%	6.7%	5.6%
Physiotherapist	5.1%	3.8%	2.3%	4.2%
All Workforce	17.8%	6.7%	4.8%	7.8%
2025 % Maori Target	34.9%	8.6%	7.2%	14.1%

(1) Dental Therapist for Waitemata, Auckland, and Counties Manukau all have its own different target of 10% due to Waitemata operating a metro Auckland dental service and would employ dental therapists for the metro DHBs.

Current Quarter New Starts and Leavers (2)

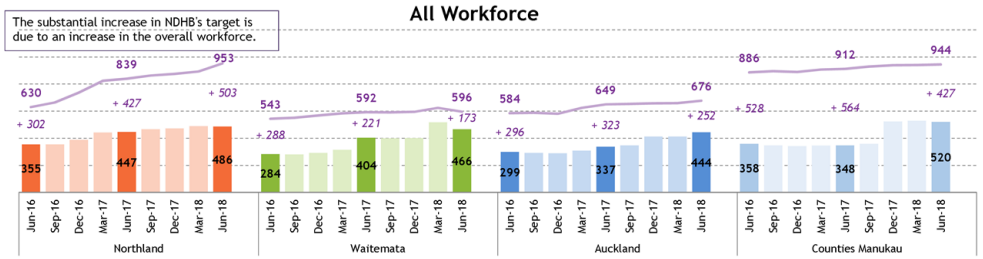


(2) Net changes are the combination of new starts, leavers and other reasons such as retrospective change in ethnicity recorded for existing employees.

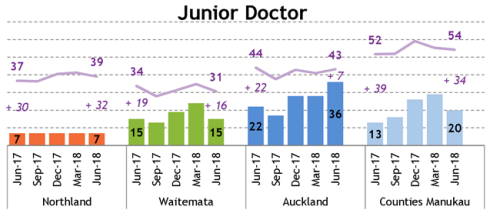
Historical Trend

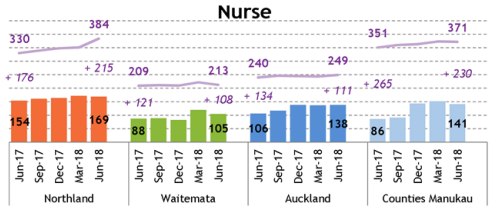
123 = Actual Employed + 123 = Extra Required(3) 123 = 2025 Target(3)

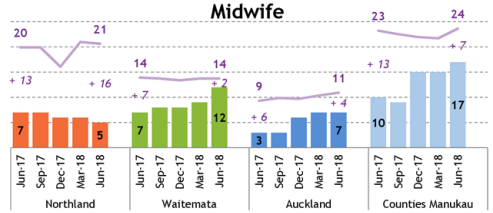
The substantial increase in NDHB's target is due to an increase in the overall workforce.

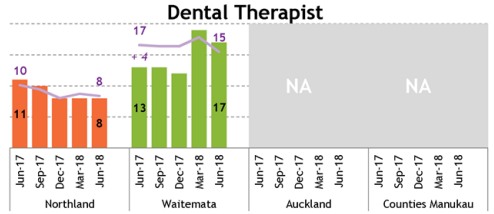


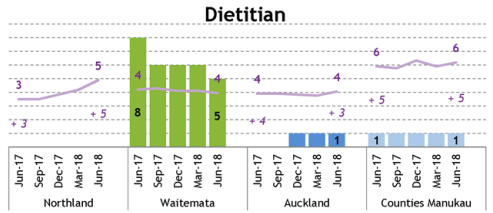
(3) 2025 Target at DHB level is determined by multiplying the % of Māori in the working age population projected for 2025 to the total DHB workforce. The sum of extra Māori required is determined at major occupation group level and aggregated to the DHB total. However, certain workforce groups (e.g. care & support) have already met/exceeded the target and therefore would not require any extra Māori workforce. Hence the sum of number employed and extra required may not necessarily add to the target number.

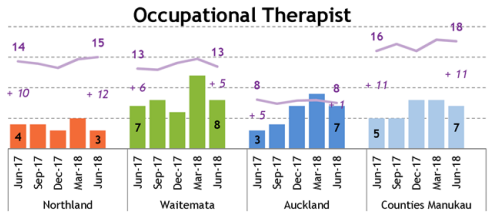


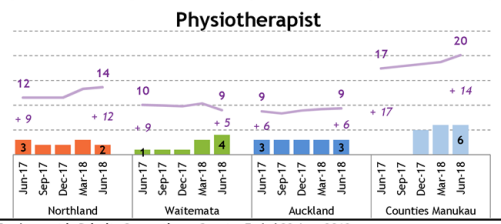












Prepared by Regional Decision Support Team
Northern Regional Alliance
Email: rdst@nra.health.nz

Northern Region Pacific Workforce Employment in Priority Occupations - Quarter Ended 30 June 2018

Please refer to the reverse side (notes page) for definitions, population projection source, occupation group and ethnicity classifications.

Source: HWIP data extracts as of 27 August 2018

Northern Regional Alliance
He Hononga o te Raki

Report Observations:

Junior Doctors: Whilst there has been a net increase (4▲) in the total number of Pacific junior doctors employed across the region this quarter, the 59 employed in the current quarter (Jun-18) is comparable with the 60 employed Jun-17.

Nurses: The total number of Pacific nurses employed has remained relatively static this quarter compared with the last. It's worth noting that the increase from one year ago is still substantial 558 (Jun-18) vs 485 (Jun-17).

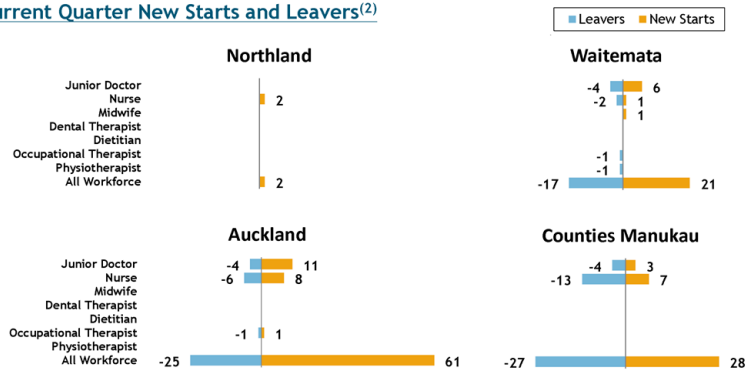
Dental therapists: Whilst there has been no net change in the number of Pacific dental therapists this quarter the percentage employed has increased to 8.2% (Jun-18) from 7.1% (Mar-18) due to an overall net reduction in the total number of dental therapists employed from 182 (Jun-18) to 158 (Mar-18).

Current Quarter Snapshot - % Pacific Employed

Workforce Group	Northland	Waitemata	Auckland	Counties Manukau
Junior Doctor	1.8%	5.3%	2.9%	5.5%
Nurse	1.1%	2.9%	5.8%	10.4%
Midwife	0.0%	1.9%	0.0%	2.4%
(1)Dental Therapist	0.0%	8.2%	N/A	N/A
Dietitian	0.0%	0.0%	3.6%	0.0%
Occupational Therapist	0.0%	1.3%	3.8%	5.6%
Physiotherapist	0.0%	5.7%	0.0%	2.8%
All Workforce	1.3%	5.4%	8.3%	12.1%
2025 % Pacific Target	2.4%	7.0%	9.2%	21.0%

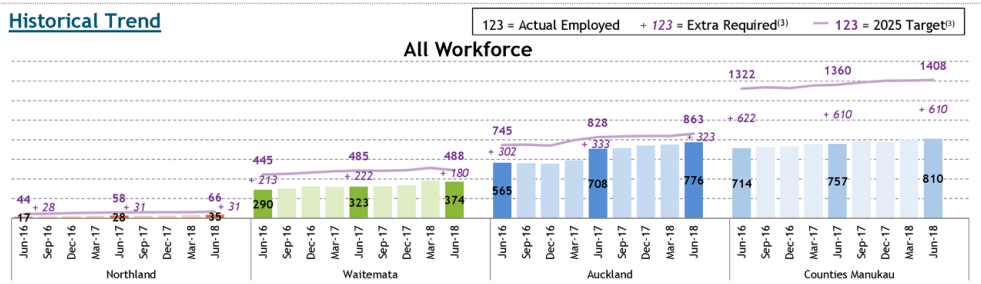
(1) Dental Therapist for Waitemata, Auckland, and Counties Manukau all have its own different target of 12% due to Waitemata operating a metro Auckland dental service and would employ dental therapists for the metro DHBs.

Current Quarter New Starts and Leavers(2)

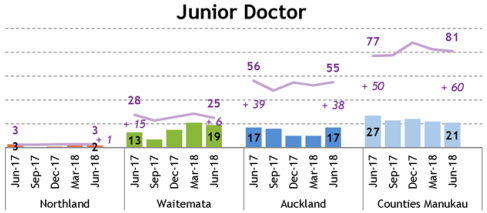


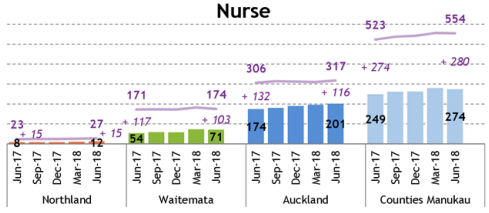
(2) Net changes are the combination of new starts, leavers and other reasons such as retrospective change in ethnicity recorded for existing employees.

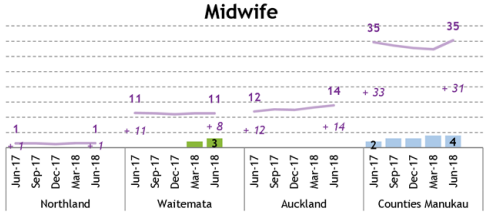
Historical Trend

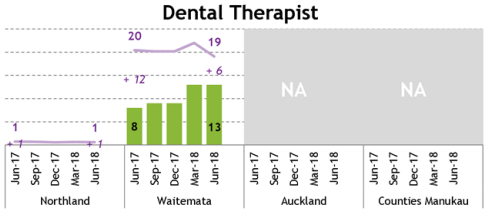


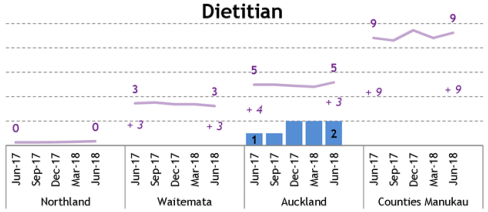
(3) 2025 Target at DHB level is determined by multiplying the % of Pacific in the working age population projected for 2025 to the total DHB workforce. The sum of extra Pacific required is determined at major occupation group level and aggregated to the DHB total. However, certain workforce groups (e.g. care & support) have already met/exceeded the target and therefore would not require any extra Pacific workforce. Hence the sum of number employed and extra required may not necessarily add to the target number.

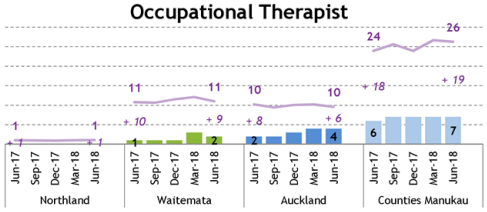


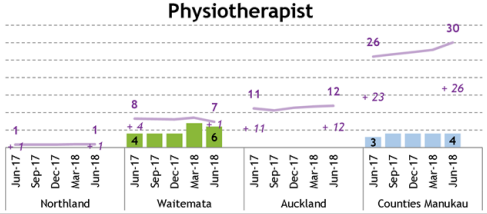












Prepared by Regional Decision Support Team
Northern Regional Alliance
Email: rdst@nra.health.nz

Notes

1. Data is sourced from HWIP data extracts submitted by DHBs to DHBSS.
2. Figures and calculations of percentages are based on headcount, not FTE.
3. The target is based on the working age population projection (aged between 20 and 64) for the year 2025, sourced from MoH Population Projection 2017 Update.
4. Only permanent employees are included. Casuals, locums and employees with zero contract hours are excluded. Casual employee is identified by field "Paid Employment Status" and locum is identified by field "Job Title".
5. Employees left during the current quarter is counted in the leavers but not the total employed workforce for the quarter.
6. Where employees have secondary positions within the same ANZSCO code and identifiable by the same employee number, it is counted only once.
7. Employees with unknown ethnicity is excluded from the denominator in the calculation of percentage by ethnicity and deriving the extra required.
8. Dental therapists in metro DHBs are mostly employed at Waitemata. The target and extra required for this group is based on the ethnicity distribution of the metro Auckland population.

Workforce Groups

The workforce groupings are based on ANZSCO codes, mapped by DHBSS to the major workforce groups. The mapping table can be obtained from the Central TAS template named "DHB-Self-analysis-template-YYYY-QX.xlsx"

ANZSCO codes for Priority workforce group are:

Grouping	ANZSCO Code & Description
Junior Doctor	253112 Resident Medical Officer
Nurse	134212 Nursing Clinical Director, 254211 Nurse Educator, 254212 Nurse Researcher, 254311 Nurse Manager, 254411 Nurse Practitioner, 254412 Registered Nurse (Aged Care), 254413 Registered Nurse (Child & Family Health), 254414 Registered Nurse (Community Health), 254415 Registered Nurse (Critical Care & Emergency), 254416 Registered Nurse (Developmental Disability), 254417 Registered Nurse (Disability & Rehabilitation), 254418 Registered Nurse (Medical), 254421 Registered Nurse (Medical Practice), 254422 Registered Nurse (Mental Health), 254423 Registered Nurse (Perioperative), 254424 Registered Nurse (Surgical), 254425 Registered Nurse (Paediatrics), 254499 Registered Nurses nec, 411411 Enrolled Nurse, 411412 Mothercraft Nurse
Midwife	254111 Midwife
Dental Therapist	411214 Dental Therapist
Dietitian	251111 Dietitian
Occupational Therapist	252411 Occupational Therapist
Physiotherapist	252511 Physiotherapist

Ethnicity

1. Population projections contain ethnicity groups of Māori, Pacific, Asian and Other.
2. The HWIP data extracts submitted by DHBs to DHBSS are grouped to match the population projections (i.e. Māori, Pacific, Asian, Other).
3. The HWIP technical documents (https://tas.health.nz/assets/SWS/HWIP/2018/HWIP-Code-Set-2018-V.9.pdf) state that "Ethnicity data must be recorded at level 4 (the most detailed level of the classification)". Codes and descriptions are included in the technical document at level 4. A full list of levels 1 - 4 can be found on the Ministry of Health website

MoH Level 2 codes are grouped as follows:

Ethnicity Group	Level 2 Ethnicity Code and Description
Māori	21 Māori
Pacific	30 Pacific Island NFD , 31 Samoan , 32 Cook Island Māori , 33 Tongan , 34 Niuean , 35 Tokelauan , 36 Fijian , 37 Other Pacific Island
Asian	40 Asian NFD , 41 Southeast Asian , 42 Chinese , 43 Indian , 44 Other Asian
Other	10 European NFD , 11 NZ European/Pakeha , 12 Other European , 51 Middle Eastern , 52 Latin America/Hispanic , 53 African , 54 Other MELAA , 61 Other
Ethnicity Not Stated	94 unknown dimension , 95 Declined to state , 97 Unspecified , 99 Not stated , No value recorded

Talent and Succession – Deep Dive

Recommendation

That the Board:

1. **Receives the Talent and Succession – Deep Dive report for November 2018.**
2. **Notes progress against the implementation of State Services Commission Talent and Leadership Framework at Auckland DHB since June 2018.**

Prepared by: Anne Silva (Organisational Development Practice Leader)
Endorsed by: Fiona Michel (Chief Human Resources Officer)

Glossary

Acronym/term	Definition
ELT	Executive Leadership Team
LDP	Leadership Development Programme
LSP	Leadership Success Profile
SLT	Senior Leadership Team
SSC	State Services Commission

1. Introduction / Background

The purpose of this report is to provide the Board with a progress update on Leadership and Talent Management at Auckland DHB, since the last paper was submitted in June 2018.

In December 2016, Auckland DHB, together with all 20 DHBs agreed to adopt the State Services Commission's (SSC) leadership and talent management framework, specifically designed for the public sector. This framework clearly lays out what good leadership looks like. It provides assessment and development tools and approaches to help leaders and team members reach their full potential. By maximising our potential leadership and talent across the public system, we will achieve better results for all New Zealanders.

2. Progress/Achievements/Activity

National, Regional and Local Approach

The National implementation Group, consisting of regional DHB, DHB Shared Services, Māori, Pacific and Professional Group representatives, continues to meet quarterly to share and drive progress. The Auckland DHB Lead for Leadership and Talent Management has now been appointed to this Group.

At a regional level, regional DHBs share thinking and tools to enable greater efficiency. At a local level, each DHB has a Lead who drives implementation in a way that is appropriate for the needs of their particular DHB.

Auckland DHB's approach

The specific key drivers for implementing the SSC framework at Auckland DHB are to:

- Grow leadership capability across the organisation
- Manage risks through succession planning
- Support our people promise: to provide outstanding personal and professional development opportunities for everyone.

We have identified 5 key steps to achieve this:

1. Build common understanding of what good leadership looks like for Auckland DHB
2. Develop leadership across the organisation
3. Engage with our people – know their aspirations, strengths and development needs; know our high potential people
4. Proactively prepare successors
5. Know where our risks are (critical roles and critical people) and plan to mitigate

Key principles we are applying in implementing talent management at Auckland DHB are:

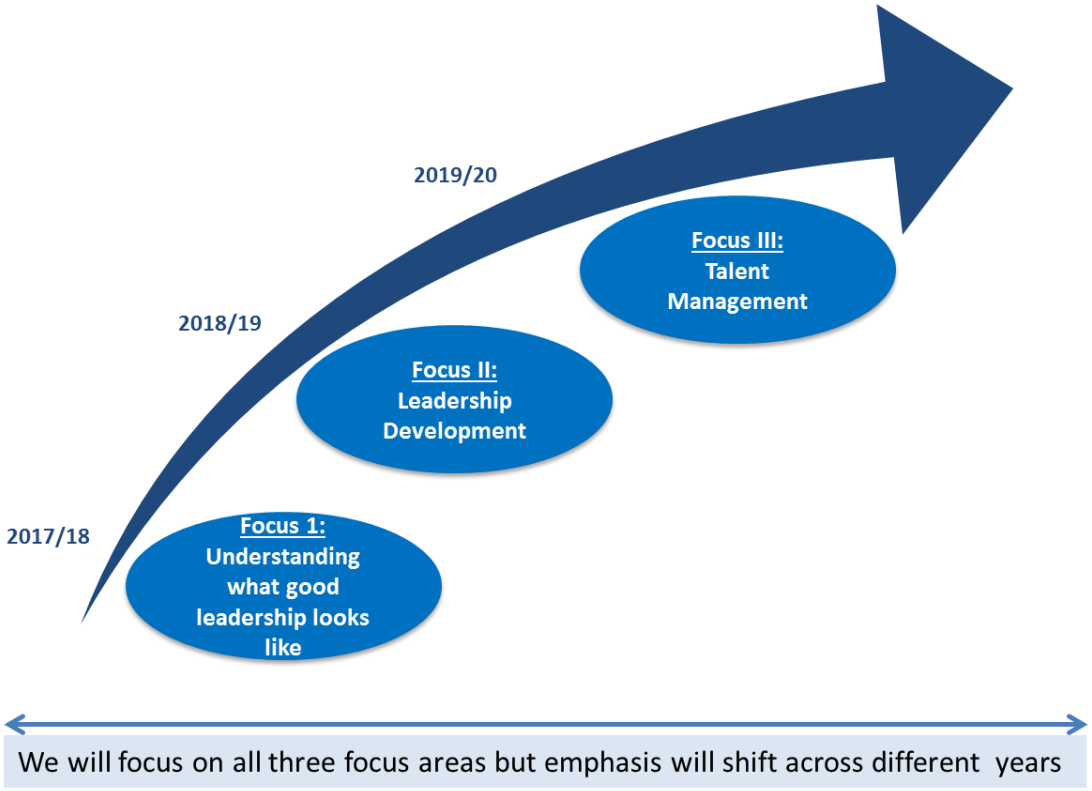
- Pull rather than push approach
- Start small and build
- Build leader comfort and confidence in the framework and tools
- Empower HR Managers to embed the leadership framework
- Ensure fairness and equity
- Flexible implementation, but consistent approach to identifying, developing and tracking talent

A multi-pronged and phased approach

We are taking a multi-pronged and phased approach, with greater emphasis initially on:

1. Understanding what good leadership looks like; then
2. Leadership development; and finally
3. Talent Management

Whilst we will focus on all three areas each year, emphasis will shift across the years.



Progress update

Please see Appendices 1 and 2 for previous progress update (June 2018) highlighting activities/milestones achieved within each of the three focus areas and planned next steps. Key milestones since the submission of the June 2018 paper are summarised below.

Auckland Career Board

We have implemented a process across the three Metro DHBs (Auckland DHB, Counties Manukau DHB and Waitematā DHB) to identify role/development opportunities across the DHBs to be presented to the Auckland Career Board. The Auckland Career Board comprises Chief Executives across the public sector who meet bi-monthly to collectively pool their knowledge of system, sector and agency need, and couple this with their insight to talent and potential. This mechanism provides an opportunity to match talent to roles, either to meet specfic system needs or where individual development can be offered through on the the job training and support. Auckland DHB Chief Executive, Ailsa Claire attends the Auckland Career Board bi-monthly meetings, representing the three Metro DHBs. The cross-metro process we implemented enables fair representation of all three DHBs at Auckland Career Board and is raising awareness of the value of talent exchange across the public sector.

Talent Exchange

Increasingly, Auckland DHB is seeking to provide development opportunities for both internal and external talent, recognising the value of talent exchange. Auckland DHB appointed Meg Poutasi from

the Department of Conservation, to the Chief of Strategy, Participation and Improvement position for one year, as part of the SSC Public Service Talent and Leadership Programme. In the last quarter, Auckland DHB also presented two additional secondment opportunities to the Auckland Career Board. Our previous HR Director – OD and Recruitment for Auckland DHB has recently been appointed to an executive role with Waikato DHB. A culture of talent exchange is starting to build.

Leadership Success Profile (LSP) Socialisation

The LSP framework, which describes good leadership, has been presented to different leadership teams and leaders at different levels across directorates, in groups and individually. In line with our 'pull not push' principle, some directorates are now asking for a deeper understanding of how they can optimise the framework. Two workshops have been run with HR Managers to experience the framework and tools including assessments so that they can better support directorates. Through the workshops, specific strategies and tactics have been identified to enable HR to role model the framework, promote good leadership practices, and embed these within directorates. A follow-up workshop has been scheduled to share learning and track progress.

LSP Integration

The LSP has been integrated into our revised Leadership Development Programme (LDP) so that all participants, approximately 90 leaders, are exposed to the framework and develop an understanding of good leadership behaviours and expectations. The LDP has been revised to ensure strategic and cultural alignment, including a stronger bi-cultural focus. LDP provides an opportunity for participants to reflect on their own leadership behaviours, gain exposure to different perspectives, leadership practices and tools, and to develop action plans and try out new leadership practices within their teams.

We have designed and developed a new 360 feedback tool which is built on our leadership framework (the LSP), positive leadership principles and our organisational values. The pilot phase is nearing completion and the 360 will be launched initially with LDP participants to support them in their leadership development.

Early discussions are underway to determine how we might integrate the LSP into recruitment of people into leadership positions.

Career and Development Conversations/Talent Management

We are promoting tools to support people in having career and development conversations with their people, and have also run 12 Performance Conversations workshops for 244 leaders. The talent management process and tools have been shared with leaders on a 'pull principle' and we have gained commitment from the Director of Provider Services to initiate the talent management process with Provider Directors. We will be working with the Director of Provider Services, Chief Medical Officer and Provider Directors to support them through this process, in line with our principles of: start small and build; and build leader comfort and confidence in the framework and tools.

3. Conclusion

We are making steady progress in implementing our multi-pronged, multi-phased approach to talent management, whilst taking heed of our guiding principles. We recognise that if we move too fast, we risk alienating people. If we move too slowly, however, we risk not developing leadership capability fast enough; reacting to talent shortages rather than taking a planned and deliberate approach to managing talent; and disengaging people and losing critical talent. An on-going commitment to leadership development and talent management is paramount.

Appendix 1: Key milestones completed within each of the three focus areas as at May 2018:

FOCUS	Understanding what good leadership Looks Like	Leadership Development	Talent Management
COMPLETED	• Completed In-depth interviews with Provider Directors to define what strong clinical leadership looks like. • Mapped and aligned clinical leadership practices and behaviours to SSC Leadership Framework. • Socialised strong clinical leadership and SSC Leadership Framework with Executive and Senior Leadership Teams. • Socialised alignment of clinical leadership and Leadership Framework with Mental Health Leadership Team. • Incorporated SSC Leadership Framework into Midwifery Career Pathing. • Developed Leadership Responsibilities - Minimum Requirements to create employee engagement and enablement.	• Introduced Leadership Development Programme (LDP) for 150 people to support clinicians to transition to clinical leadership roles. • Delivered over 20 Coaching Conversations Programmes to enable leaders to have impactful coaching conversations with individuals and teams. • Introduced 360 Feedback Development process and tools to provide leaders with insight to their strengths and development areas. • Provided secondment opportunities for developing leaders. • Provided individual and team coaching to support leaders on a needs basis.	• Developed Talent Management Strategy and Implementation Plan. • Established regional DHB talent management steering and working groups. • Active participation in public sector Career Board (Chief Executives across Auckland public sector meet bimonthly to present talent profiles and opportunities to grow leadership capability). • Developed tools and templates to support Executive in succession planning. • Ran initial session for ELT to introduce them to talent management and succession planning process and tools. • Developed guide and process to support leaders in talent management. • Socialised talent management strategy, process and tools with Mental Health Leadership Team.

Appendix 2: Next Steps as at May 2018

FOCUS	Understanding what good leadership Looks Like	Leadership Development	Talent Management
NEXT STEPS	• Socialise clinical leadership and SSC Leadership Framework with all Directorate Leadership Teams. • ELT and SLT to role model leadership behaviours. • Embed leadership framework in Leadership Development Programmes and manager toolkits. • Embed leadership framework in people processes (e.g., recruitment, performance).	• Train leaders to have high impact Development Conversations. • Formalise Development Plans so that everyone has agreed a development plan with their leader. • Implement self-assessment tools for leaders. • Implement 360 Degree Feedback for ELT and SLT. • Create intentional developmental opportunities through experience (e.g. secondments); exposure (e.g. mentoring programme); education (e.g. LDP). • Run LDP for an additional 90 leaders in 2018. • Continue to develop coaching skills in leaders through Coaching Conversation Programmes. • Develop Management Development Programme primarily online for scalability with drop-in skill centres.	• Socialise talent management strategy, process and tools with all Directorate Leadership Teams. • ELT to lead the talent management process and experience it. • ELT to engage in talent management process with their direct reports. • Provider Directors to engage in talent management process with their direct reports. • Develop criteria for critical roles and identify potential successors.

Fit for the Future

Recommendation

That the Board:

1. **Note that the Fit for the Future Project (implementation and evaluation) has been completed with the final Evaluation report sent to the Ministry of Health at the end of September 2018.**
2. **Note that the positive evidence and findings presented in Synergia's Evaluation supports continuance and upscaling of the suite of interventions.**
3. **Note that Auckland DHB is funding the initiative until the end of December 2018.**
4. **Note that Auckland DHB has been directed by the Ministry of Health not to make any changes to funded mental health and addiction services until the Government Mental Health and Addiction Inquiry is completed to avoid pre-empting any National strategic changes following the Inquiry.**
5. **Note that the success of the project was the result of the collaborative partnership and governance by Auckland DHB, NGOs and PHOs with their innovation and commitment to the pilot and to work within an ambitious and tight time framed project.**

Prepared by: Trish Palmer (Funding and Development Manager Mental Health and Addictions)
Endorsed by: Dr Debbie Holdsworth (Director, Funding), Dr Karen Bartholomew (Director, Health Outcomes)

Glossary

ADHB	-	Auckland District Health Board
DHB	-	District Health Board
ETHC	-	East Tamaki Health Care
FftF	-	Fit for the Future
HIPs	-	Health Improvement Practitioners
MoH	-	Ministry of Health
NGO	-	Non-Governmental Organisation
PHOs	-	Primary Healthcare Organisations

1. Executive summary

In the 2017/18 financial year, the Ministry of Health put out a request for proposals for existing initiatives designed to support people with mild to moderate mental health needs. Auckland DHB Fit for the Future (FFtF) project funding was applied to existing interventions from Tamaki Mental Health and Wellbeing initiative (Awhi Ora Supporting Wellbeing) and up scaling primary mental health and addiction nurse credentialing programme, implementing new roles within General Practice teams (Health Intervention Practitioners (HIPs) and Health Coach); and evaluating this process of implementation and service delivery. The initiative was supported and overseen by a steering group representing all the partners and collaborators of this project.

The final evaluation report undertaken by Synergia was submitted to MOH on 1 October 2018 and supports a positive outcome. It lists benefits and positive wellbeing indicators from people accessing the services and also those providing the services or GP services having new roles as part of their enhanced integrated primary care teams. Early benefits and emerging efficiencies for people providing the services indicate reducing the burden on general practice teams, giving GP staff

confidence to have the conversation about mental health as they have immediate access to new services, better use of primary mental health psychological services and reduced wait times, ability for people to access support to deal with pressing social determinants of poor health and distress (with housing and WINZ issues identified as having significant impact on people's distress levels) and reduction in prescribing for antidepressants. The findings also suggest without providing support for people with mental health need in primary care, there is a risk these people's needs will continue to go unmet, and they will continue to experience poorer health and wellbeing outcomes that impact on their ability to go about their daily lives and contribute to the wellbeing of others.

The evaluation report recommends continuing the services and upscaling and continuing to evaluate and increase the evidence base for this new suite of services shown to provide immediate support to people experiencing mild to severe mental health distress accessing primary care services. Based on the evaluation ADHB is continuing to fund the initiative until end of December 2018 while the Government Inquiry is completed, an initial analysis of the Inquiry report by MOH and National strategic priorities are identified.

2. Introduction

In the 2017/18 financial year, the Ministry of Health put out a request for proposals for existing initiatives designed to support people with mild to moderate mental health needs. This funding sought to build on existing initiatives to support the development of an evidence base for interventions targeting people with mild to moderate mental health needs. This evidence base should guide decision making and investment to support the sector in becoming 'Fit for the Future' (FftF), as indicated by the title of the tender.

Auckland and Waitemata District Health Boards and their partners successfully responded to this tender. Each DHB worked with its local Primary Healthcare Organisations (PHOs) and Non-Governmental Organisations (NGOs) to respond to the requirements of the Ministry, alongside support from Specialists in Secondary Mental Health Services. Both applications built on existing work, including:

- Auckland DHB Tamaki Mental Health and Wellbeing initiative with NGOs (Awhi Ora Supporting Wellbeing)
- ProCare Stepped Care model
- East Tamaki Healthcare (Peer) Health Coach model
- Our Health in Mind Strategy (Waitemata DHB).

The FftF funding provided an opportunity to establish and evaluate enhanced integrated practice teams in practices across both DHBs. This included an expansion of Awhi Ora Supporting Welling in Auckland DHB, and its roll out in Waitemata DHB.

In September 2017, Synergia was commissioned to evaluate the interventions supported through FftF funding, following a competitive tender process. This report presents the findings from the evaluation of the interventions primarily allocated in the Auckland DHB region. The enhanced integrated practice teams in Waitemata DHB and the roll out of Awhi Ora are also presented here to present a comprehensive evidence base. The formative evaluation adopted a mixed methods design, drawing on service and outcome data, key stakeholder interviews, client feedback surveys and interviews, and a review of existing data and documentation relating to existing primary mental health interventions. Integrating insights across these data sources enabled the evaluation to provide robust feedback on the delivery and benefits of the enhanced integrated practice teams.

The initiatives supported through FftF funding have been overseen by a steering group of key stakeholders facilitated by the DHBs. These stakeholders also link FftF with related initiatives including the Our Health in Mind programme of work, existing primary mental health initiatives and the Tāmaki Mental Health and Wellbeing initiative. Supporting the integration of services and supports across key players from the sector requires strong project management and governance processes.

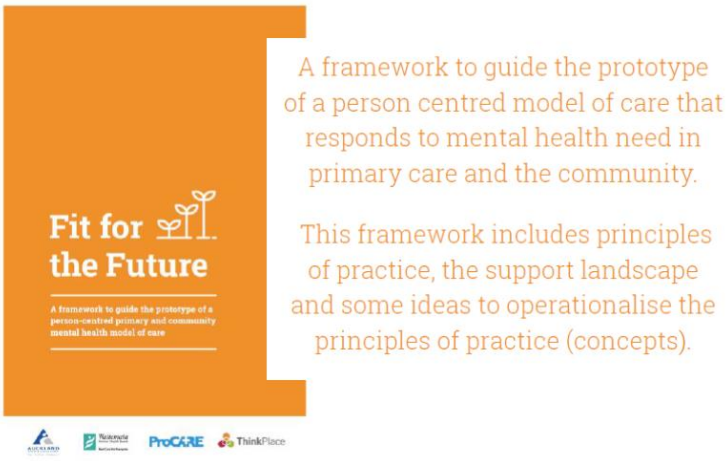
The complexity of this network of initiatives and relationships cannot be underestimated. Many of the organisations represented are contributing from the perspective of their own organisational pilots and change programmes (Table 1 below Auckland DHB Partnerships and Collaboration teams). FftF is not a discrete project or initiative in the traditional sense; there are many moving parts, each working towards an improved response for people with mild to moderate mental health needs. The Framework Document has provided a lens through which to view and evaluate the multifaceted activity across Auckland DHB, and reaching into the Waitemata DHB region.

Table 1 ADHB FFtF Partnerships and Collaboration Teams

1.	**ADHB Awhi Ora NGO Providers**	Kāhui tū Kaha, Emerge Aotearoa, Mind & Body, Mahitahi Trust, Pathways, Framework Trust and Vaka Tautua
2.	**GPs and Awhi Ora Partners**	Panmure Medical Centre; Orakei; Avondale Family Doctors; Calder Centre; Mt Wellington; Doctors Onehunga; Avondale Health Centre; Glen Innes; Mission Bay; Tamaki Family Health Centre; Mt Wellington Family, Turuki Health Centre; Stoddard Road Clinic; University Health and Counselling Services; Avondale, Grey Lynn, Mt Roskill, Sandringham Clinic; Mt Roskill Urgent Care; Mt Smart; Mt Wellington Integrated; Langumalie Health Centre; and Health Star Medical
3.	**PHOs**	National Hauora Coalition; ProCare, Auckland PHO, East Tamaki Health Care (ETHC), Comprehensive Care and Alliance Plus
4.	**Framework Practices with HIPs and/or Health Coaches**	Peninsula Medical Centre; Health New Lynn, University Health and Counselling Service; Mangere Health Centre; Turuki Health Care (results not included in evaluation as later starting) ; Orakei Health Services and Glen Innes (ETHC).
5.	**Fit for the Future Steering Group:**	Bev Monahan; Ruth Williams; Johnny O'Connell; Sue Hallwright; Trish Palmer, Brendan Short; Camille Gheerbrant; Barbara Disley; Raewyn Allan; Jill Moffat; Kirstin Good; Anne Bateman; Dominique Cummins; David Codyre; Jane Petraska, Fiona Trevelyan; River Paton; Mark Gosche; and Jo Chiplin

The Framework Document

In November 2017, the Framework Document was published and was the culmination of a co-design initiative that involved people and providers developing a response to meeting the needs of people with mental health issues in primary care and the community.



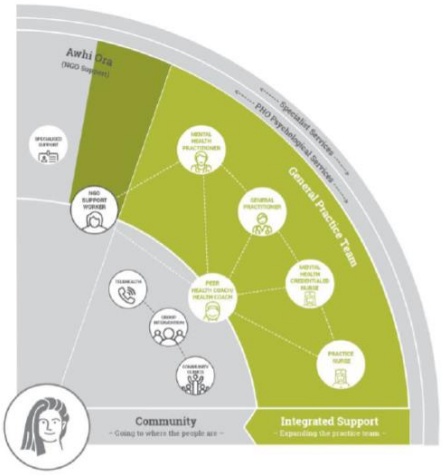
The co-design process provided insights that evolved into twelve "actionable principles of practice to guide the development of a person-centred service in primary care and community."

These principles are:

- address needs before diagnosis
- normalise conversations about mental health
- address people's holistic needs
- help people to help themselves
- connect for the whole journey
- one size doesn't fit all
- provide timely support
- develop trusted relationships
- go to where people are
- be responsive to cultural needs and preferences
- be persistent
- recognise lived experience.

The Framework Document identified the people and places necessary in the support landscape. Three core aspects of this landscape are:

- an enhanced general practice team; enhanced with new roles that work with each other and the existing practice team. The new roles identified are a mental health practitioner, peer Health Coach/ Health Coach and NGO support worker. These enhanced integrated general practice teams are referred to as Framework practices in this report
- 'walk alongside' community support (Awhi Ora) that is accessible from and beyond the GP practice and will support people with what matters to them
- reach into the community by providing points of access in homes and community settings beyond the practice as well as other modes of delivery such as telehealth.



FIT FOR THE FUTURE

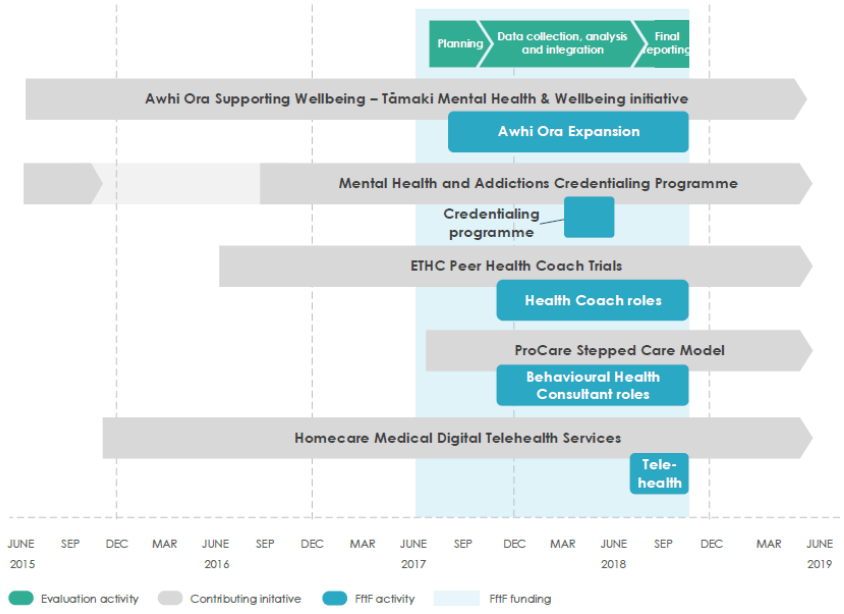
Implementation of the Framework Document

FftF was designed to build on existing interventions; this has expedited the delivery of initiatives recognised under the FftF umbrella. It is important to recognise some of these initiatives were still in the early planning stages at the beginning of the FftF funding period or were not operating at scale. The introduction of new roles and relationships into general practice is a change process of real significance. The implementation science research literature reminds us implementation processes take time, greater time than the FftF period, with maturity occurring within a two to four-year period. This stage of implementation is considered when making evaluative judgements about the delivery and achievements of the enhanced integrated practice teams.

The following timeline illustrates these contributing components, the FftF funding and evaluation window (Figure 2 below) success was achieved in compressed implementation and evaluation timeframes. This demonstrates:

- The up-scaling of Awhi Ora across the Auckland DHB region and its roll out into Waitemata DHB. This is the most mature of the interventions delivered, although it has not been evaluated as a model of support or for its readiness for upscaling.
- The introduction of Health Improvement Practitioners (HIPs) and/or Health Coaches to seven practices. This was supported by existing work at ProCare and East Tamaki Health Care (ETHC):
    - Planning for ProCare's Stepped Care Model began in late 2017 with the PHO facilitated the very first training of HIPs in November 2018. This role and its function is a New Zealand first and this is in the early stages of implementation.
    - ETHC ran its first pilot of Health Coaches in 2016 to support diabetes care. These roles are new to the Framework practices primary care teams and are at the initial implementation stage to respond to people with high levels of distress.
    - The delivery of an additional Mental Health and Addictions Credentialing Programme (Comprehensive Care PHO).

Figure 2: FftF timeline



Awhi Ora, the HIP and the Health Coach roles are the main focus of the FFtF evaluation report, other interventions, including the Mental Health and Addictions Credentialing Programme and Telehealth are also outlined. Examples from Waitemata DHB are included in the evaluation report to strengthen the evidence base and insights from the evaluation.

In terms of the enhanced integrated practice teams, the evaluation evidence found that Awhi Ora, the HIP and the Health Coach roles:

✓ **reach the missing middle** - people with complex mental health needs who are not eligible for secondary services and would not be referred to and/or would not access existing referral based psychology services.

✓ **reach people with a range of mental health needs** relating to physical, social, economic and behavioural determinants of ill health. This is evidenced through the use of validated assessment tools and insights from people accessing services and supports, and insights from health professionals and providers

✓ **Available much more rapidly than traditional referral based psychological services** and have reduced demand for those services and enabled people with more intensive needs to access interventions while they wait to access referral-based services

✓ **provide immediate/rapid access to a range of person-driven support options.** This is supported by the focus on a person-centric approach that enables the person to identify the areas of their wellbeing that they need to address. The brief rapid response also encourages and supports this self-activation

✓ **facilitate equity of access for Māori, Pacifica and youth**, particularly through location at high-needs or youth-focused practices. The cultural competence of the Health Coaches and some Awhi Ora Support Workers supports access and engagement for Māori and Pacifica. This is supported by an analysis of access rates by enrolled practice and DHB populations

✓ **provide a brief preventative response** that also encourages a more holistic response to supporting wellbeing than psychological support services in isolation. This is supported by recognising the broader determinants of ill health, including social and economic needs, such as support with housing

Based on the mixed methods integration, the evaluation provides good evidence through which to understand the contribution of the enhanced practice teams to people with mild to moderate mental health needs. More specifically, the evaluation demonstrates the positive contribution that the enhanced practice teams make and the value of continuing to support and further roll out their implementation. Integrating HIP, Health Coach and Awhi Ora roles with existing practice roles and systems is not without its challenges and is supported by a change-management process that is not complete. The following table identifies key aspects of the enhanced integrated practice teams that are important for supporting success:

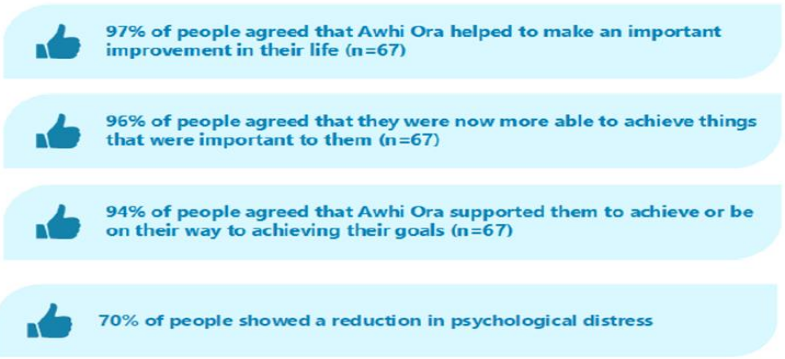
Aspects of the integrated practice teams that support success	
• **No entry criteria** • **Warm handover and immediate/ fast access to support**	No entry criteria makes it easy for people to be introduced to services and supports. Warm handover is achieved when the HIP, Health Coach or Awhi Ora are at the practice. This approach was extremely valued by clients and practice staff. Warm handover was more consistently achieved through the HIP and Health Coach roles due to being located at the practice. Leaving every other booking free in the schedules of HIPs and Health Coaches facilitates immediate access. Awhi Ora sees most people within five working days.
• **Person-centric support**	The services and supports provided are determined by client-driven goals. These focus on the immediate or key things that need to be addressed to support their wellbeing. *One size does not fit all.*
• **Presence at the practice** • **Feedback to GPs**	Presence within the practice builds relationships with existing practice staff. These relationships support integration with existing services enabling mental health services and supports to become part of the primary care landscape. This aspect is more challenging for Awhi Ora, as many practices do not have physical space to accommodate them seeing people on site. The HIP and Health Coach roles are emerging as gateways for people to access Awhi Ora supports. Feedback to GPs is important for building trust and also provides an opportunity to build capability.
• **Awhi Ora community networks and connections** • **Value of HIP, Health Coach and Awhi Ora Support Worker skill sets**	The community networks and connections of the Awhi Ora support moved beyond general practice to connect people to a broad range of services and supports. These are important for also addressing the social and economic determinants of mental health. Workforce and cost considerations can easily lead to the consideration of one role or choices about which roles should be implemented and where. Evidence in this space is emergent at this very initial stage of implementation. The evaluation, however, does indicate that: - BHC support those with higher levels of need/distress - HC supporting with health-related behaviours and LTCs, and providing culturally appropriate or relevant support - Awhi Ora Support Workers can provide support across for a range of psychosocial needs.
• **Adaptive workforce**	This way of working requires an adaptive workforce that provides services in a different way to traditional therapist or support work roles. Staff have been passionate and invested in this way of working.

Awhi Ora Supporting Wellbeing

Awhi Ora provides access to community support to people experiencing life challenges or stress. Previously such support has only been available to people through secondary mental health services. Awhi Ora is designed to enable primary care practices and cross sector agencies to have a lead NGO they can introduce people to who would benefit from wellbeing or social support. Following an introduction, people are seen by a support worker. This may be in the GP clinic, their home or in the community. A plan to address the person's presenting need is developed with the support worker. Support is usually brief – typically weekly for up to three months – but varies according to need. People with multiple or more complex issues may require support for a longer period.

Awhi Ora Key Evaluation Findings:

- Awhi Ora provides important support for people with high level of need
- Social and housing outcomes are particularly important
- Awhi Ora connects people to a wide range of health and community resources
- Awhi Ora effectively supports people to make changes to support their wellbeing
- 70% of people demonstrated an improvement in K10 score within a brief timeframe
- Reaching those whose needs would have likely gone unmet
- Reaching Māori and Pacifica effectively
- Reaching those with needs relating to physical, social, economic and behavioural determinants of ill health
- The data indicated that two thirds are like to experience severe psychological distress (K10s only available for 30% of all introductions)
- Awhi Ora partners value the NGOs for their:
    - mental health expertise and connections
    - community knowledge and connections
    - ability to navigate and align with other services and supports
    - ability to support introductions to a broad range of services and support.



Voices of the people accessing Awhi Ora Supporting Wellbeing

Health Improvement Practitioner and Health Coach

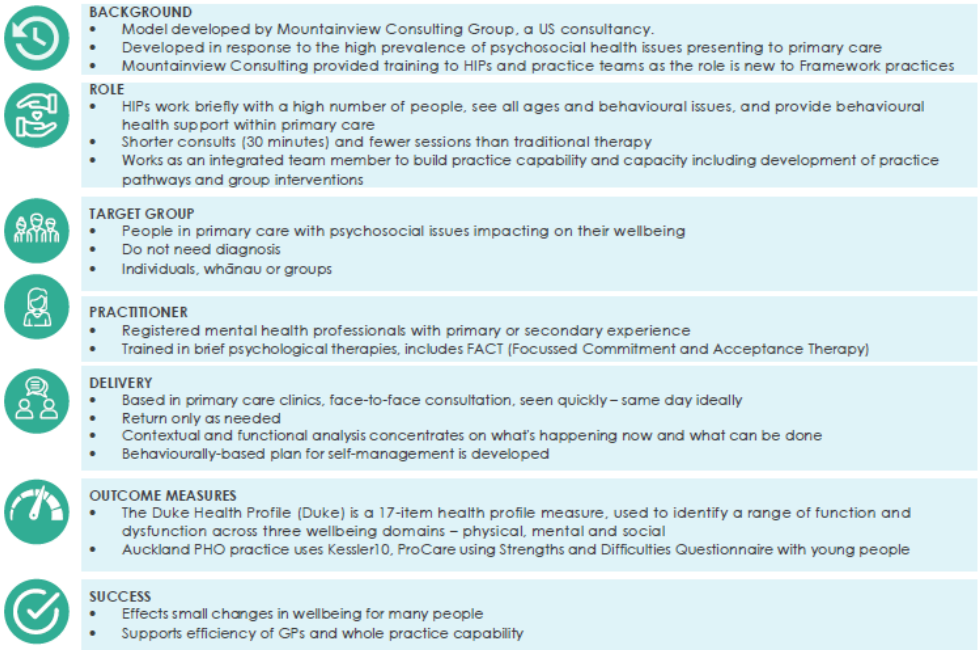
The 'Framework practices' refers to practices supported by FftF funding plus additional PHOs investment supported the introduction of new roles into their practice teams. This was designed to enhance and promote the integrated team approach to supporting wellbeing needs. Practices were selected to reach high-needs populations including Māori, Pacifica and youth. The new roles introduced at these practices are the HIPs and/or Health Coaches. All of the practices also had an Awhi Ora support worker.

A total of seven practices had a HIP and/or Health Coach role. Three of the practices were in Auckland DHB, two in Waitemata DHB, and one is situated in Counties Manukau Health. All six practices are included in the evaluation scope, as collectively they provide better opportunities for understanding and learning than an analysis segregated by DHB.

> "I don't know of any primary care programme that has hit the ground running and taken off so fast...this has just flown. There's a need and we all recognize the value of it. It makes our lives so much easier so why wouldn't we be flying with it?"
> (GP)

Health Improvement Practitioner ('HIP')

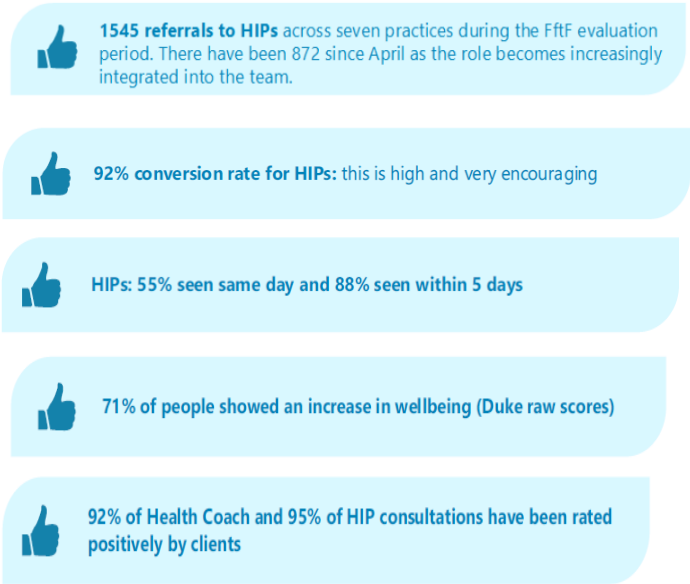
HIPs are registered health professionals who can work briefly with a high number of people (8+ per day) to provide targeted behavioural health support within primary care. The HIP is a generalist role, although the level of demand at the practices has seen HIPs predominantly support clients with moderate to severe mental health and wellbeing issues. These are issues that impact on someone's life and may present risk. The HIPs are also seeing people who have accessed secondary services in the past and people who were described as having high needs relating to mental health but not meeting the criteria for secondary mental health services. In some practices the role is more generalist than in others, and a greater proportion of people present with mental health-related issues, such as undiagnosed symptoms, headaches, neck and back pain and poor sleep. HIP Role overview described below:



What is the reach of the HIPs?

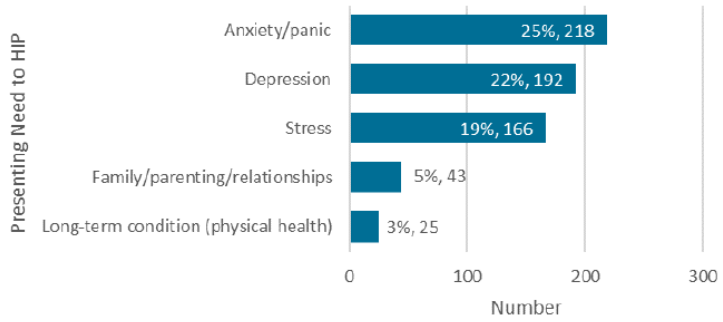
The 92% conversion rate for HIPs (1 April to 30 June 2018) is encouraging because:

- five of the six practices have conversation rates above 90%
- conversion is reasonably consistent across ethnic groups (Māori 94%, Pacifica 93% and NZ European 91%)
- male and female clients have equal rates of conversion
- conversion is reasonably consistent across the age ranges with those under 16 and over 65 slightly more likely to convert.



Across the practices, the top reasons for support identified by HIPs were anxiety, depression and stress (Figure 25). These descriptions are chosen by HIPs from a list of 27 conditions that all HIPs and Health Coaches use.

Figure 25: Top presenting client needs for HIP (n=872)



Health Coach Role

Health Coaches are non-regulated workers who support people with health literacy and self-management relating to long term conditions. The warm handover, a face-to-face introduction that enables immediate or same day consultations, where possible, is an important dynamic of these roles within the practice team. Practical action and self-management plans are developed with people that focus on the wellbeing issues of concern to them and repeat consultations occur as and when required by the client. Health Coach Role described in more detail below:

BACKGROUND
- ETHC has been delivering HC training based on the University of California Centre for Excellence in Primary Care model since 2015
- ProCare staff attended ETHC and Counties Manukau Health Coach training

ROLE
- Health Coaching helps people build knowledge, skills and confidence to manage their health conditions
- The role uses evidence-based practices to support clients to self-manage condition, bridge gap between client and doctor, navigate health system and offer client emotional support
- Be the client's first point of contact if they have questions

TARGET GROUP
- People with low health literacy and chronic conditions
- People with co-morbidity, psychosocial issues who need support to engage with primary care and other support services and manage their wellbeing

PRACTITIONER
- People who are health literate, have usually held social/health worker, navigator or kaiawhina roles
- Can be peer roles - people with lived experience of mental health or living with chronic conditions
- Health Coaches may be selected also for their cultural expertise and /or language skills

DELIVERY
- Based in primary care clinics and work as an integrated member of the practice team, consults to people in the practice
- Deliver self-management and other wellbeing groups in the community and use a range of evidence-based approaches to have motivating conversations and engage people in health behaviour change
- Sees people who are referred or proactively identifies client group within the practice

OUTCOME MEASURES
- ProCare use Partners in Health – a tool that measures patient activation and have recently begun using Duke
- The Duke Health Profile (Duke) is a 17-item health profile measure, used to identify a range of function and dysfunction across three wellbeing domains – physical, mental and social
- Health Coaches at ETHC have been using PHQ9 (used as screening tool in the practice)

SUCCESS
- Increased patient activation, self-management and health literacy. Better chronic condition management

Reach of Health Coaches?

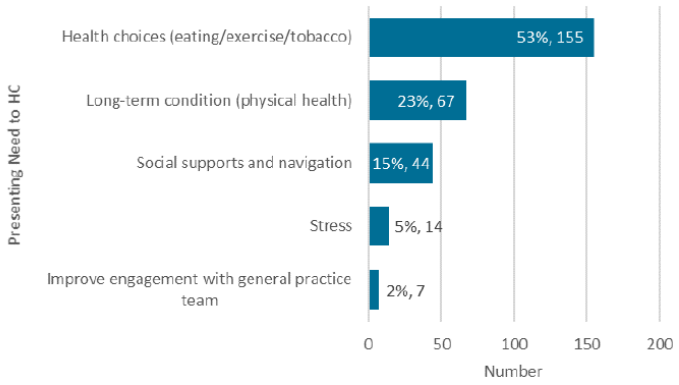
421 referrals to Health Coaches across seven practices, 308 since April 2018.

85% conversion rate for Health Coaches; this is high and very encouraging.

Health Coaches: 69% seen same day and 92% seen within 5 days

The primary presenting reasons recorded for Health Coach Clients are predominantly related to lifestyle choices and long-term.

Figure 31 Presenting needs profile for people introduced to Health Coaches (n=293)



Key Points that demonstrate the success of implementing HIPs and Health Coaches include:

- HIPs and Health Coaches provide an immediate gateway to support in primary care
- Supporting those who would not be reached or engaged through other services; reaching the "missing middle". Those people experiencing mild, moderate and severe mental health needs, with the latter not meeting the criteria for support from secondary services.
- High conversion rates for both roles across all ethnic groups with overall 92% conversion rate for HIPs and 85% for Health Coaches.
- HIP support those with higher levels of need/distress.
- Health Coaches supporting people with health-related behaviours and LTCs, often associated with anxiety and depression.
- Health Coaches are providing culturally appropriate or relevant support and providing support to more men than HIPs.
- Youth being reached predominantly through University practice, although there is good reach across all age groups for both roles.
- Effective reach for primary care prevention work (primary, secondary and tertiary levels of prevention).
- Language skills and cultural expertise enabled Health Coaches to be more relatable to Māori and Pacifica people in particular. These skills were used explicitly to make those connections, build trust and support change.
- Integration into the general practice team supported by the high value of these roles to general practice.
- Practice roles and pathways for referrals and management of specific conditions emerging.
- HIP role requires the learning and unlearning of ways of working. This might not fit everyone's ways of working and requires some adjustment.
- Health coaches are highly valued for their cultural knowledge and expertise.
- Warm handovers support access and engagement.
- General Practice staff and people accessing services and supports are highly satisfied with the HIP and Health Coaches.
- The integration of Awhi Ora provides value when fully utilised such as at the University Health, ETHC and Auckland PHO practices.

The introduction of HIPs and Health Coaches into practices to work as integrated team members has and continues to be a significant learning experience. Overall, this is going very well, and a lot has

been achieved in this relatively short time. Each practice has had its unique approaches and experiences but there were many common themes relating to this change process:

- practice and staff readiness
- relationships
- making the space work
- understanding the roles
- warm handovers work best
- integrating into the team
- feedback.

Practice teams have responded positively to these new roles and benefits they have identified include:

- **Time saved in consultations,** as GPs and PNs can refer on to Behavioural Health Consultant or Health Coach for longer conversations when required. This was obviously a source of relief as clients were getting connected to the right support; it also reduced the stress for GPs of running late on their schedule.
- **Confidence** to have conversations about mental health now GPs and nurses have someone within the practice they can refer people to. High confidence in the HIP and Health Coaches' ability to support people well, builds this confidence.
- **A broader range of options, beyond prescribing**. Previously GPs were restricted to referrals for psychological support or prescriptions for people presenting with mental health issues. HIP is seen as an immediate and effective response. GPs are under less pressure to prescribe simply because there is another option that may suit their patient better.
- **Efficiencies through new practice pathways** that include identification of routine referral to HIPs, regarding depression for example, or to Health Coaches, regarding diabetes. Such pathways direct patients through the most appropriate pathway for their needs and enables practice to routinely optimise efficiencies that enable GPs and nurses to work at top of scope.
- **A potential for credentialed nurses** to contribute to practice teams, which has been highlighted by these new roles and teamwork processes. There are plans in a couple of the practices for HIPs and credentialed nurses to work closely together; one of the ideas is for nurses to complete follow up consultations.

Mental health and addictions nurse credentialing

Following a successful pilot in 2015, Comprehensive Care has been contracted by the three metro Auckland DHBs to lead and deliver a Collaborative Mental Health and Addictions Credentialing Programme for Primary Health Care Nurses across Auckland DHB, Waitemata DHB and Counties Manukau Health. The programme aims to enhance the competency and confidence of nurses in their everyday practice when supporting individuals and whānau impacted with moderate mental health and addiction issues. Successful participants are accredited by Te Ao Māramatanga New Zealand College of Mental Health Nurses. The nurse credentialing programme has previously been evaluated by Auckland University of Technology in 2016. The evaluation confirmed the quality and value of this training programme both in its delivery and achievement of learning objectives. There is little value to add by evaluating this programme again. This evaluation however, does seek to understand the current and potential contribution of credentialed nurses to the Framework.

ADHB FftF has funded Comprehensive Care to run a fourth nurse credentialing programme. This was delivered over a shorter four-month period: March to June 2018. All 17 nurses who enrolled have completed the programme. Portfolios are currently being submitted for assessment.

FFTF SUMMARY OUTCOMES

How much was done?
The enhanced integrated practice teams and Awhi Ora have:

- Reached the missing middle through engaging people with a range of mental health needs who would otherwise have fallen through the cracks, as they were unlikely to engage with traditional psychological support services or meet the criteria for specialist support.
- Provided immediate/rapid access to a range of person-centred support options. People are seen the same day at the practice or within a week through Awhi Ora.
- Facilitated equity of access for Māori, Pacifica and youth, particularly through location at high-needs or youth-focused practices.
- Provided a brief preventative response that recognises and responds to broader determinants of ill health, including social and economic needs.

How well was it done?
Implementation is going well for something so new to primary care:

- The change-management process is still underway. Providers and clients were passionately supportive of this way of working; those close to service delivery told us it just made sense to be providing services in this way.
- Practice team relationships are key to success. This provides the interface that makes these roles work. A consistent presence onsite facilitates relationship building.
- Complementary role strengths emerged quickly with HIPs supporting those with higher levels of psychological distress, Health Coaches supporting physical health-related behaviour, and Awhi Ora responding to a range of psychosocial needs.
- Health Coaches and Awhi Ora provide a culturally responsive connection point for people accessing support.
- High satisfaction and acceptability from providers and clients.

Is anyone better off?
The evaluation provides a good level of evidence through which to understand the contribution of the enhanced practice teams to people with mild to moderate mental health needs. More specifically, the evaluation demonstrates the positive contribution that the enhanced practice teams make, and the value of continuing to support and further roll out their implementation.

Outcomes for people accessing services and supports:

- improvements in mental health and wellbeing
- improvements in and towards the broader determinants of wellbeing, such as housing, money matters and employment
- immediate or fast access to services and supports
- improved access for Māori, Pacifica and youth
- access for people whose needs would have gone unmet.

Benefits for people providing services and supports:

- **reducing the burden** on general practice teams
- giving general practice **staff confidence to 'have the conversation'** about mental health
- **able to access community support** for practice population via Awhi Ora

Practice and system outcomes:

- **better use of psychological support services** as reduced demand and wait times are emerging
- efficiencies are supporting GPs and PNs to work at **top of scope**

- emerging **reductions in prescribing** for antidepressants.

What does this mean for the missing middle?
The range of interventions that were expanded and supported by the FftF funding has provided an important and timely insight into the value of reaching the missing middle through providing:

- immediate access to services and supports for people in primary care
- services and supports that respond to the psychological, social and economic determinants of ill health and wellbeing without barriers to entry and
- brief interventions and supports that help people at a point in time and enable them to move upwards on their wellbeing trajectory.

The evaluation also indicates that people with complex mental health needs can be managed within primary care, if it is equipped with the capacity and capability to do so. The findings also highlight the preventative nature of the support offered, as without it there is a real risk that these people and their needs will continue to go unmet.

What's next for Fit for the Future?
The evaluation evidence demonstrates the importance of providing services and supports for people with mild to moderate mental health need in primary care. The evaluation also highlights the value that can be provided for people needing services and supports when DHBs including support from PHOs and NGOs partners to strengthen the capability and capacity of primary mental health.

The evaluation also indicates that people with complex mental health needs can be managed within primary care, if it is equipped with the capacity and capability to do so.

The findings also suggest without providing support for people with mental health need in primary care, there is a risk these people's needs will continue to go unmet, and they will continue to experience poorer health and wellbeing outcomes that impact on their ability to go about their daily lives and contribute to the wellbeing of others. Existing evidence also suggests that without appropriate support, a high proportion of these people will go on to require supports from secondary services and/or continue to require other supports from government agencies and organisations.

Based on the evidence presented in this evaluation and considerations of existing evidence relating to services and supports for people with mental health needs in primary care, we would recommend:

- Extending the current enhanced integrated practice teams and provide additional funding to support the expansion of the HIP, Health Coach and Awhi Ora Support Workers to other high needs practices.
- Consideration should also be given to supporting reach for Māori, Pacifica, Asian and youth when selecting future practices (as it was for the FftF funding).
- Emphasis should be placed on whole-of-practice education to promote speedy and effective implementation.
- The role of credentialed nurses warrants exploration as newly trained nurses become available to practice teams. Initial implementation has highlighted the value of these roles, when given the time, supervision and support to use their expertise.

In terms of the enhanced practice team themselves, we would recommend:

- Ensuring that practices with HIP and Health Coach roles have an Awhi Ora support worker connected to them.
- Expanding the provision of Awhi Ora support workers across a broader range of practices but have the HIP or Health Coach as they key point contact, reducing the burden and ongoing

challenge of support workers trying to negotiate access to practices. This will maximise the value of the support worker expertise.
- Ensuring that practices understand that Awhi Ora is much more than housing and social support. Awhi Ora provides an important opportunity to meet the needs of people with a wide range of support needs, including emotional support.

In terms of meeting the needs of Māori, Pacifica and young people:
- Awhi Ora and the Health Coach roles are also important for supporting a culturally responsive approach for Māori and Pacifica, and it is important that this is considered in any future roll out. Any integration or overlap of roles in specific practice contexts that might not be able to sustain or require all three roles must ensure that these skills are not lost.
- Considerations for youth highlight the potential value of connecting NGOs with expertise in engaging young people with youth specific organisations, such as HealthWEST in Waitemata DHB. This would support the sector in providing a broader range of options for young people, in addition to the current packages of care and be an efficient way for NGOs to reach youth.

There is a need to enhance the interface between primary and secondary care to further strengthen the enhanced integrated practice teams. This could be supported by some of the interventions being implemented in Waitemata DHB, and direct telephone access to specialist MH/Psychiatry support in particular. This provides an immediate link to a community psychiatrist who can provide support that enables GPs to better manage the needs of people in primary care. The psychiatrist provides support through being able to share secondary service information not visible to GPs, providing advice in relation to prescribing and the navigation of other services and supports.

References

Synergia. (2018). *Fit for the Future: Evaluation Enhanced Integrated Practice Teams.* Auckland: www.synergia.co.nz.
Think Place. (2017). *Fit for the Future: A framework to guide the prototype of a person-centred primary and community mental health model of care.* Auckland: Think Place NZ Limited.

System Level Measures – Quarter 4 Report

Recommendation:

That the Board note the Quarter four final results for the second SLM Improvement Plan.

Prepared by: Wendy Bennett (Planning & Health Intelligence Manager – Auckland and Waitemata DHBs)
Endorsed by: Karen Bartholomew (Acting Director Health Outcomes – Auckland and Waitemata DHBs) and Tim Wood (Funding and Development Manager Primary Care – Auckland and Waitemata DHBs)

Glossary

ACP	Advance Care Plan
ALT	Alliance Leadership Team
ARPHS	Auckland Regional Public Health Service
ASH	Ambulatory sensitive hospitalisations
CEO	Chief Executive Officer
CVD	Cardiovascular disease
DHB	District Health Board
ED	Emergency Department
HT	Health Target
HQSC	Health Quality and Safety Commission
PES	Patient Experience survey
PHC	Primary health care
PHO	Primary Health Organisation
POAC	Primary Options for Acute Care
SLM	System level measure
WCTO	Well Child/Tamariki Ora

1. Strategic Alignment

Community, whānau and patient centred model of care	Our commitment to improvement against the System Level Measures (SLMs) demonstrates our dedication to our communities, patients and families to work to continually improve the quality of care we deliver and enhance the experience of our patients in their interactions with health care providers.
Emphasis and investment on both treatment and keeping people healthy	System Level Measures focus us to make improvements across the whole system. Activities focused on both treatment and keeping people healthy are identified within the 2017/18 System Level Measures Improvement Plan.
Intelligence and insight	The SLM programme of work is focused on using evidence-based solutions to effect change across the system and monitoring for that change to help us understand how our activities contribute to our overarching goals.
Evidence informed decision making and practice	
Operational and financial sustainability	Taking a whole of system approach also focuses us on how we work together to achieve not only better outcomes for our patients and communities, but also how we achieve that sustainably, effectively and efficiently.

2. Introduction

The New Zealand Health Strategy outlines the high-level direction for New Zealand's health system to 2026 to ensure that all New Zealanders live well, stay well, get well. One of the five themes in the Strategy is value and high performance. This theme places greater emphasis on health outcomes, equity and meaningful results. Under this theme, the Ministry of Health (MoH) worked with the sector to develop a suite of System Level Measures to provide a system-wide view of performance. Building on the work outlined in the 2017/18 System Level Measures Improvement Plan, in 2018/19, improvement milestones and contributory measures for each of the system level measures (SLMs) have been prioritised and focused, in recognition of the significant amount of activity needed to make meaningful change for each measure.

The Counties Manukau Health and Auckland Waitemata Alliances are firmly committed to including additional contributory measures that are well aligned with SLM milestones over the medium to longer term. This plan reflects a strong commitment to the acceleration of Māori health gain and the elimination of inequity for Māori.

The steering group continues to meet in order to further develop key actions (particularly at a local level), monitor data, and guide the ongoing development of the SLMs. Steering group membership includes senior clinicians and leaders from the seven PHOs and the three DHBs. The steering group is accountable to the two Alliance Leadership Teams (ALTs) and provides oversight of the overall process. A PHO Implementation Group has been meeting throughout 2018 to support and enable implementation of SLM improvement activities.

The ALTs are strongly committed to improving performance where it matters most over the medium to longer term. The 2018/19 SLM Improvement Plan has been approved by the Ministry and is currently being implemented.

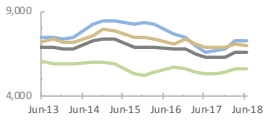
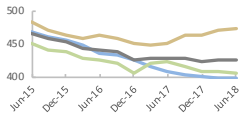
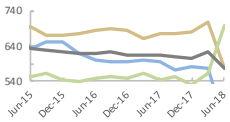
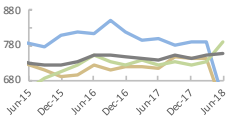
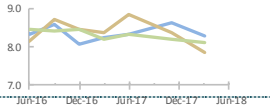
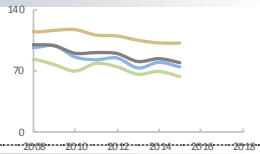
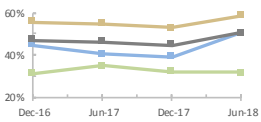
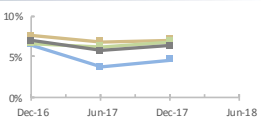
This paper is the final report on the current (second) improvement plan for 2017/18. Note that measures 5 and 6 have been developed over 2017/18 and therefore the focus has been on base lining data, data quality improvement, and identifying key health sector partners and appropriate activities for the 2018/19 planning cycle.

1. Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0 – 4 year olds
2. Acute hospital bed days per capita
3. Patient experience of care
4. Amenable mortality rates
5. Babies living in smokefree households at six weeks
6. Youth are healthy, safe and supported.

For each SLM, there is an improvement milestone to be achieved in 2017/18. The milestone must be a number that improves performance from the district baseline, reduces variation to achieve equity, or for the developmental SLMs, improves data quality. For each SLM, there is a set of contributory measures which show a clear line of sight to the achievement of the improvement milestones.

This report includes the latest available data for each DHB for both the SLMs and their contributory measures. It also outlines progress against the improvement activities identified in for each SLM in the SLM Improvement Plan.

System Level Measure Reporting: Scorecard

		DHB / Region	Target		Performance: Actual	Performance: Data Period	Performance: Trend
1. Ambulatory Sensitive Hospitalisations: 0-4 Year-Olds							
Measure:	Rate per 100,000 domiciled 0-4 year-olds.	Auckland	7,278	(max.)	7,218	12-monthly to Jun-18	
		Counties Manukau	6,754		7,012		
Target 2017/18:	5% reduction in rate by June 2018	Waitemata	5,409		5,577		
		Metro Auckland	6,420		6,539		
2. Acute Hospital Bed Days							
Measure:	Age-standardised rate per 1,000 domiciled population.	Auckland	425	(max.)	400	12-monthly to Jun-18	
		Counties Manukau	451		475		
Target 2017/18:	2% reduction for total population by June 2018	Waitemata	414		407		
		Metro Auckland	429		426		
Target 2017/18:	3% reduction for Māori population by June 2018	Auckland	578	(max.)	429	12-monthly to Jun-18	
		Counties Manukau	670		576		
		Waitemata	538		700		
		Metro Auckland	605		577		
Target 2017/18:	3% reduction for Pacific population by June 2018	Auckland	826	(max.)	628	12-monthly to Jun-18	
		Counties Manukau	689		605		
		Waitemata	709		790		
		Metro Auckland	730		758		
3. Patient Experience of Care							
Measure:	DHB Adult Inpatient Experience Survey: Aggregated Domain Score	Auckland	8.5	(min.)	8.8	Quarterly to Jun-18	
		Counties Manukau	8.5		8.3		
Target 2017/18:	Aggregated domain score of 8.5(/10)	Waitemata	8.5		8.2		
Measure:	Practices participating in Patient Experience Survey.	Alliance Health Plus	50%	(min.)	94%	Total to May-18	
		Auckland PHO	50%		92%		
		Comprehensive Care	50%		86%		
		EastHealth	50%		73%		
Target 2017/18:	50% of each PHO's practices	National Hauora Coalition	50%		88%		
		Procare	50%		91%		
		Total Healthcare	50%		100%		
		Metro Auckland	50%		90%		
4. Amenable Mortality							
Measure:	Age-standardised rate per 100,000 domiciled 0-74 year-olds.	Auckland	71.4	(max.)	74.0	12-monthly to Dec-15	
		Counties Manukau	102.3		101.2		
Target 2017/18:	2% reduction (on single year baseline) by June 2018	Waitemata	64.3		62.9		
		Metro Auckland	78.6		78.9		
5. Youth Health							
Measure:	Chlamydia testing coverage for 15-24 year-olds.	Auckland	80%	(max.)	50%	Quarterly to Jun-18	
		Counties Manukau	80%		59%		
Target 2017/18:	80% of pregnant women aged 15-24 years are screened for chlamydia	Waitemata	80%		32%		
		Metro Auckland	80%		50%		
6. Babies Living in Smokefree Households							
Measure:	Percentage of babies for whom smoke-free household status is not recorded by 6 weeks.	Auckland	10%	(min.)	5%	6-monthly to Dec-17	
		Counties Manukau	10%		7%		
Target 2017/18:	Reduce to less than 10% by June 2018	Waitemata	10%		7%		
		Metro Auckland	10%		6%		

Legend

- Target met / on track
- Improvement needed
- Significant improvement needed

- Metro Auckland Region
- Auckland DHB
- Counties Manukau DHB
- Waitemata DHB

Overall Progress Report

Overarching activities for Q4:

- The 2018/19 Metro Auckland SLM Improvement Plan was approved with no revisions required, and received praise from the Ministry of Health for its collaborative and equity focused approach.
- Implementation of the plan is on-going and has become business as usual for many of the stakeholders involved.
- Q4 reporting approved by the Ministry
- Static and dynamic reporting is embedded, with dynamic reporting being released regularly. Updates are released via Citrix Sharefile, which allows safe and secure sharing of confidential information via email
- Training has been provided for PHOs in use of StatPlanet and DHB staff continue to give ongoing support and advice around use of StatPlanet and data interpretation
- The PHO Implementation meeting continues to meet bi-weekly and has been the starting point for planning for 2018/19. PHOs are focussing on completion of their implementation plans, which will be collated with DHB activities and form the basis of the regional implementation plan for 18/19. This will support strong accountability for agreed actions.
- Throughout the quarter we have held workshops to consult on broad planning themes. This has involved consumers via HealthLinks, Māori and Pacific providers and Mana Whenua, and key stakeholders. We have received good feedback on this approach.

Ambulatory Sensitive Hospitalisations 0-4 year olds

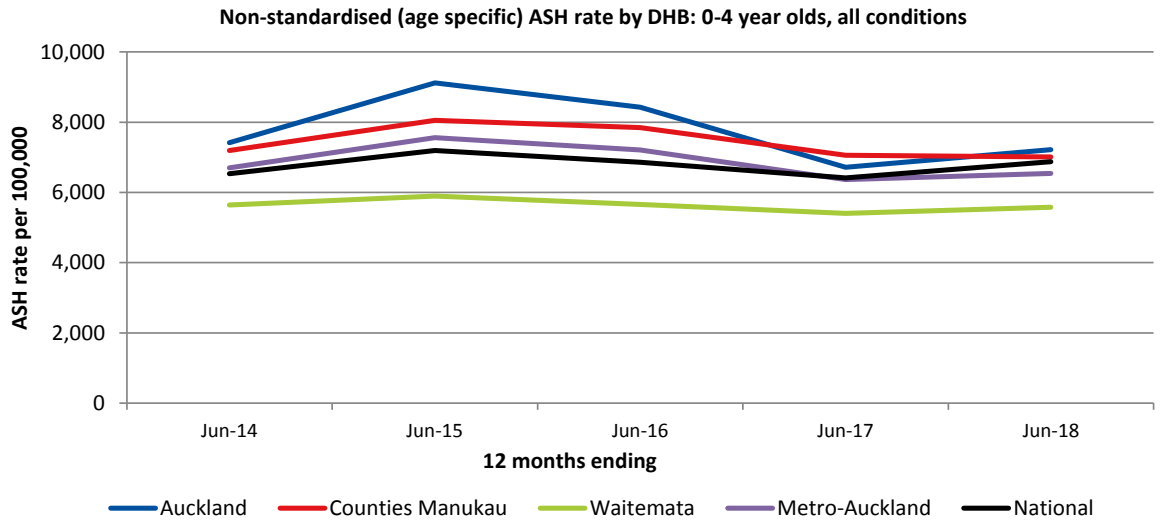
Ambulatory sensitive hospitalisations (ASH) are mostly acute admissions that are considered potentially reducible through prevention or therapeutic interventions deliverable in a primary care setting.

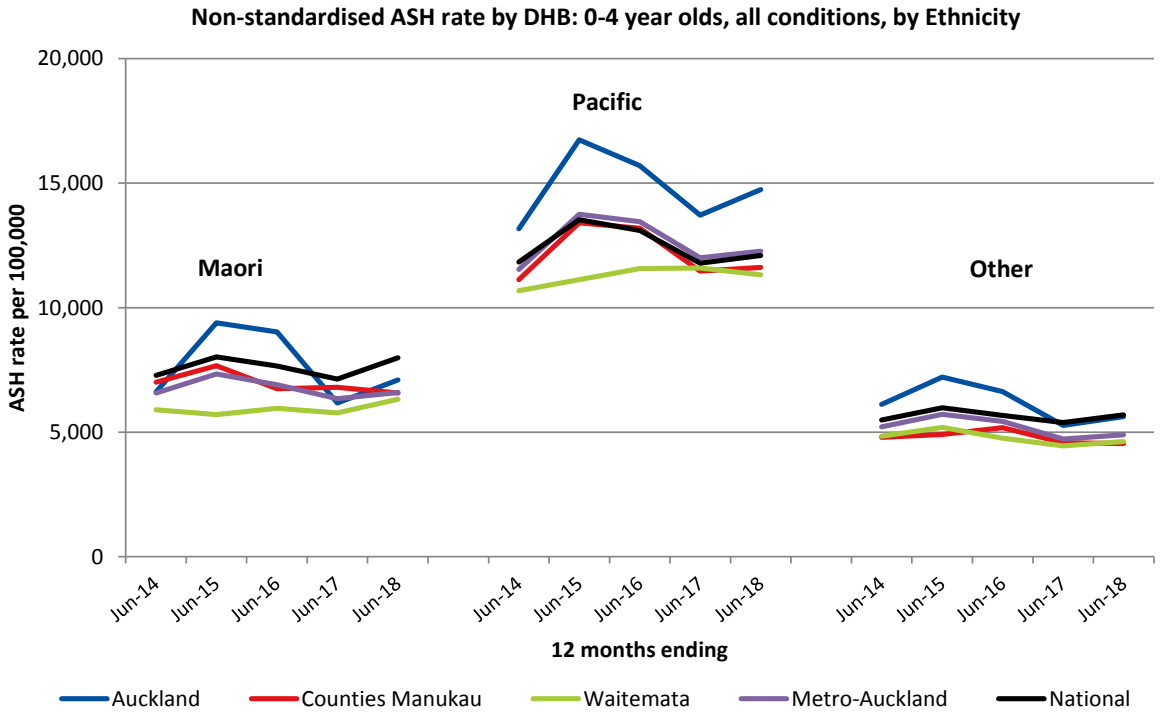
In New Zealand children, ASH accounts for approximately 30 percent of all acute and arranged medical and surgical discharges in that age group each year. However, determining the reasons for high or low ASH rates is complex, as it is in part a whole-of-system measure.

It has been suggested that admission rates can serve as proxy markers for primary care access and quality, with high admission rates indicating difficulty in accessing care in a timely fashion, poor care coordination or care continuity, or structural constraints such as limited supply of primary care workers.

ASH rates are also determined by other factors, such as hospital emergency departments and admission policies, health literacy and overall social determinants of health. This measure can also highlight variation between different population groups that will assist with DHB planning to reduce disparities.

In 2017/18, the overall improvement milestone was to achieve a reduction in ASH rates for 0-4 year olds of 5% by June 2018. There is no ethnic specific target reduction set at present, however ethnic specific rates must be monitored and reported alongside interrogation of approach to ensure that interventions reduce not worsen inequity. Metro Auckland's rate is 6,539 per 100,000 for the 12 months to June 2018. This is a 3.2% reduction on the results to September 2016 (baseline) of 6,758 per 100,000 population.



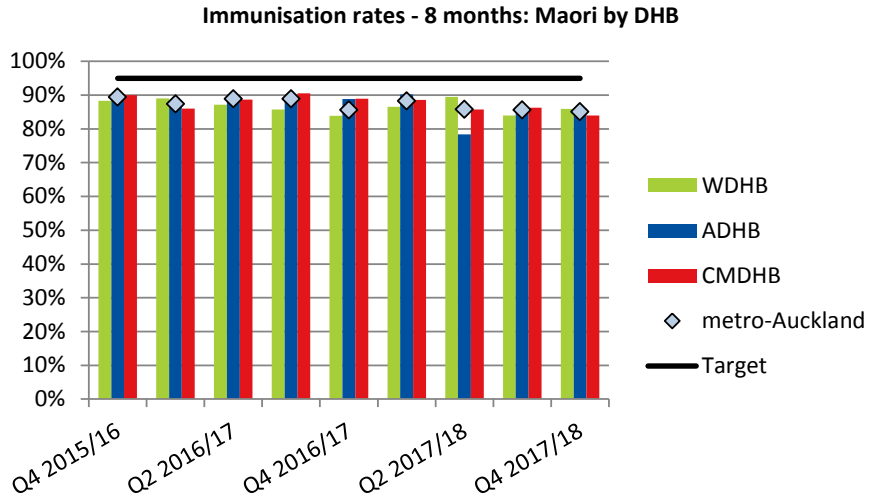


The higher rates for Auckland DHB Pacific children persist – non-standardised rates, particularly for asthma, respiratory infections, pneumonia and cellulitis far outweigh those for other ethnicities. There is also a higher proportion of 'seen, not admitted' children at Auckland DHB (remain in ED longer than 3 hours, but are discharged before needing to be admitted to a ward), than at other DHBs, which requires further analysis.

Contributory Measures

1. Māori babies fully immunised by 8 months of age

The goal for 2017/18 was to achieve the national target of 95% coverage per quarter. Towards achievement of this goal, the current whole-of-pathway focus of the immunisation programme has continued. For Quarter 4 2017/18, none of the metro-Auckland DHBs met the target overall and the rate is little changed from Quarter 3, though results for Waitemata rates have improved 1.9% from last quarter.

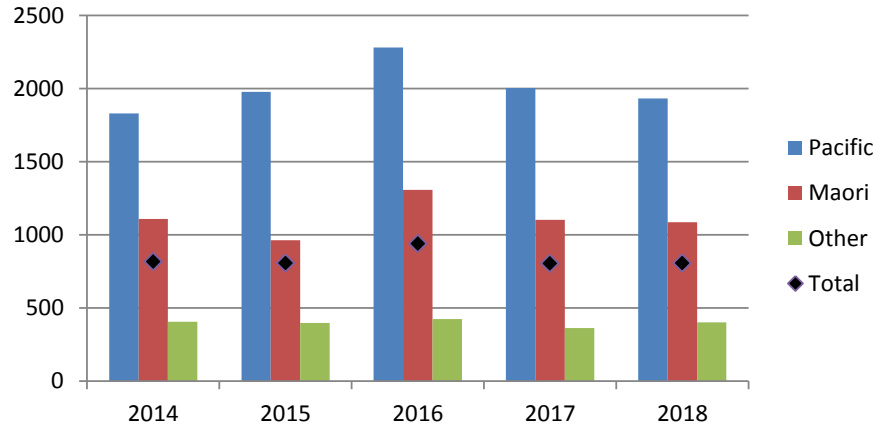


Improvement Activities	Progress Report
• Current immunisation programme (primary care coordinators, general practice systems, outreach immunisation service, Māori and Pacific providers, secondary care). • Continue to develop specific activity to improve Māori coverage (including ways to improve timeliness of immunisation), with leadership from Māori health gain teams and Māori leaders within primary care. • Develop links between immunisation outreach services and Māori Tamariki Ora providers to improve immunisation coverage for their enrolled children. • Investigate the possibility of Well Child Tamariki Ora nurses providing immunisation. • Utilise Whānau Ora services for immunisation of hard to reach children. • Promote immunisation in antenatal classes. • Investigate whether significant numbers of Māori babies are not engaged with general practice, with a view to include improvement activities to connect Māori whānau into the current newborn enrolment work.	All DHBs and PHOs continued with business as usual activities throughout the quarter. Closing the equity gap and targeting high risk children are priorities for DHBs, and scoping activities have begun for in-hospital immunisation monitoring and documentation. There is activity in each of the named improvement activities, although Well Child/Tamariki Ora (WCTO) immunisers and Whanau Ora service utilisation has not yet been addressed. The PHO implementation group has developed a set of strategies to identify and engage high risk children. This work is focused on opportunistic vaccination in various settings. NIR inform of issues weekly related to Māori babies and provide overdue lists for follow up by immunisation coordinators - good partnerships have developed. This also picks up messaging errors from Medtech to NIR. Improving enrolment in primary care for Māori infants is a focus of the 2018/19 Plan.

2. Skin infections

The goal is a reduction in hospitalisation rates by 5% by June 2018, from a baseline of 907 per 100,000 0-4 population as at September 2016. To achieve this goal, there have been a number of targeted activities around promotion of key prevention messages, in various community settings. The latest data for the 12 months to June 2018 shows a result of 807 per 100,000 0-4 population, around an 11% reduction on baseline. However, results are much higher particularly for Pacific but also for Māori populations and also typically fluctuate between quarters.

Metro-Auckland age specific skin infection rates 0-4 year olds to June



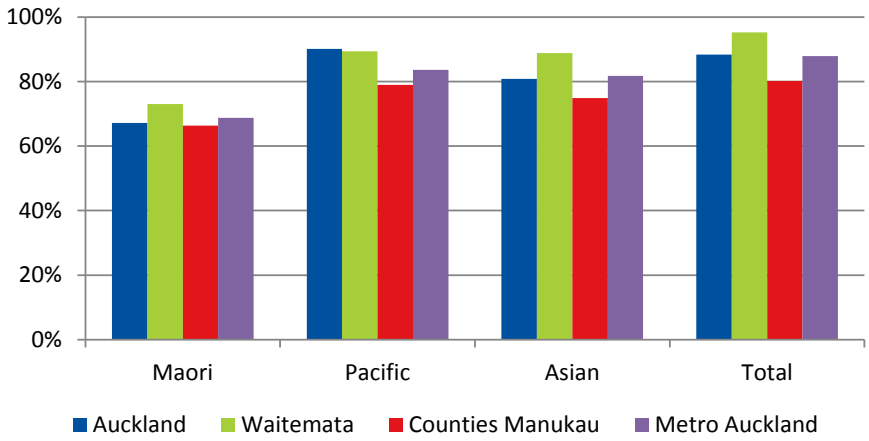
Improvement Activities	Progress Report
• Improve distribution of resources to primary care, urgent care, Well Child Tamariki Ora services, and early childhood education centres • Deliver an educational package 'skin infection combined key messages' to primary care, urgent care, WCTO services, and early childhood education centres. Use forums such as the Pacific Community Child Health Network (managed by TAHA, the Well Pacific Mother and Infant Service) to reach community groups • Use DHB nurse educators and other health promotion resources in a coordinated way, so that health promotion messages reach early childhood education centres and other organisations that connect with families of young children. Currently Counties Manukau DHB and Auckland DHB have nurse educators; Waitemata DHB does not • Link in to early childhood education centre health promotion activities delivered Auckland Regional Public Health Service • Consider further development of primary care skin clinics. (Working group suggest this is an analysis or discussions document activity about reinstatement of primary care skin clinics) • Consider new approaches for providing access to care, e.g. community outreach, pharmacies, parish nurses. • Consider the opportunities for community pharmacy to provide more education on the best use of topical and oral products • Consider targeted outcomes for Pacific and Māori children.	The clinical network has a working group who are implementing education resources to PHOs which enables key messaging to families. They have been focused on clarification of key messages and implementation in community settings (including early childhood education) for Pacific children. Regionally shared PHO CME has been filmed and will shortly be available on Ko Awatea Learn.

3. Oral Health

The goal is 95% enrolment with oral health services amongst preschool children. The Oral Health Strategy, finalised in 2017, is the basis of the improvement, with SLMs aligning and supporting this work.

As at June 2018, the metro-Auckland result shows that around 88% of 0-4 year olds are enrolled with the Auckland Regional Dental Service. This is much lower for Māori at 69%. Counties Manukau have the lowest rate of enrolment overall at 80%, Waitemata the highest at 95%.

Percentage of preschool children enrolled in DHB funded oral health services as at June 2018 (rolling 12 months)



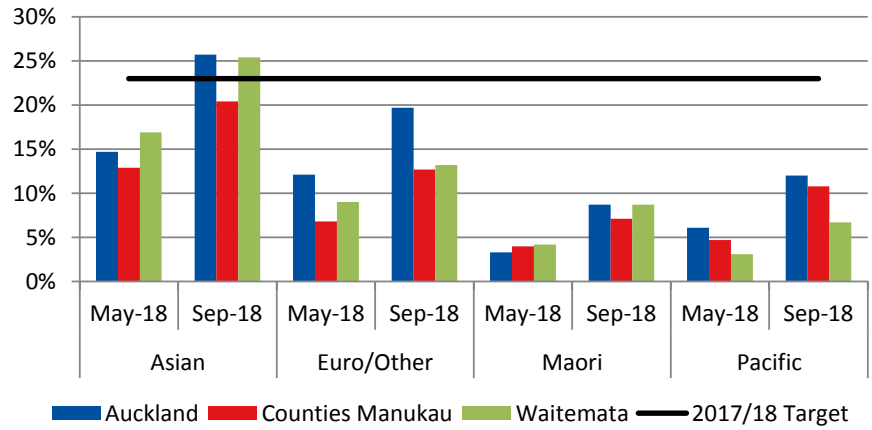
Improvement Activities	Progress Report
From the 2017 Pre-school Oral Health Strategy: • Oral health promotion at national, community and individual level. Focus on Pacific churches and parenting groups. • Messaging to align with Raising Healthy Kids National Health Target. • Increase awareness of free dental services. • Upskill primary care, Well Child Tamariki Ora and secondary care providers in lift-the-lip assessments, knowledge of dental services and referral processes. • Engage with the newborn enrolment project, which is: implementing systems to refer newborns for enrolment with the National Immunisation Register, general practice, oral health providers, Well Child Tamariki Ora providers and newborn hearing screening services. • Increased number of extended hours and Saturday dental clinics in appropriate locations. • Consider a targeted intervention for Pacific and Māori children to address inequity.	The Oral Health strategy has been finalised and is now being implemented. Primary care continues to support increased Auckland Regional Dental Service (ARDS) referrals and train the trainer for lift the lip assessments have been attended by all PHOs. Many of the activities in this measure are the agreed responsibility of ARDS under the Pre-School Oral Health Strategy. An ongoing relationship with ARDS has been facilitated to support implementation as far as possible. Regional lift the lip CME has been filmed and will be available on Ko Awatea Learn for Primary Care use.

4. Respiratory Conditions Potentially Preventable by Immunisations

The goal was to increase flu vaccination coverage by 10% (from a baseline of 13% at December 2016) for children who are eligible for funded vaccine. To achieve this goal, there has been a focus on provision of information throughout the influenza season and improved key messages around flu vaccine for eligible children. This measure is across the calendar year in line with the flu season May to December. So the cohort is established at 1 March and vaccination rates are measured for these children at 31 May, 31 July

and 30 September, with the final measure as at 31 December. Below shows rates at May and September 2018. Rates were highest overall for Auckland DHB at both time points and lowest for Counties. However, Auckland DHB showed the most improvement between time points (7.5%). Only rates for Asian reached target by September 2018. Māori and Pacific rates are lowest. Rates are up on the same time last year, but not as significantly for Māori and Pacific.

Flu vaccination rates between May to September 2018 for children hospitalised with a respiratory condition



Improvement Activities	Progress Report
• Develop the current activity to identify and vaccinate all children aged 0–4 who are eligible for free influenza vaccine • Build on current activity to support both influenza and pertussis vaccine offer to all pregnant women, e.g. vaccinator at antenatal clinics, promotion campaigns, lead maternity carers education opportunities • Undertake activities in primary and secondary care: *Secondary care* ○ Develop a documented, consistent system for providing lists of hospitalised children to PHOs and monitoring through the Influenza season (when the vaccine is available) ○ Make it mandatory to fill in the sections on discharge letters on eligibility for special immunisations ○ Promote vaccinations to patients and their families and proactively refer patients back to GPs for vaccinations. *Primary care* ○ Immunisation coordinators in PHOs provide education to general practice staff on special immunisations while visiting practices ○ The Immunisation Advisory Centre will provide education and support to general practice, to improve understanding of who is eligible for special immunisations and to enhance processes for identification and recall, through continuing medical and nursing education sessions • Develop systems for measuring the impact of these activities, e.g. on readmissions for respiratory illness	Centralised (regional) processes for the flu vaccination eligibility notification are now embedded, in line with early and more consistent supply of eligibility information to primary care. There is work in progress to consistently note eligibility for influenza vaccine for children on hospital discharge summaries across the region. An education programme was agreed, with key messages at conferences and on web based platforms to decrease barriers to access. Conversations about the feasibility of offering influenza vaccination to all children 0-4 years are ongoing at a regional level. PHOs have received their lists of eligible children early in this quarter via Sharefile, which has enabled the safe sharing of NHI level information. The PHO implementation group monitors uptake throughout the season. Immunisation in pregnancy education has been embedded in midwife immunisation updates provide by IMAC for metro-Auckland. IMAC have produced an online webinar about immunisation in pregnancy for midwives that is available on their website and has been promoted to midwives. An antenatal vaccine coverage indicator was developed for pertussis and influenza vaccine during pregnancy. A centralised (regional) process has been developed and monitoring points agreed.

Improvement Activities	Progress Report
• Consider the feasibility of offering Influenza vaccination to all children aged 0-4 years • Pregnancy related immunisations: develop data definitions and agreed consistent process steps and monitoring points.	

Acute Hospital Bed Days Per Capita

Acute hospital bed days per capita is a measure of the use of acute services in secondary care that could be improved by efficiencies at a facility level, effective management in primary care, better transition between the community and hospital settings, optimal discharge planning, development of community support services and good communication between healthcare providers. Good access to primary and community care and diagnostics services is part of this.

The measure is the rate calculated by dividing acute hospital bed days by the number of people in the New Zealand resident population. The acute hospital bed day's per capita rates will be illustrated using the number of bed days for acute hospital stays per 1000 population domiciled within a DHB with age standardisation.

Certain conditions are more likely to result in unplanned hospitalisation alongside other contributory factors such as the referral process to ED (self, provider variation, ambulance etc.). The social determinants of health are a key driver of acute demand.

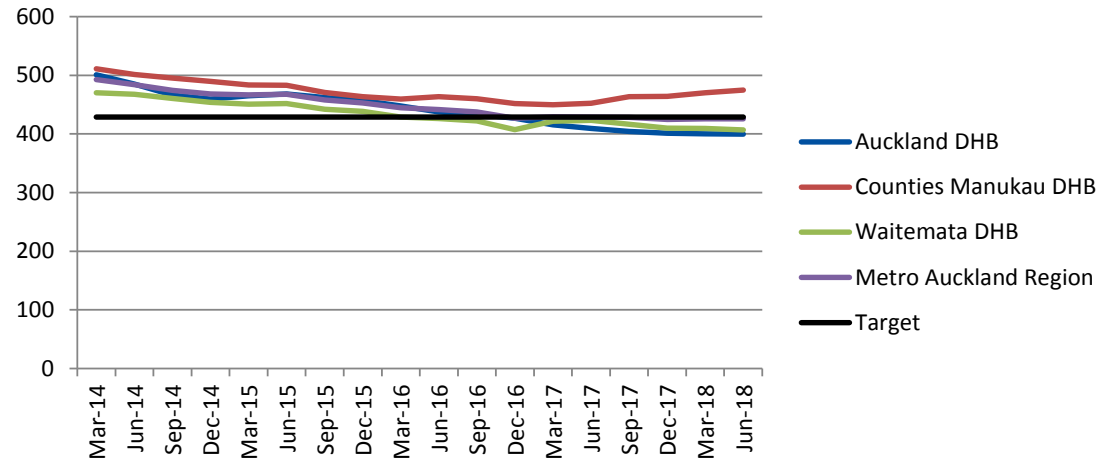
The Auckland Metro age standardised acute bed day rate per thousand population was calculated to be 437.7 as at September 2016 with a target set to reduce the rate by:

- 2% for the total population – 428.9 standardised acute bed days/1000 by June 2018
- 3% for the Māori population – 604.6 standardised acute bed days/1000 by June 2018
- 3% for the Pacific population – 729.6 standardised acute bed days/1000 by June 2018

It must be noted that any new beds opening will require accounting for, as supply side changes will impact this indicator in a stepwise fashion.

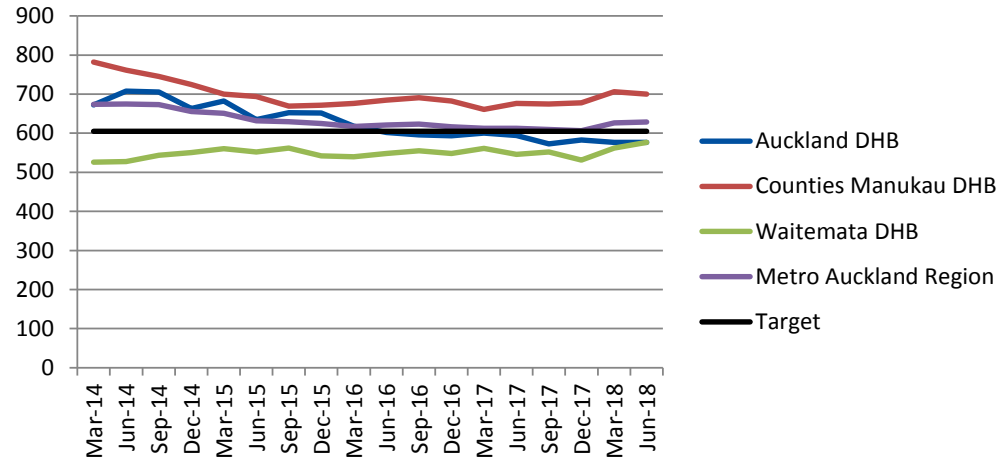
While overall standardised rates for Auckland and Waitemata DHBs have been generally declining each year, Counties Manukau DHB's rates remain above target and increasing. The metro-Auckland overall rate to June 2018 remains slightly better than the June 2018 target at 426 standardised acute bed days/1000 (target was 428.9).

Standardised Acute Bed Days per 1,000 Total Population: 12 months ending

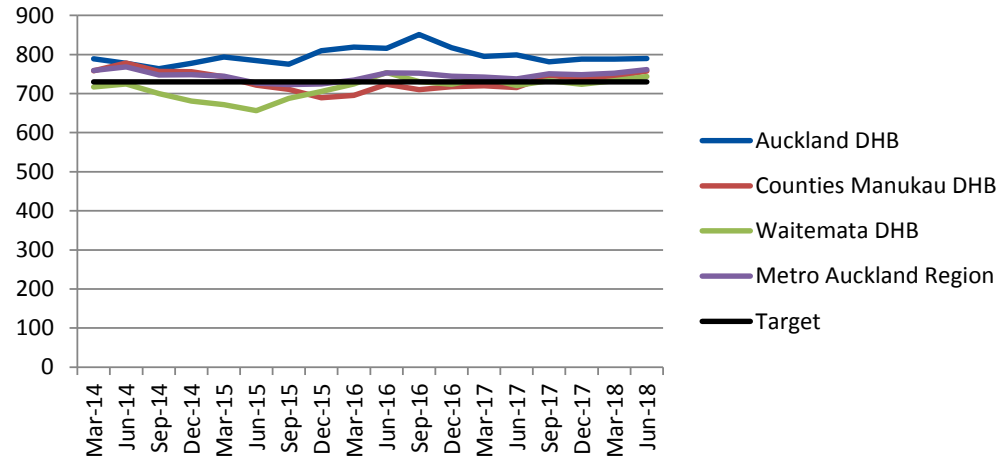


However, rates are much higher and more static for Māori and particularly Pacific populations. While both Auckland and Waitemata have rates better than target, Counties Manukau is some way from achieving for Māori. For Pacific, no DHBs met the target, with Auckland well away from target.

Standardised Acute Bed Days per 1,000 Maori Population: 12 months ending



Standardised Acute Bed Days per 1,000 Pacific Population: 12 months ending



Contributory Measures

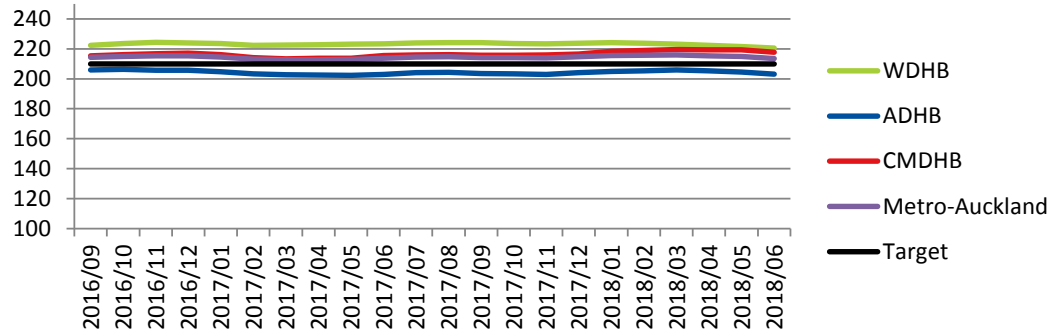
1. ED Presentation Rates.

Overall reduction in ED presentations may result in less admissions and bed day use. There is complexity involved in this measure as the likelihood of admissions may depend on the acuity of the patient and the availability of beds. Other measures such as Primary Options for Acute Care (POAC) utilisation rates are also being monitored.

Once the methodology for calculating this measure was finalised and approved a baseline was established of 214.3 ED attendances per 1000 population (standardised), for the 12 months to 30 September 2016. The 2017/18 SLM Improvement Plan set a target of reduction of 2% by June 2018. Data to June 2018 shows ED presentation rates are highest for the Waitemata DHB population. Only Auckland DHB has sustained performance below the target. The overall metro-Auckland rate for the year was a little over the target of 210.014 attendances per 1000 population (standardised) at 213.6.

Note that these rates are aged standardised to allow comparison between the metro-Auckland DHBs.

Age standardised ED presentation rates per 1,000 population - rolling 12 months



These rates are per 1,000 of the population and age standardised to the New Zealand population 2013 and presented as a moving 12 month rolling figure. Note that the data will be refreshed retrospectively for each reporting period, so previously reported figures may change.

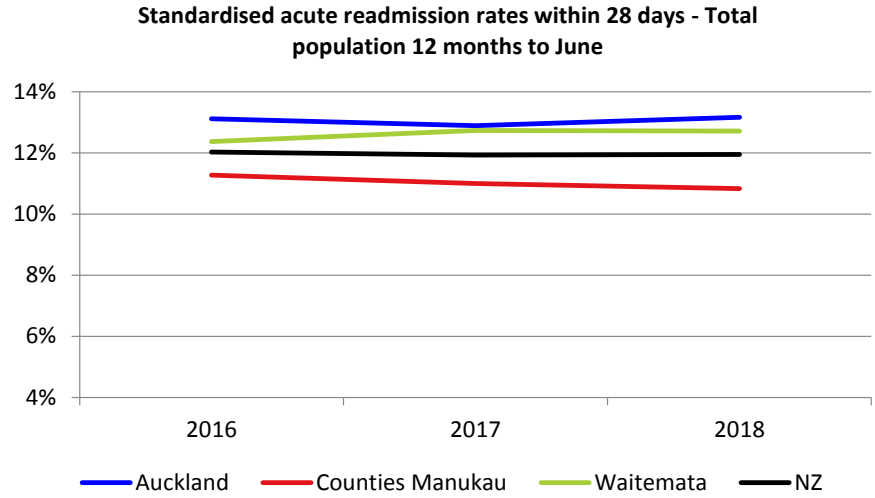
Improvement Activities	Progress Report
Primary Options in Acute Care (POAC) activities: • Determine baseline utilisation of POAC across the region, including an ethnicity-level and a practice-level analysis • Identify gaps and areas for potential improvement • Convene expert group to determine and agree consistent interventions. • Monitor POAC utilisation, intervention rate and impact • Develop and implement an education programme to promote appropriate use of POAC • Explore current barriers to general practices using POAC • Develop practice-level reports showing POAC usage relative to peers • Pilot new and innovative ways to encourage patients to use primary care services appropriately, e.g. social media campaigns, vouchers for after-hours care.	Initial POAC data analysis was undertaken in quarter 2. An increase in visibility and CME/CNE resulted in a marked increase in utilisation, which has now normalised and returned to usual rate. We are now working towards more targeted utilisation for high risk populations to further reduce presentations. Development of an education programme is underway and we aim to embed routine practice level POAC utilisation reporting next financial year. Individual PHOs are additionally incorporating this and other SLM focused education into their annual CME/CNE calendars and peer group sessions.

2. Acute readmission rates at 28 days

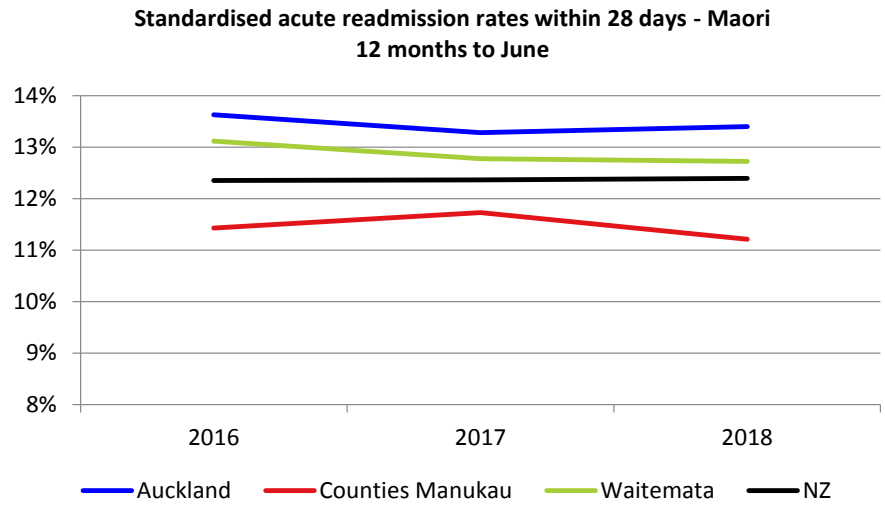
Avoidance of readmission to hospital following a recent discharge from hospital. Readmissions included here are only those that contribute to the acute bed days milestone, so may differ from readmission rates presented elsewhere. Readmissions within 28 days of a prior discharge have complex drivers and are likely to reflect a combination of clinical management (both acute and chronic care), discharge and transfer of care and care coordination issues.

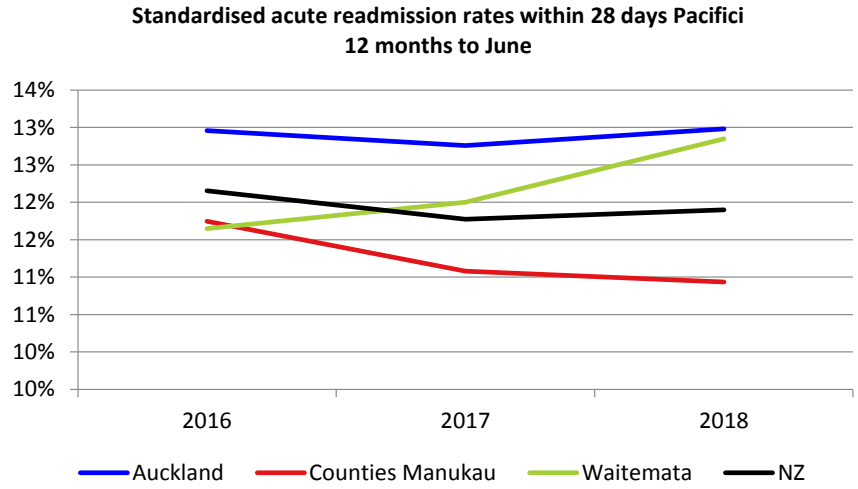
The Ministry of Health changed the methodology last year for calculating acute readmission rates at 28 days significantly. The June 2018 Ministry results show Auckland DHB has a result of 13.2%, Counties Manukau 10.8% and Waitemata DHB 12.7%. There has been little movement across the three data

points, though Counties Manukau shows a small but steady decline. Auckland and Waitemata rates are amongst the highest in the country. Only Counties Manukau is below the New Zealand rate.



For Māori, readmission rates for Auckland are highest, though relatively static compared to last year. Results are lowest and declining for Counties Manukau. Waitemata rates have remained the same between this and last reporting period. There is a consistent decline across the data points for Pacific for Counties Manukau, and a sharp increase for Waitemata across the reporting periods, with Auckland relatively static.





Improvement Activities	Progress Report
• Determine baseline readmission rates by ethnicity, by PHO and across the region • Explore the potential of risk stratification to identify patients at highest risk of readmission • Review discharge planning processes across the hospital systems • At the point of discharge and in primary care, target patients discharged with CHF, COPD and the frail elderly • Encourage active follow up of patients discharged from hospital with a relatively high risk of readmission, in particular for those with CHF, COPD and the frail and elderly • Ensure that patients discharged from hospital with a relatively high risk of readmission have a patient centred care plan and, ensure Advance Care Plans (ACP) are in place, with a focus on initiating the ACP in primary care settings.	The Acute Hospital Bed Days working group continue to monitor these data and have considered practice level analysis to gain further insights. Counties Manukau Health has several working groups newly created to address the condition-based issues. Risk stratification is also ongoing at Counties Manukau Health. Auckland DHB has 'Using the Hospital Wisely' programme and a specific consideration of chronic obstructive pulmonary disease (COPD). Waitemata DHB has the TransforMED programme which has a bed day reduction focus, and a frail and elderly emphasis The three programmes above are linking up with the Auckland DHB working group and sharing ideas and successes. The SLM Steering group continue to monitor these data and have considered practice level analysis to gain further insights.

Patient Experience of Care

'Person centred care' or how people experience health care is a key element of system performance that can be influenced by all parts of the system and the people who provide the care. Integration has not happened until people experience it. The intended outcome for this SLM is improved clinical outcomes for patients in primary and secondary care through improved patient safety and experience of care.

Measures

1. DHB Adult Inpatient Survey

The nationally applied DHB Adult Inpatient Survey has been conducted quarterly since 2014 and continuing from 2016/17 the SLM milestone for patient experience has focused on the Adult Inpatient Experience Survey. This survey captures four measured domains - communications, partnership, coordination, physical and emotional needs. The 2017/18 target was to achieve an aggregate score of 8.5/10 across all four domains measured.

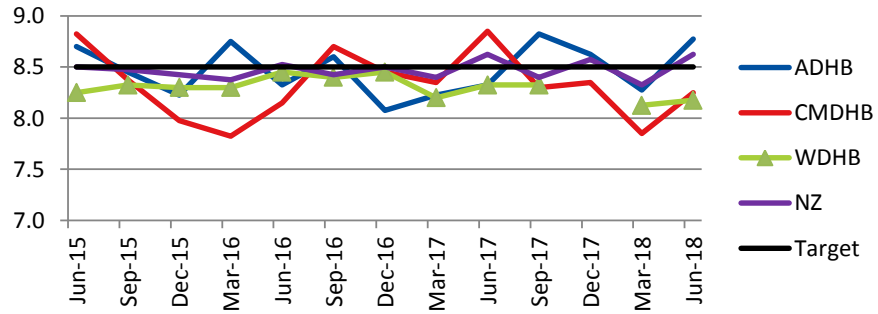
Interventions are aimed at improving patient experience scores in the four domains along with promoting the survey to improve participation and using the results to improve quality. Individual DHBs need to

improve survey participation, particularly with respect to equity and foster greater regional collaboration. This may include working with Māori, Pacific and Asian provider teams within the hospital to facilitate feedback from recently discharged patients, and/or language specific initiatives.

Related interventions to improve response rates include exploring other modality options (e.g. use of tablets at the time of discharge), increasing email uptake during administration processes, and promoting the patient experience survey to patients via pamphlets and other resources.

Despite little variation over the time period observed generally, there has been some improvement in scores since the last reported period, for Counties Manukau and Auckland DHBs and New Zealand as a whole. The national response rate for the latest time period is 25%, compared to 31% for Waitemata, 26% for Auckland, but only 21% for Counties Manukau. Response rates for surveys invited via post are still a little better than those invited via email and much better than those invited via SMS. Nationally, respondents were reasonably representative of all ages and genders, however, under-representation continued for people in the 15–24 and 25–44 age groups and for people in Māori, Pacific and Asian ethnic groups.

DHB Adult Inpatient Experience Survey: Aggregated Domain Score (/10)



Note: no Waitemata DHB data available for December 2017

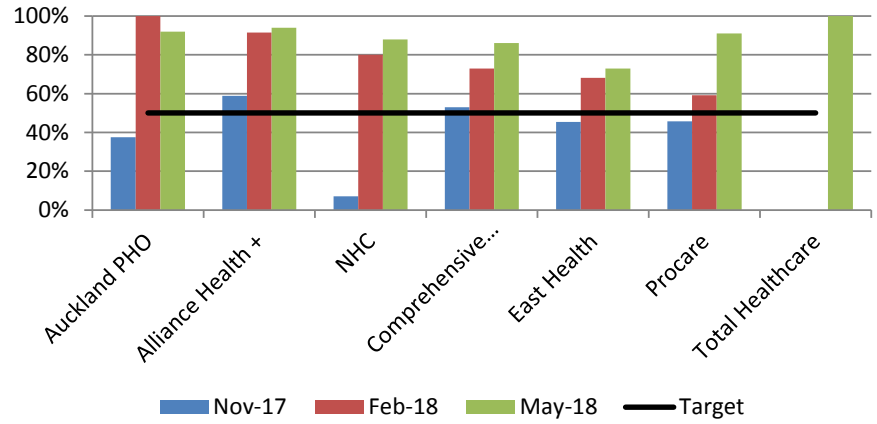
Improvement Activities	Progress Report
• Individual DHB focus areas via annual planning will be worked on at a local level. For 2017/18 there will be a particular focus on enhancing connections through improved communication and addressing equity gaps, via specific programmes and initiatives, which will be locally delivered • A regional DHB group for patient experience of care meets monthly via teleconference and quarterly face-to-face. The SLM Improvement Plan will become core business for this group • Develop long-term strategies in response to specific equity challenges (Pacific and Māori specialist team engagement), and broaden communication and conversations for patients to improve their experience and journey of care • Share individual DHB learning and harness opportunities to replicate successes across Metro Auckland.	This work in ongoing in DHBs. Regular joining-up occurs, with lessons learnt contributing to initiatives in primary care. Key stakeholders meet regularly to share learnings. The 2018/19 Plan focuses on response rates for Māori and Pacific. Note: due to an extraction error, Waitemata DHB did not return survey results for December 2017 (missing from graph).

2. The Primary Health Care Patient Experience Survey (PHC PES)

Rollout of the Primary Health Care Patient Experience Survey (PHC PES) across Auckland is largely complete. In Auckland six PHOs with a total of 143 practices participated in the November Primary Health Care Patient Experience survey week. Surveying has continued regularly since February 2018.

The aim of the Health Quality and Safety Commission (HQSC) is to have this implemented in all practices, and has been critically dependent on establishment of the National Enrolment System (NES), which has now been implemented in every PHO. The 2017/18 target was to ensure 50% of each PHO's practices (approximately 166 practices) were participating in the PHC PES by June 2018. Between the November 2017 and the May 2018 surveys, there has been a huge increase in the percentage of practices participating. As at May 2018, all PHOs have exceeded the 50% target. The delay for Total Healthcare has been due to the late linking to NES, which was out of their control, as this was implemented in steps and they were in the final group.

Percentage of practices within each PHO who are participating in the Primary Health Care Patient Experience Survey (PHC PES)



Improvement Activities	Progress Report
• Ensure socialisation of resources and support for practice-related activities, such as, PHOs follow HQSC/Ministry of Health 'Getting Started' resource pack and advice • PHOs advise Complicity of PHO name and contact for survey, and IT key contact to enable log on via email address • Practices are supplied with and follow getting started guide and resources • Practices provide PHO with details to appear on survey invitation email, text message and online survey • Marketing of the survey week (one week every quarter), process and survey intent across practices is enabled • Practices check email addresses of all patients 15 years and over and save preferences • Follow up by PHO and practices to view real-time patient experiences and appropriately respond to request for contact or any indicated follow up required • Once survey is closed, practices and PHOs will review the final results of the survey.	PHOs are rolling out the survey to practices in tranches with a view to full participation by the end of the financial year. The PHO Implementation meeting identified survey participation as a concern. Although overall survey participation is good, participation for Māori and Pacific is very low, and there are concerns the survey is not fit for purpose. The Ministry have advised there will be some activity in 2018/19 to address these issues - the 2018/19 Plan focuses on response rates for Māori and Pacific.

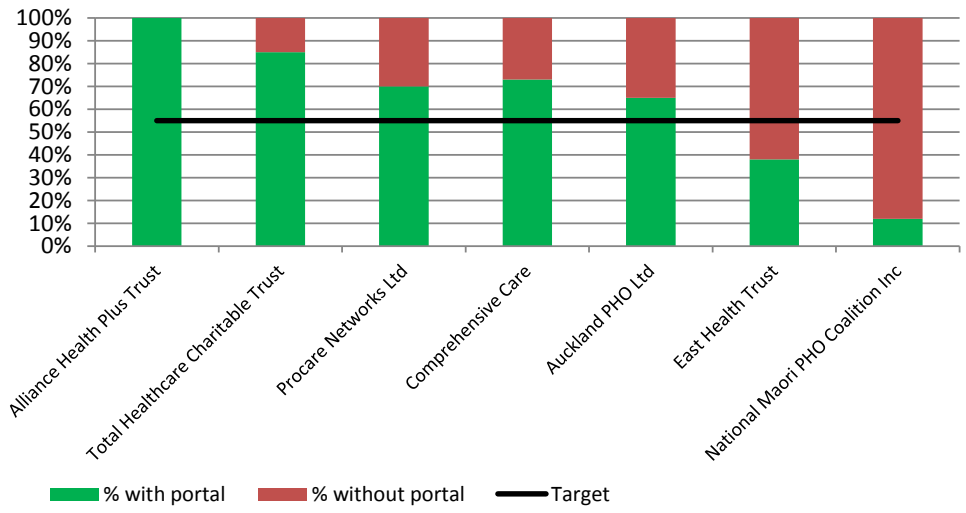
Contributory Measures

1. E-Portals.

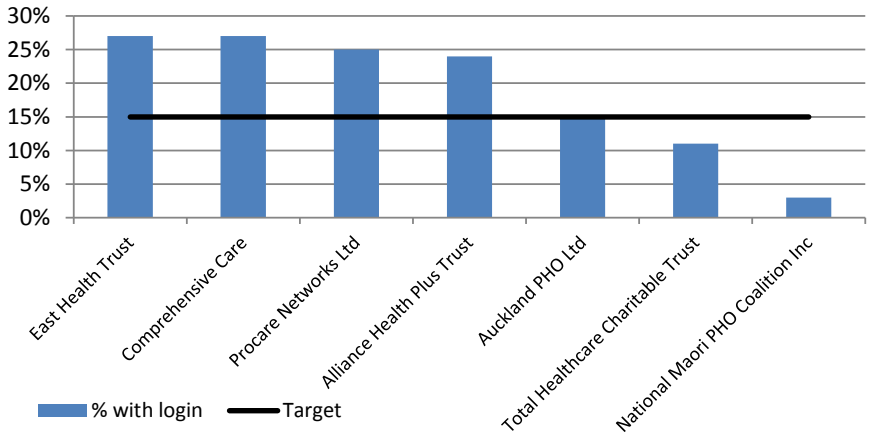
E-portals are a single gateway for patients to gain access to their general practice information which can include: booking appointments, ordering repeat prescriptions, checking lab results, and viewing clinical notes/records. More general practices are offering patient portals and there is scope within primary health care for them to positively impact the SLM milestone. This can be enabled through alternative access point/navigation for the patient, enabling coordinated self-managed care provision; maintaining and providing online communication; and partnering with the patient to work collaboratively online (lab results, appointment bookings, care monitoring-physical needs).

For 2017/18 the target was that 55% of each PHO's practices are registered with a portal and 15% of each PHO's population would have access to a portal. June 2018 results show that only two PHOs had still to meet the 55% target for having portals in place however they all show progress towards the target. Two PHOs had yet to meet the 15% target of enrolled patients registered to use portals.

Percentage of practices with/without patient portal - by PHO: as at June 2018



Percentage of enrolled patients with e-portal login - by PHO: as at June 2018



Improvement Activities	Progress Report
• E-portal ambassadors and provider options will continue to be socialised amongst clinicians and consumers via PHOs and practices • PHO teams will provide support to practices to implement e-Portal enrolment systems • Portal options are explored by practices and adopted in a staged approach relative to level of clinician confidence and consumer request. These will include: ○ access to clinical data – diagnoses, notes, allergies, immunisations, lab results; ○ access to communications – messaging to doctor or nurse, repeat prescription, requesting appointments, self-scheduling; ○ access to education – condition specific information, websites with merit, self-management activities, and ○ PHOs will access resource materials and actively use these to support e-Portal implementation in practices and e-Portal uptake by patients.	Update of e-portals is now increasing and PHOs are generally using a tranche approach to engage groups of practices per quarter. For those outstanding practices, plans are in place for many to on-board over the forthcoming year. We note that portal offerings with varied language options would be desirable for some practices i.e. Chinese language options. Some smaller practices have considerations to be made of the added value to patients and the cost implication of portals within their current operating model. Those PHOs without e-portals have a plan to implement. In particular the National Hauora Coalition report that they have an e-portal in development.

Amenable Mortality

Amenable mortality is defined as premature deaths that could potentially be avoided given effective and timely care. That is, deaths from diseases for which effective health interventions exist that might prevent death before 75 years of age.

For 2017/18 the decision was made to continue with the two contributory measures that have the greatest evidence-based impact on amenable mortality – cardiovascular disease (CVD) management and smoking cessation.

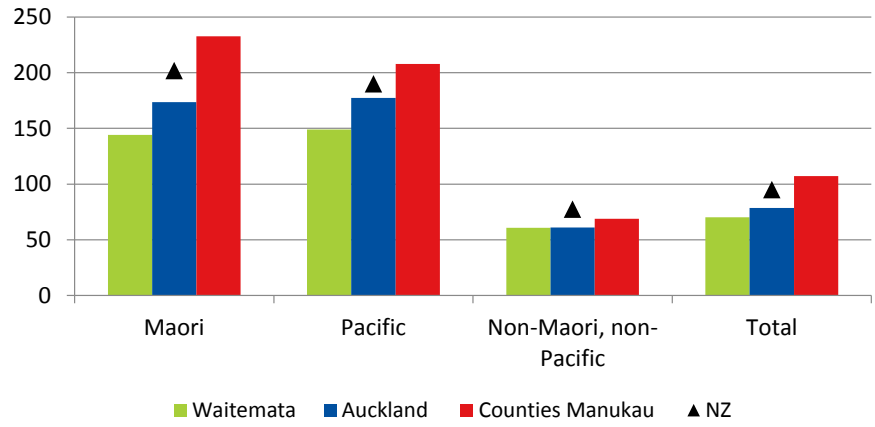
Amenable mortality rate per 100,000 population (age standardised), 0–74 year olds, using New Zealand estimated resident population as at June 30 was used as baseline.

	Baseline		Current	
DHB	**2013**	**2009-2013**	**2015**	**2011-2015**
Auckland	72.9	87.5	74.0	78.5
Counties Manukau	104.4	113.0	101.2	107.1
Waitemata	65.6	74.6	62.9	70.2
Metro Auckland	80.2	89.4	78.9	84.3

The goal is to achieve a 6% reduction for each DHB (on 2013 baseline) by June 2020, noting that changes in rates would generally only be seen over an extended timeframe of at least 3-5 years.

The current level of inequity in amenable mortality indicates the scope for health gain.

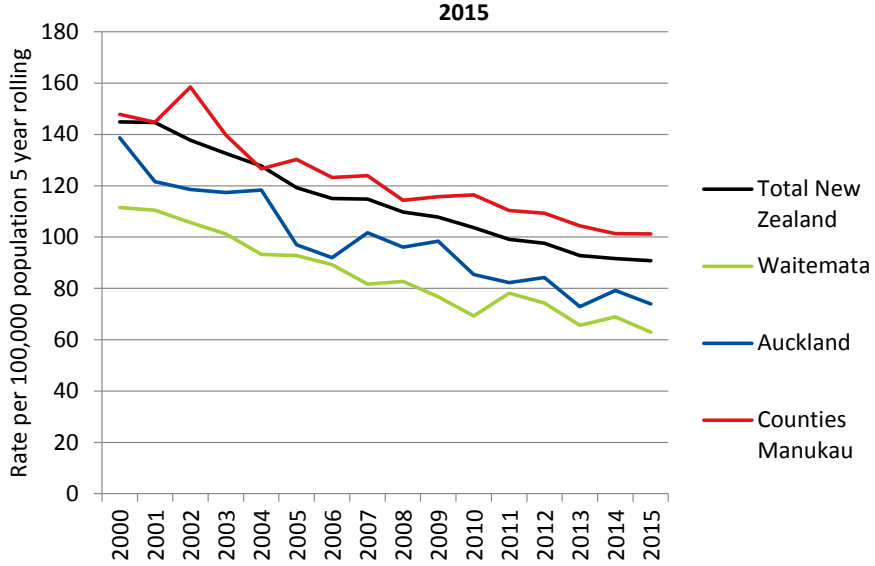
Standardised Amenable mortality (rates per 100,000) by ethnicity: 2011-2015

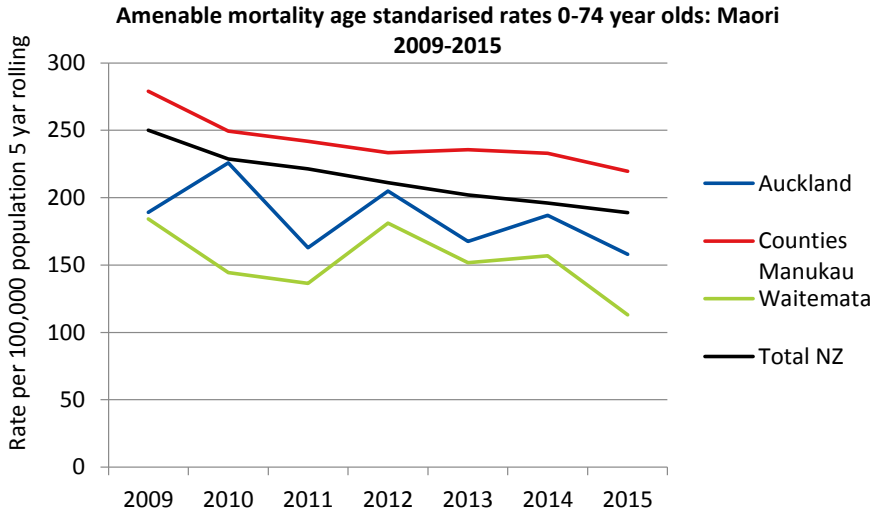


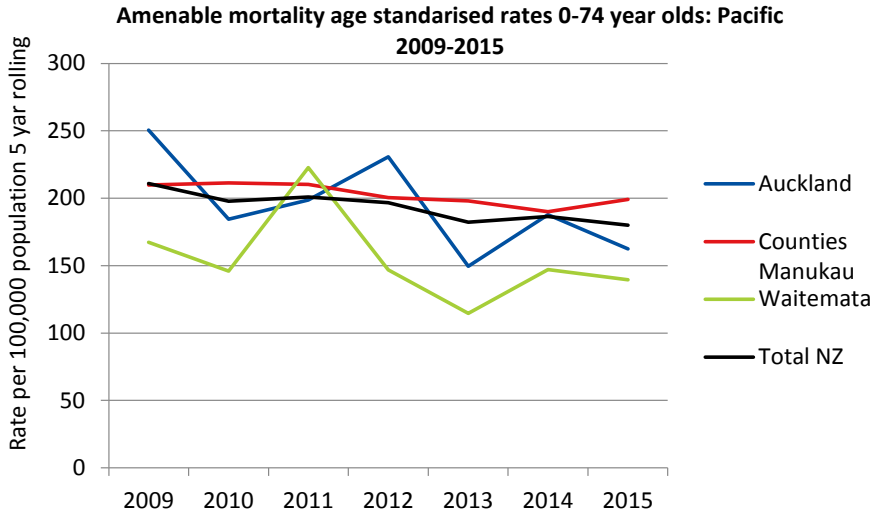
Based on five year trends, all three Metro Auckland DHBs show consistently declining rates as per graph below, despite an increase between 2013 and 2014 for Auckland and Waitemata DHBs. Comparing current (2015) rates with baseline (2013) rates, there is a 2% decline in rates for metro-Auckland, or 6% when comparing the 5 year rates. Given that there will always be some annual fluctuation and that the target extends to 2020, we should be on track to meet the 6% reduction by 2020.

While rates for Māori are also declining, the sharp, consistent decline seen for overall rates is not evident. This is even more so for Pacific rates, however smaller numbers will mean greater year on year variation.

Amenable mortality age standardised rates 0-74 year olds 2000-2015



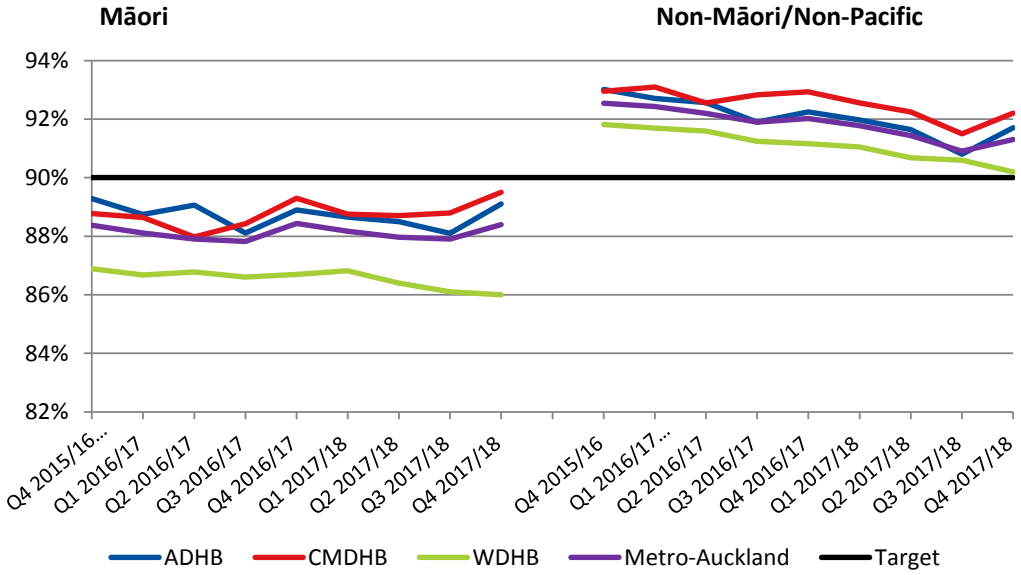

Amenable mortality age standarised rates 0-74 year olds: Maori
2009-2015
Rate per 100,000 population 5 yar rolling
300
250
200
150
100
50
0
2009
2010
2011
2012
2013
2014
2015
Auckland
Counties Manukau
Waitemata
Total NZ


Amenable mortality age standarised rates 0-74 year olds: Pacific
2009-2015
Rate per 100,000 population 5 yar rolling
300
250
200
150
100
50
0
2009
2010
2011
2012
2013
2014
2015
Auckland
Counties Manukau
Waitemata
Total NZ

Contributory Measures

1. CVD Risk Assessment – to increase coverage of Māori to 90%

As at June 2018, Māori screening rates were slightly below the target with Counties Manukau DHB screening 89.5% of the eligible population, while Auckland DHB had screened 89.1% and Waitemata DHB 86.0%. For metro-Auckland, these results show a small increase from the preceding quarter's results.



Improvement Activities	Progress Report
• Follow up phone calls (evenings) for practice generated CVD RA recall letters to Māori • Pilot of phlebotomy services in the practices or point-of-care testing when Māori males visit opportunistically.	These activities were discussed in the recent PHO implementation meetings, with a focus on increasing access to practices for young Māori males and facilitating the five year anniversary of CVD RA, which represents a workload bubble. Changes to the CVD consensus statement were also discussed, with implementation plan in early stages. Several practices are piloting use of the cobas machine to opportunistically test Māori males on presentation to clinics, with an informal evaluation to follow. Work will continue to be supported via a MACGF working group to address the new Cardiovascular Assessment and Management Guidelines. Implementation of these guidelines are likely to result in an initial drop in coverage, however it is expected that this will improve over time as primary care and patients become familiar with the expanded number of measures required to calculate the new risk formulae.

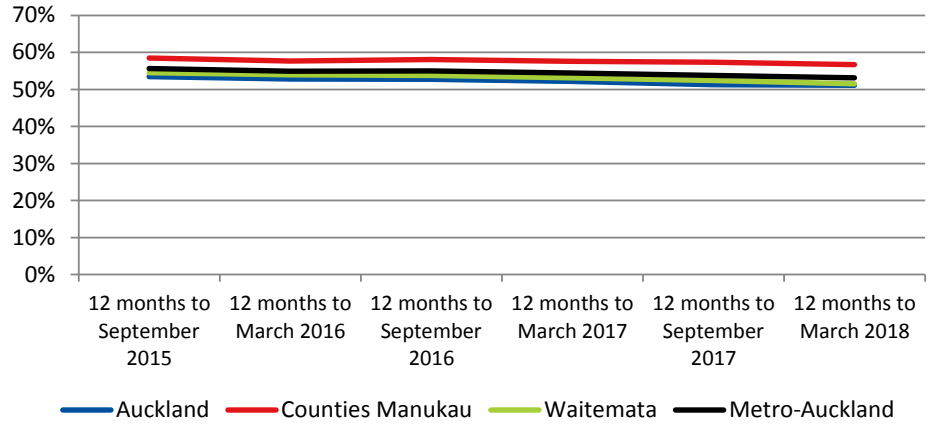
2. CVD Management - to increase triple therapy by 5% (relative) for those with a prior CVD event and dual therapy for those with a CVD RA of ≥ 20%

Dual therapy is used for management of people with an elevated risk of a CVD event, but who have not yet had an event (primary prevention). For dual therapy pharmaceuticals dispensed to those with a CVD risk assessment score greater than 20% baseline as at the twelve months ended September 2016 were 41.6% for Auckland DHB, 49.1% for Counties Manukau and 41.4% for Waitemata DHB. Little change can be seen in rates of dual therapy for any of the DHBs in the twelve months ended March 2018, with results recorded as 41.5% for Auckland DHB, 49.5% for Counties Manukau and 41.5% for Waitemata DHB, or 45.1% for the metro-Auckland region. By ethnic group there is variation across the region with Māori living in Auckland DHB having the lowest rate at 40% and Pacific living in Counties Manukau having the highest rate at 55%.

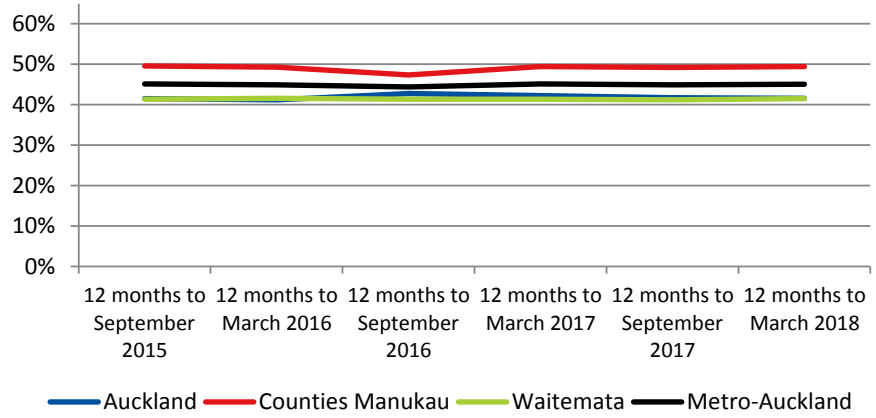
Triple therapy is used for management of people who have had a CVD event in order to prevent future events (secondary prevention). Baseline for 2017/18 was set on performance as at the twelve months ended September 2016, and for Counties Manukau Health was 58.1%, Auckland DHB 52.7% and Waitemata 53.8%.

Triple therapy results for the 12 months to March 2018 show a small deterioration for all DHBs – 51.1% for Auckland, 56.7% for Counties Manukau and 51.5% for Waitemata, with a metro-Auckland rate of 53.2%. Amongst those ethnic groups at highest risk of an amenable death from CVD (death before 75 year of age), the triple therapy treatment rate is lowest for Māori at 53% across metro-Auckland compared with 60% for Pacific and 63% for Indian.

Percentage of enrolled patients with a prior CVD event dispensed triple therapy pharmaceuticals - Total Population



Percentage of enrolled patients with a CVD risk assessment score ≥20% dispensed dual therapy pharmaceuticals - Total Population

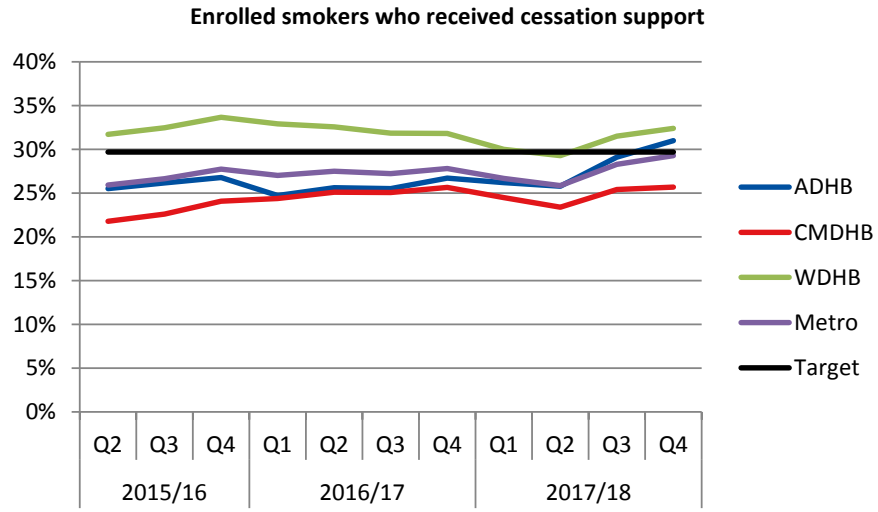


Improvement Activities	Progress Report
• Identification of patients at a NHI level who have had a CVD event and are not dispensed triple therapy. Feedback and comparison of these results to GPs via PHOs • Total population and specific interventions for Māori, Pacific and Asian peoples to improve uptake and adherence to dual and triple therapy • Post-event medication counselling and other rehabilitation services in	There are regionally agreed definitions and standardised format of reporting for CVD dispensed medications available from the Northern Region Cardiac Network. All PHOs have agreed to identify patients who are not on optimal therapy and feedback these results to GPs. Regional CME detailing the new CVD Assessment and Management Guidelines, released in this quarter, will be available shortly. Filming has already taken place. Implementation of these guidelines are likely to result in an initial drop in dual therapy management rates, however it is expected that this will improve over time as primary care and patients become familiar with the expanded number of measures required to calculate the

Improvement Activities	Progress Report
hospital • Ongoing medication counselling by community pharmacists • Consider an activity focussed on ensuring access to prescription subsidy cards and reducing prescription co-payments • Establish a single process to report CVD indicators from PHO practice management systems. This dataset includes collection of ethnicity data to level 2 supporting equity interventions.	new risk formulae. In 2018/19 analysis of the difference between prescribed and dispensed rates will be undertaken.

3. Increase rate of cessation support provided to enrolled smokers by 10%

The Auckland Metro DHBs have achieved the 'brief advice 'better help for smokers to quit' health target since 2012. However, the routine provision of brief advice has not resulted in a substantial number of smokers accepting the offer of help to quit. For 2017/18 the target was an increase in cessation support by 10% disaggregated by ethnicity. Baseline data, for the quarter ended September 2016 showed rates of cessation support provided to smokers enrolled in PHOs was 24.7% for Auckland DHB, 24.4% for Counties Manukau Health and 32.9% for Waitemata DHB – with a metro-Auckland result of 27%. Results for the quarter ended June 2018 show some improvement on baseline rates for Auckland DHB which recorded a result of 31.0% and Counties Manukau increasing to 25.7%. However, Waitemata recorded a small decrease to 32.4%. Overall metro-Auckland rate was slightly better at 29.3%, almost meeting the 30% target for the year. The Ministry of Health is not currently able to provide ethnic specific results for this indicator. PHOs have agreed to provide the data locally but initial data sets are not of sufficient quality to include currently.



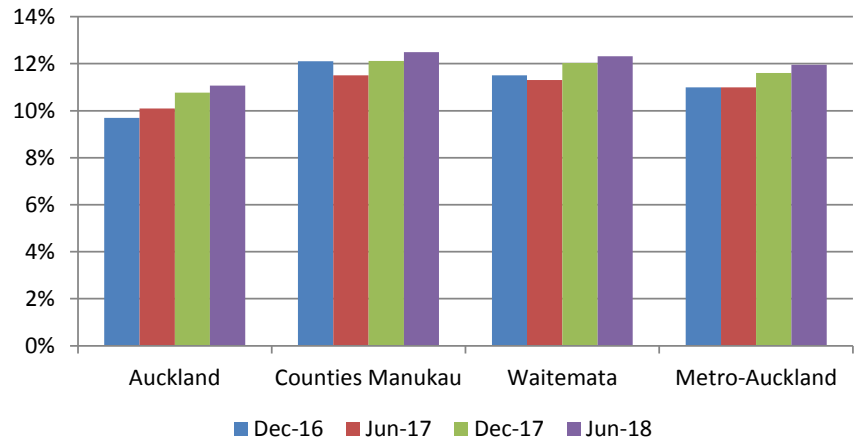
Improvement Activities	Progress Report
• Analyse reasons for historical low referrals to smoking cessation providers • Improve referral pathways to smoking cessation providers • Improve feedback to referrers from smoking cessation providers • Access aggregated data for Auckland population • Establish a single process to report smoking from PHO practice management systems. This dataset includes collection of ethnicity data to level 2 supporting equity interventions	Regionally agreed definitions have been developed which have been approved by the data custodian group. These have also been approved by the SLM steering group, with ongoing data uploads now taking place quarterly. To date, uploaded data sets have not been of sufficient quality to include in reporting and therefore Ministry of Health quarterly reported data is presented here.
• Benchmark 'access to smoking cessation' READ codes across PHOs: i.e. the number of patients with codes 1, 2 and 3: 1. ZPSC10 – referral to smoking cessation support; 2. ZPSC20 – prescribed smoking cessation medication, and 3. ZPSC30 provided smoking cessation behavioural support.	This activity has been completed, although the improved data quality in uploaded data will provide more reliable reporting.

Youth Access to and Utilisation of Youth-appropriate Health Services

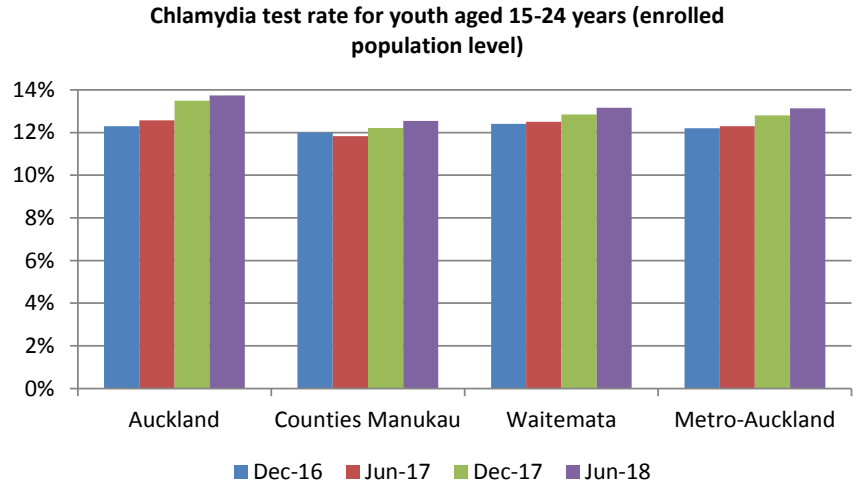
The Youth Domains are 5 separate areas of youth health which combine to support a positive youth experience of health care. This domain was developmental for 2017/18, therefore the focus has been on base lining data, data quality improvement, and identifying key health sector partners and appropriate activities for the 2018/19 planning cycle.

The focus for the year was on Sexual and Reproductive Health. The overarching milestone was to achieve 80% of pregnant woman aged 15-24 years screened for chlamydia during pregnancy, however screening rates for youth generally were also an area of focus.

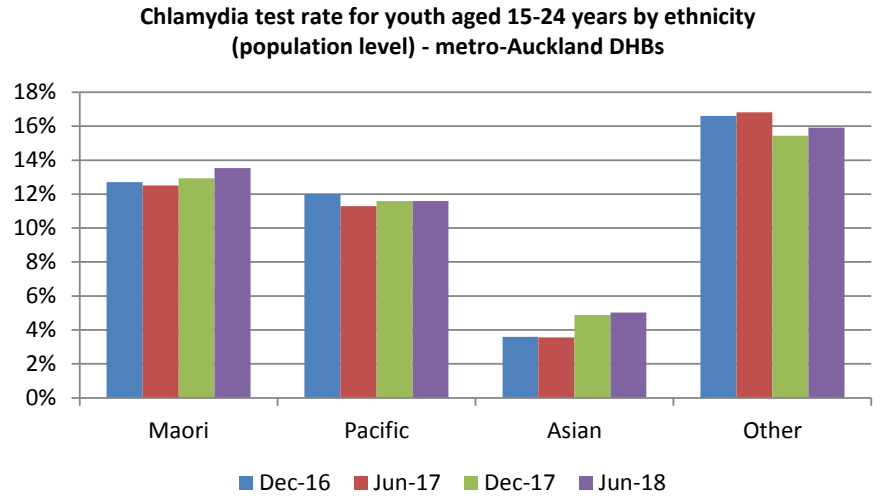
Chlamydia test rate for youth aged 15-24 years (population level)



There has been a small overall improvement in screening rates at both a population and PHO enrolled level across metro-Auckland.



Note: a small number of enrolees within a practice outside of the Auckland region have not been included

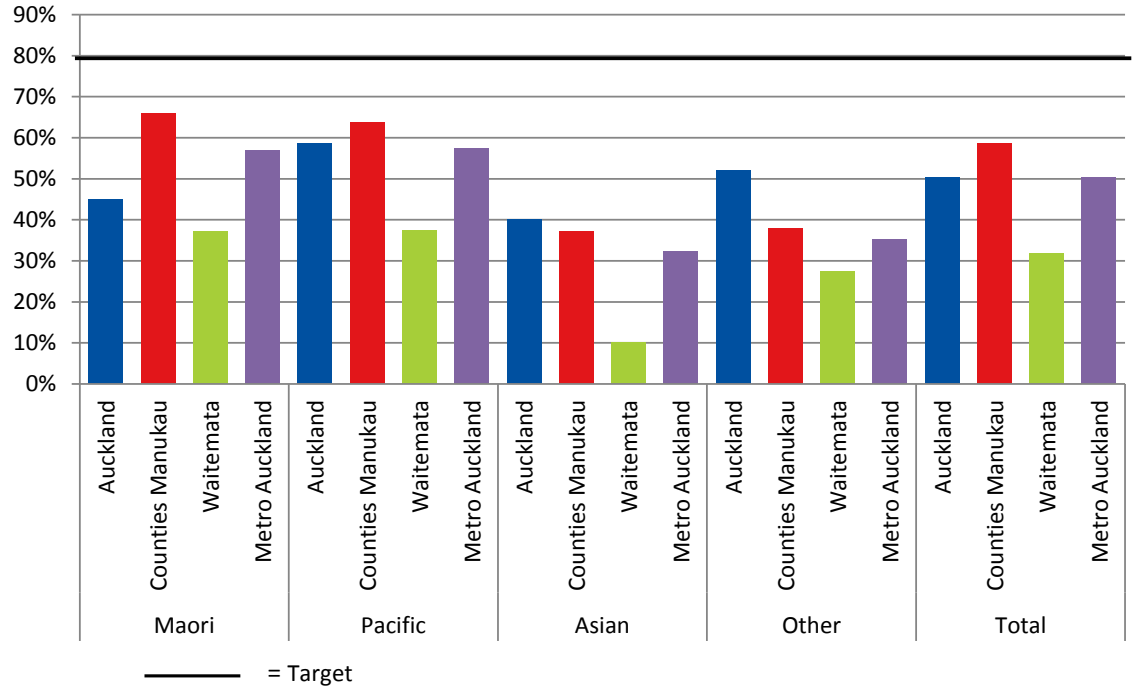


There is a small, gradual improvement in Māori screening rates, but little shift for other ethnicities.

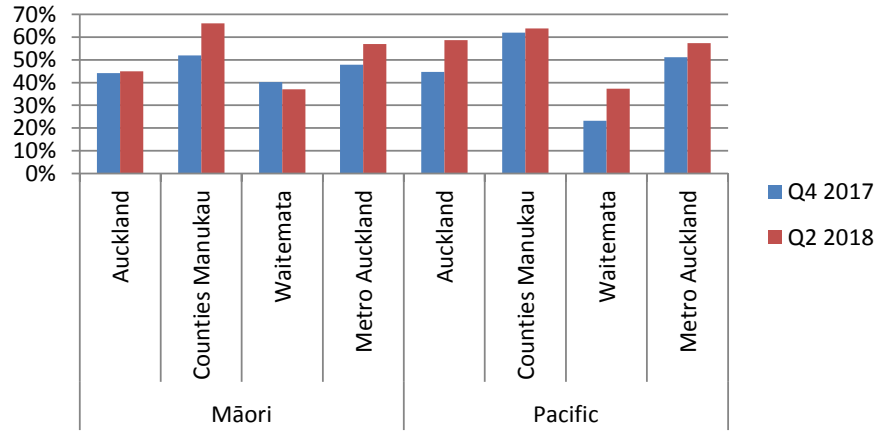
All Pregnant Women are Screened for Chlamydia

The target for this year is 80% of pregnant women aged 15-24 years are screened for chlamydia during pregnancy. Overall rates have increased by about 6% across metro-Auckland between this and last reporting periods – rates for Maori are up 9% and up 6% for Pacific. Rates for Maori have improved by 14% at Counties Manukau DHB and for Pacific by 14% at both Auckland and Waitemata DHBs. However, note there are small numbers in some cases.

Chlamydia testing coverage for women giving birth in Q2 2018 (15-24 years) by ethnicity



Chlamydia testing coverage for Maori and Pacific women giving birth in Q4 2017 and Q2 2018 (15-24 years)



Improvement Activities	Progress Report
• Workforce development activities for lead maternity carers • Data analysis looking for missed opportunities, e.g. primary care visits during pregnancy • Data analysis looking for the potential to report back screening rates to lead maternity carers.	• Development of a prospective methodology to enable a pregnancy alert to be provided to PHOs so that chlamydia testing can be carried out in a timely way has been implemented. • There is on-going communication with LMCs regarding chlamydia screening coverage in pregnancy in general.

Contributory Measures

1. Development of Future Sexual and Reproductive Health Contributory Measures

The target for the year was to establish a baseline in this measure.

Improvement Activities	Progress Report
• Analysis of SLM data by age, ethnicity, and PHO • Identify gaps and potential areas for improvement • Review the literature to identify options for improving access to chlamydia testing for Māori and Pacific youth including school-based services, pharmacy, community laboratories, primary care, outpatients, justice systems, and other opportunistic settings.	• Indicator definitions for the SLM has been completed, as has analysis • There is ongoing work to identify gaps and promote improvement, particularly in primary care and student and youth health services • A registrar has been identified to undertake the literature review and will be supervised by Dr Farrant, Chair of the Youth Network.

2. Chlamydia Burden of Disease

The target for this year is to establish a baseline in this measure.

Improvement Activities	Progress Report
• Establish regular reporting of chlamydia prevalence by age, ethnicity and locality.	• This data definition is in progress and has been approved by the Data custodians in September. The SLM Steering Group approved this data request in September, and the user request form was submitted in late September.

3. Healthcare Utilisation by 15-24 year olds

The target for this year is to complete the analysis detailed in the activities.

Improvement Activities	Progress Report
• Explore the availability of data across services potentially accessed by youth and the feasibility of data linkage to explore systems-wide youth health service utilisation and identify gaps • Baseline primary health care enrolment and utilisation.	• Baseline enrolment established, further activities have not been progressed.

4. Development of Baseline Data for Youth Domains:

a. Alcohol and Other Drugs

b. Access to Preventative Services

c. **Mental Health and Well-being**
d. **Youth experience of the health system**

The target for this year is to establish a baseline in these domains.

Improvement Activities	Progress Report
• Analysis of SLM data by age, ethnicity, and PHO • Identify gaps and potential area for improvement.	• Baseline data are now available for the SLMs in these domains • Data is of variable quality.

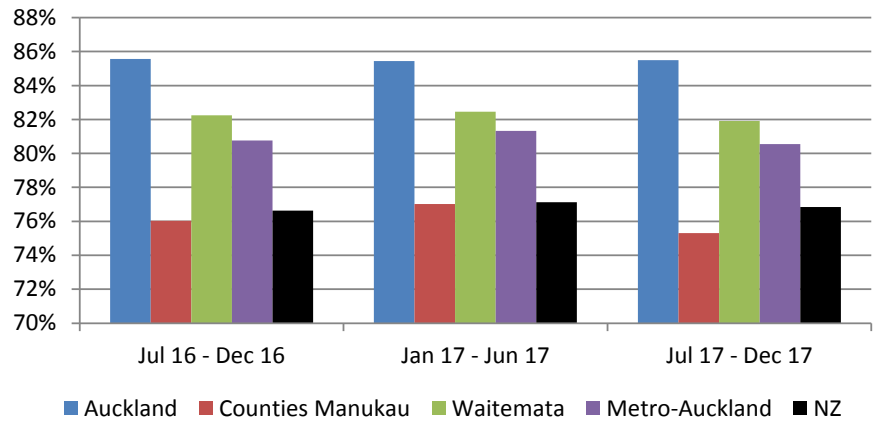
Proportion of Babies Living in Smokefree Homes at 6 weeks postnatal

The original Well Child Tamariki Ora (WCTO) dataset from the Ministry of Health showed the data for this measure was of poor quality, with a high proportion of 'unknown', missing or 'not asked' data.

A later dataset has recently been released which shows less significant data quality issues. Noting that the following information was included in the previous report – no further data has yet been released.

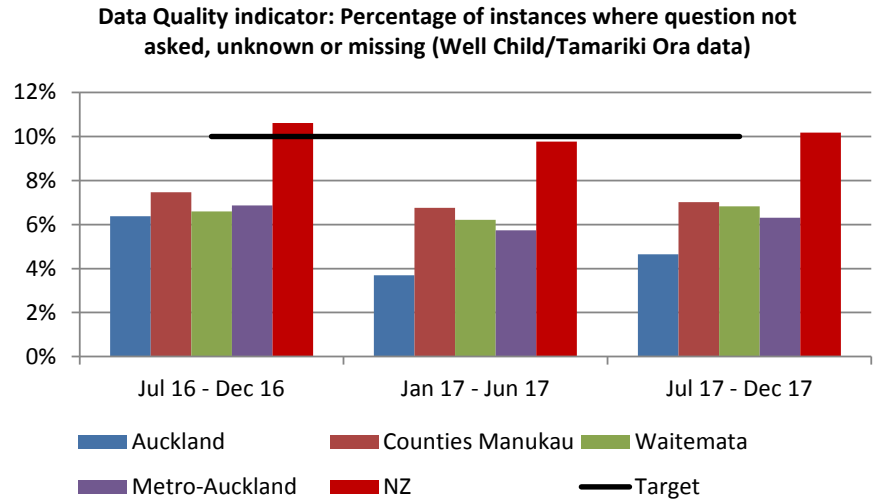
The more recent data shows little shift in results over time. In the six months to December 2017, around 81% of metro-Auckland babies lived in a smokefree household at 6 weeks post-partum – of those enrolled with a Well Child provider and asked at their first core contact check (within 56 days of birth).

Babies who live in a smokefree household at 6 weeks post natal by DHB of domicile (Well Child/Tamariki Ora data)



About 6% of WCTO enrolled babies in Metro Auckland did not have smokefree household data recorded within this same time period. WCTO activities in the 2017/18 plan focused on improving data quality. As data quality improves, the proportion of babies living in smokefree households is likely to decline initially. Therefore, measuring the impact of activities on the SLM will be challenging in the short term. Not all babies are captured in the WCTO data – approximately 20% of births over the time period July 2016 – December 2017 are missing. These may not be enrolled with a Well Child provider, may not have had a first core contact check or may have had their first core contact check outside of the 56 day timeframe.

The milestone target for this measure is to reduce missing smokefree household data to <10% by June 2018. This has already been achieved – when using the later dataset to assess performance.



Contributory Measures

1. Maternal Smokefree Services

The target for the year was to establish a baseline in this measure.

Improvement Activities	Progress Report
• Improve regional data collection so that timely maternal smoking prevalence data is available, brief advice and quit support can be monitored, and referral to SSS for women who are pregnant and are current smokers can be monitored • Analyse reasons for historical low referrals to smoking cessation providers, particularly for Māori women • Promote regional pathway for first trimester visit (includes smoking cessation referral) with a focus on Māori women • Facilitate early enrolment of pregnant women with lead maternity carers • Provide lead maternity carers and GP training on smoking cessation • Provide feedback to lead maternity carers on their referral rates • Provide pregnancy SSS incentives programme • Arrange for SSS providers to attend pregnancy and parenting classes in the community (particularly those for Māori and Pacific) • Explore innovative ways of engaging pregnant smokers to quit, with a focus on Māori women, e.g. through use of a Sudden Unexpected Death in Infancy App.	• The smoking cessation health pathway has been reviewed and is awaiting clinical editor approval • A maternal smoking incentives programme began in quarter 2 at Auckland/Waitemata DHB and is ongoing at Counties Manukau Health. All three programmes have a whānau incentives component to support whānau members to quit • CME sessions have now been filmed and are available regionally. • LMC online training has been developed and was launched on May 31 and is available regionally through Ko Awatea.

2. Household Smoking Cessation

The target for the year was to establish a baseline in this measure.

Improvement Activities	Progress Report
• WCTO Data Quality Improvement: Review and align data collection processes for SLM measure across WCTO providers and provide SOPs for data collectors • Provide WCTO providers feedback on missing smokefree data rates • Scope processes to identify household members of pregnant women and newborns who are current smokers, including data collection processes • Explore opportunities to offer smoking cessation support to whānau of newborn inpatients and outpatients, and paediatric ED attendances • Explore additional ways of offering smoking cessation support to whānau of young children, e.g. pharmacy initiatives, Well Child providers • Support the work undertaken in the Amenable Mortality SLM.	• The Ministry have convened a working group who have decided on data definitions and are in the process of rolling out improvements in the national data collection. These are to be finalised through Well Child contracting • We anticipate some further data later in 2018

Auckland District Health Board

Research

Annual Report 2017

9.5

Welcome *Haere Mai* | **Respect** *Manaaki* | **Together** *Tūhono* | **Aim High** *Angamua*

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

GROWING RESEARCH

Research at ADHB continues to grow and this year we were delighted to see Professor Stuart Dalziel become the first ADHB recipient of an HRC programme grant. We are proud of the investigator lead research that the DHB supports and congratulate all those who received grants for such over the last year.

ADHB has a sound framework for the governance of research involving human participants. The Research Review Committee assesses all new projects, considering scientific merit, ethical issues, feasibility and budget. The Research Governance Committee provides assurance to our board about the safety and appropriateness of research undertaken at ADHB. We have now complemented that with a joint ethics committee with the University of Auckland, the Auckland Health Research Ethics Committee. That committee provides ethical review of projects that fall outside the scope of the Health and Disability Ethics Committees and is comprised of members from both university and ADHB. Finally, the research office has updated relevant policies and procedures and that is all available to current and potential researchers on our refreshed website.

This year saw the third round of Auckland Academic Health Alliance research grants, just one aspect of our strong relationship with the Faculty of Medical and Health Sciences, University of Auckland. We encourage ADHB researchers to find a university research partner with the aim of growing research activity and enabling great ideas on this side of the road to be translated into reality, via research methodologies demonstrating efficacy.

All of this would not happen without the hard work of our research office team led by Dr Mary-Anne Woodnorth and Dr Colin McArthur, plus the individuals who commit time and energy to the committees listed above. Thank you.

Dr Margaret Wilsher

Chief Medical Officer and Head of Research, Auckland DHB

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A WORD FROM THE AUCKLAND DHB RESEARCH OFFICE

This document is a snapshot of the research activities that commenced at Auckland District Health Board in the year 2017. Every Auckland DHB department and service area participated in research activity. Hundreds of our people trained in ICH-GCP, the international quality standard for the conduct of clinical research. Many more made personal commitments to further hone their research skills and enrolled in higher research degrees. Considering the size and energy of the Auckland DHB workforce participating in research it isn't surprising that research activity spans the organisation and extends beyond it, as evidenced by the breadth and quality of our external collaborations both nationally and internationally. In fact, Auckland DHB has been experiencing something of a research boom, with each successive year since counting began having the highest number of new projects commencing. The new record set in the 2017-2018 year was 354, which represents a 100% increase in volume since Auckland DHB starting producing research reports in 2006. The number of commercial clinical trials approved has doubled since 2010. Our portion of annual Health Research Council funding has continued to trend upwards but with a steeper incline than usual in 2017 because of Dr Stuart Dalziel's $5 million programme grant investigating prevention of asthma in children.

These metrics are reassuring that research support services and the research governance structure at Auckland DHB are performing well. Describing the framework of services and governance, and their more notable outputs such as the acquisition of major grants by our people, have been a major focus of the annual research report in previous years. We've got more good news funding stories to share in this 2017 edition. However as our research processes have matured and our knowledge about how our people are addressing key priorities through research deepens, we now want to use this report to through a spotlight upon what research achieves. The three stories featured this year are about research making an impact - PREP2 on changing clinical practice, TRANSFUSE on confirming optimal treatment, and mother and baby studies on the dollar value of clinical trials.

What's new?

- Auckland DHB now has a single combined clinical research policy – long overdue! The combined policy replaces the previous four separate policies, thus eliminating overlap and obsolete references. We hope having up to date information about best practice expectations for both researchers and the organisation in a streamlined document will make navigating the research maze less daunting.
- Auckland DHB now has a functioning research ethics committee though our partnership with the University of Auckland's Faculty of Medical and Health Sciencesresearch ethics. The Auckland Health Research Ethics Committee (AHREC) was accredited by the Health Research Council and began reviewing applications in 2017.

What's on the radar?

- The National Ethics Advisory Committee is updating ethical guidelines for clinical research. A working group has pulished a draft for consultation, parts of which are likely to be controversial. Whatever the outcome of the consultation and final form of the guideliens, these will undoubtedly create important change in the New Zealand clinical research landscape.

EXCITING NEW PARTNERSHIP!

9.5

Auckland Health Foundation

Through donations from grateful patients and the public, the Auckland Health Foundation financially supports projects, research and education for adult health services, which have the capacity to transform healthcare and wellness and the way it is delivered within Auckland DHB.

The Foundation goes beyond what is presently funded in the healthcare system to focus on promising ideas, innovations and technologies that have the potential to benefit our patients and community, but could otherwise not be developed without external investment.

Our goal is to ensure the future of healthcare in Auckland is world-class, providing greater positive health outcomes not only for Aucklanders, but for the whole of New Zealand. Success is not just the equipment, research and facilities our supporters have funded, but the lives they have enriched and saved in doing so.

Thanks to our supporters, we will fund projects that meet our four priorities:

- Promote population health and wellness
- Support the training and education of both medical and non-medical staff who work for Auckland DHB
- Transform patient care by supporting new processes, innovation and technology for delivery of healthcare
- Advance Discovery – patient-focused research involving Auckland DHB staff and leveraging through other collaboration

We will achieve these priorities through three categories for donors to contribute:

- Capital appeals for specific projects, e.g. a fully-resourced simulation centre
- Department directed or targeted initiatives, e.g. equipment and facilities (beyond what is currently funded)
- Research and Discovery Fund, e.g. towards cancer or transplant research]

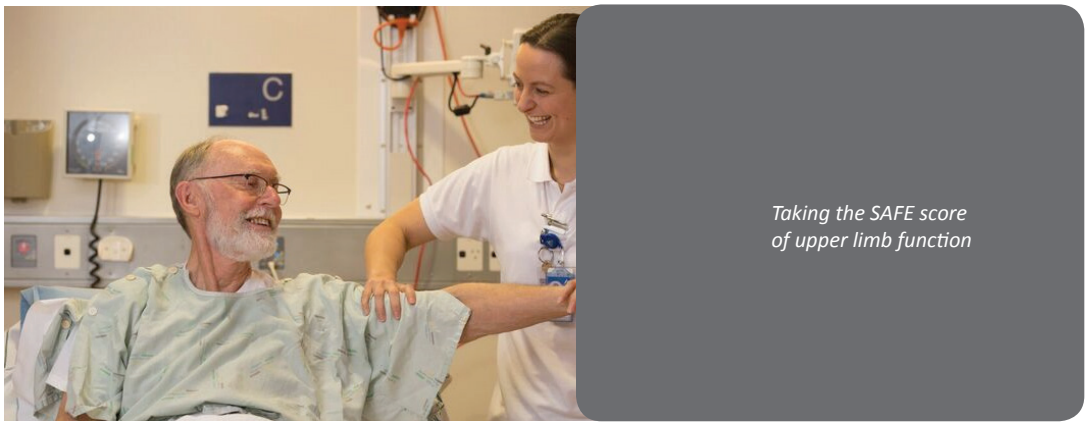
Thanks for taking the time to find out about our research year 2017.

Mary-Anne Woodnorth, Auckland DHB Research Office

MAKING AN IMPACT

PREP2 predicts upper limb function after stroke

A year ago the physiotherapists at Auckland District Health Board had no objective, prognostic tools to tell in advance how much a stroke patient's hand and arm function could be improved with therapy. Fast-forward to 2018 and this situation has changed dramatically for the better as an outcome of a long-standing research collaboration between the University of Auckland's Associate Professor Cathy Stinear and Auckland DHBs Neurology and Allied Health teams. Cathy's TRIO (Targeted Rehabilitation, Improved Outcomes: funded by HRC grant 11/270) project investigated the use of a three-step clinical algorithm called PREP2 (Predicting REcovery Potential). The results showed that when clinical teams looking after the patients were provided with the PREP2 prediction of the patient's outcome, their patients were, on average, able to be discharged from hospital one week earlier compared to patients treated in the absence of PREP2 predictions. Importantly, this was not at the expense of patient outcomes, indicating that PREP2 information can safely improve rehabilitation efficiency.



Taking the SAFE score of upper limb function

The key advantage of targeting rehabilitation is that the clinical team can invest its energy into setting goals and providing therapies that are appropriate for a patient's expected recovery. For example, when a poor upper limb outcome is predicted the team can focus on helping the patient learn to carry out daily activities using mainly their other hand and arm, and on therapies to address other impaired functions such as walking, swallowing, and communicating. More importantly, the algorithm allows physiotherapists to identify patients with initially severe weakness who have potential for a good recovery, which might otherwise go unrealised if therapy was not targeted appropriately.

One crucial enabler for translating this new knowledge into practice has been the co-location of the research team and the clinical setting. Cathy's team have been working alongside Auckland DHB Neurology and Reablement for nearly a decade. Thus there was no need for any preliminary work to raise awareness of the PREP2 algorithm, as the clinical teams had been able to directly observe it utilised within their midst during the research phase.

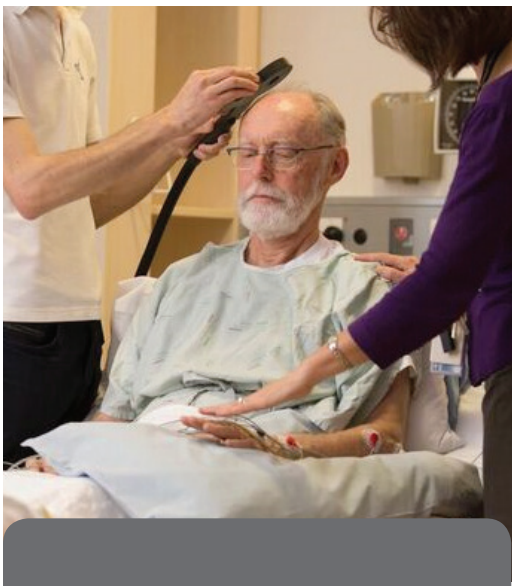
A unique feature of the collaboration is that Cathy uses her research funding for secondments for allied health clinicians to join the research team for periods of time. This custom has yielded both a benefit to the research, as qualified hospital professionals are the points of contact for the study participants, but also for the translation into practice, as members of the physiotherapy team became expert at undertaking the PREP2 assessments.

A second key enabler was the pragmatic approach Cathy took in designing the clinical trial of PREP2. In the study the intervention was not a therapy delivered by the research team. Instead, the intervention was information about the patient's capacity for recovery being made available to the hospital clinical teams. The clinical teams used this information to guide their own decisions about the best therapeutic focus for their patients. Therefore the research had already established that tight, protocol-driven control of rehabilitation programmes was not necessary. The professionals making the rehabilitation plans made good decisions when armed with good information.

Electrodes are placed on the patient's arm before transcranial magnetic stimulation (TMS) test

Once the research was completed Cathy and Auckland DHB neurologist Prof Alan Barber obtained clearance from the Northern Regional Practice Committee for PREP2 to become routine clinical care. Cathy's role changed to become that of support person for the implementation process. The process was completed and PREP2 rolled out as a standard clinical practice at Auckland DHB in January 2018.

Although the success of the Auckland DHB PREP2 implementation project is due to the efforts of a large number of DHB staff it is important to recognise that the implementation process was initiated by individual physiotherapists and it is chiefly through their commitment and energy that the process reached its conclusion. The implementation team of Emma Monigatti, Benjamin Scrivener, Olivia Norrie, Claire Valentine, Gemma Nolan, Hayley Collard, and Desiree McCracken achieved some notable milestones. They obtained authorisation from the Auckland DHB Allied Health Professional Leader and Chief Health Professions Officer as well as approval from the national Physiotherapy Board that conducting PREP2 assessment is within physiotherapists' scope of practice. With support from Cathy and the research team, they developed numerous paper resources, including competency documents, a PREP2 assessment form, patient stickers (for the clinical record) and templates for patient handover. Cathy's team also provided these physiotherapists with training in the safe use of transcranial magnetic stimulation (TMS), to test movement pathways in the brain. This test is required for around one-third of patients. Cathy's team are now in the process of training senior physiotherapists to become TMS trainers, so that they can continue to upskill their colleagues and ensure the sustainability of PREP2 in clinical practice.



The TMS coil is passed over the patients head to detect how well the brain and arm can communicate

Olivia says having PREP2 in the toolkit has given physiotherapists much more confidence in the rehabilitation strategies they recommend, and given them greater ability to have honest conversations about recovery of hand and arm function with patients. The patients' rehabilitation can now be specifically targeted in a way that ensures maximal recovery for each individual as their advice is now backed up by evidence. The team is spreading the news about PREP2 via presentations at national conferences and DHB's across New Zealand. They are excited about helping with the roll out of PREP2 at Waitemata and Counties Manukau DHBs, where there are also committed local champions. Plans are in development for the implementation and support of PREP2 in other DHBs, such as Hutt Valley DHB. The ultimate aim of the PREP2 workforce, both researchers and clinicians, is to see the assessment brought into practice nationwide.

HRC Chief Executive Professor Kath McPherson says

"This is a great example of translational research in action. Cathy and her team have trained therapists at Auckland Hospital to use this tool and they are currently busy helping other hospitals in New Zealand and the US and UK to use it too. They've also committed to making all of the resources developed freely available to download online through their wikispace site to give back to the community and maximise New Zealanders' return on investment."

The clinical implementation of PREP2 has required enormous enthusiasm, constructive leadership, and most of all partnership between researchers and clinicians having the shared vision that individualised rehabilitation based on biomarkers of the brain's potential for recovery becomes standard practice in New Zealand and internationally. This will take much of the guesswork out of rehabilitation planning for the 8,000 New Zealanders who experience stroke each year and ensure that their therapy needs are more effectively and efficiently met. In turn, this will reduce the burden of stroke on patients, families, communities and health services.

PREP2 Research team

A/P Cathy Stinear, Prof Winston Byblow, Dr Marie-Claire Smith, Prof Alan Barber, Dr Suzanne Ackerley. These are the University of Auckland staff who have developed, tested, validated and refined the PREP2 algorithm, and developed resources for implementation.

PREP2 Auckland DHB Implementation team

Emma Monigatti, Benjamin Scrivener, Olivia Norrie, Claire Valentine, Gemma Nolan, Hayley Collard, Desiree McCracken. These are the ADHB physiotherapists who have led the implementation of PREP2 into clinical practice.

No benefit of fresher versus older red blood cell transfusion for critically ill patients –

The results of the TRANSFUSE Study

A ground breaking has found the transfusion of older stored red blood cells is safe and, surprisingly, associated with fewer side effects than fresher blood cells.

In the TRANSFUSE trial, researchers from the Australian and New Zealand Intensive Care Society Clinical Trials Group (ANZICS-CTG) led teams in five countries to investigate the effect of the age of transfused red blood cells on critically ill patient outcomes. At Auckland City Hospital the study was led by intensive care specialist Dr Colin McArthur.

The findings, published in the New England Journal of Medicine on 27 September 2017, showed that fresher blood was no better than older blood. The investigators also found fewer transfusion reactions, including fever, with the older blood; and in the most severely ill patients, the transfusion of older blood was associated with fewer deaths.

Lead researcher, Monash University's Professor Jamie Cooper, said:

"Older blood appears to be like a good red wine – better with some age."

"The findings of our trial confirm that the current duration of storage of red blood cells for transfusion is both safe and optimal."

Red blood cells are stored for up to 42 days before transfusion. Routine practice in most hospitals is to allocate the oldest available compatible blood. Concerns regarding changes in the red blood cells during storage have led some countries to reduce this to 35 days, and some doctors to request fresher blood for specific patients under the belief that “fresh must be best”.

“Such practices can significantly reduce the availability of blood for transfusion” said Professor Cooper. *“Our study shows these practices are not required and are potentially counterproductive”.*

The TRANSFUSE trial was of 5000 Intensive Care patients in Australia, New Zealand, Finland, Ireland and Saudi Arabia. The study was funded in New Zealand by the Health Research Council of NZ via a 2012 project grant to Dr Colin McArthur.

About TRANSFUSE

TRANSFUSE-RCT is a multi-centre, randomised, controlled trial, testing the effect of the freshest available red blood cell (RBC) unit compared to standard practice, on mortality in critically ill patients who require RBC transfusion.

Rationale:

RBC transfusion is a very common and potentially life-saving treatment in intensive care units (ICUs). However, RBC transfusion has also been associated with an increased risk of morbidity and/or mortality in critically ill patients. Although this association may reflect a variety of factors, attention has increasingly focused on the possible adverse impact of transfusing RBCs stored for a prolonged time, and have developed a so called "storage lesion". The term "storage lesion" refers to the fact that during the 42-days storage, in a way that increases over time, red cells develop important biochemical and structural derangements. These age-related changes in transfused RBCs may have important clinical consequences. However, clinical studies on this fascinating topic remain observational, often retrospective and have very conflicting results.

Goal:

The hypothesis was that in critically ill patients who require a RBC transfusion, compared to standard practice, administration of the freshest available compatible RBC decreased 90-day patient mortality. Patients were randomised to either the "Freshest available blood group" or the "Standard care group". Freshest available blood group: These patients received the freshest available group-specific compatible RBC unit in the transfusion service. Standard care group: These patients received standard practice, which was the oldest available group-specific compatible RBC unit in the transfusion service.

Mother and baby clinical trials could save the health system $290 million over five years

Not only do findings from clinical trials save lives and improve people's health, they potentially lead to health savings of millions of dollars – so investing in them is a "no-brainer", a researcher and neonatologist says.

A team of researchers in New Zealand and Australia have crunched the numbers from 23 clinical trials in the area of mother and baby health which began recruitment in 2008 and completed by 2015. According to their calculations, the studies generated potential savings of up to NZ$290.4 million over five years – almost 13 times the funding investment.

The 23 trials – which include the high-profile "Sugar Babies" trial led by Liggins Institute Distinguished Professor Jane Harding that transformed the treatment of low blood sugar in newborn babies - had together received NZ$22.4 million in funding.

Treatments tested in six of the trials with results available were proven to be superior to existing practice. The authors calculated that if only 10 percent of eligible patients received those six superior interventions, it would save the health system an estimated NZ$25.8 million (AU$23.3 million) over five years, paying off the investment. But, if all eligible patients received them, it would save NZ$290.4 million (AU$262.8 million) over the same period – a thirteen-fold return.

"Our analysis provides further evidence that investing in clinical trials should be a no-brainer - it actually saves the health service money, and so the more high quality trials that are done, the more there will be savings in health care expenditure that can be invested elsewhere,"

says Professor Frank Bloomfield, one of the report authors and Director of the University of Auckland-based Liggins Institute.

Professor Bloomfield, who is also a neonatologist at National Women's Health, Auckland City Hospital, says New Zealand compares "very poorly" to other OECD countries in terms of the percentage of GDP invested in research, which includes health research

"The recent increase in Health Research Council funding, for example, although extremely welcome and critically important, only puts us back to where we were 10 years ago in terms of actual spending power when it comes to clinical trials."

The gap between the costs of clinical trials and investment from funding agencies has also grown as a result of funding contract restrictions - most public good funding contracts in New Zealand have budget caps that are too low for high quality clinical trials. Recruitment timelines in clinical trials can also be unpredictable, and the growing pressures to stick to schedules despite this unpredictability is another challenge.

Fellow author Dr Katie Groom says: "Ongoing research is essential for healthcare professionals to be confident that they are doing the best they can for patients. It is crucial to use treatments that have been shown to be effective - and, equally, not to use treatments that do not have proven benefit or, worse, have been proven to be ineffective, even though this still occurs."

Dr Groom is a senior lecturer in obstetrics and gynaecology at the University of Auckland's Faculty of Medical and Health Sciences and maternal fetal medicine specialist at National Women's Health. She says the dramatic difference in savings between 10 percent and 100 percent uptake highlights the importance of communicating new research findings to patients and getting clinicians to change their practice. "This 'translation' work is a major focus for us, too."

"Hopefully analyses of cost-effectiveness like this one will help demonstrate to funders that their investment in clinical research is well spent." Professor Frank Bloomfield

(Article courtest of the Liggins Institute, University of Auckland)

Read the study: "Randomised clinical trials in perinatal health care: a cost-effective investment" in the Medical Journal of Australia

https://www.mja.com.au/journal/2017/207/7/randomised-clinical-trials-perinatal-health-care-cost-effective-investment

FUNDING FOR RESEARCH

In 2017 Auckland DHB researchers and their colleagues have enjoyed considerable success in obtaining funding in the millions for their research from a variety of charitable and public-good sources.

A+ Trust Research Grants

The hallmark of a great hospital is having a research programme of excellence. The Auckland DHB Charitable Trust (the A+ Trust) is a major supporter of research and the culture of research and innovation. This culture is helping reshape healthcare for our patients to ensure that they receive the best care possible. A+ Trust Research Grants have been awarded annually via a contestable funding round since 2007. The funding has supported Auckland DHB researchers from all disciplines to undertake research across the health spectrum, from patients to population, disease to prevention, and service delivery. Applications are externally peer reviewed and assessed by the Research Review Committee for scientific merit, feasibility, rationale and methodology, deliverables, and opportunities to develop the capacity of new researchers in the organisation. Here are the successful applications for 2017.

A+ Trust Project and Small Project Grants

Kim Brackley (Pharmacy)- Measuring patients' medicine information needs – development of a clinical assessment tool ($43,150)

Alison Burge (Starship Community Services)- Early Childhood Development in Tamaki: The prevalence of health, developmental, behavioural, and social needs among 3-4-year-old children in the Tamaki Community ($49,920)

Carolyn Deng (Anaesthesia)- A pilot trial of the MAnagement of Systolic blood pressure during Thrombectomy by Endovascular Route for acute ischaemic STROKE (MASTERSTROKE Trial) ($14,340)

Helen Lindsay (Anaesthesia)- Continuous subcostal transversus abdominis plane block in HepAtobiliary and Pancreatic surgery patients compared to Intrathecal mOrphiNe (CHAmPION) Randomised Pilot Trial ($35,000)

Moira Nelson (Starship Community Services)- Communication difficulties in preschool in Tamaki ($14,992)

Rachael Parke (Cardiothoracic and Vascular Intensive Care Unit) A Multi-centre, Open Label, Randomised Controlled Trial to Compare a Conservative Fluid Management Strategy to Usual Care in Participants after Cardiac Surgery- The FAB study ($49,500)

Sarah Primhak (Paediatric Infectious Diseases) and Alison Leversha (Starship Community Services) Comparing the Old with the New: Randomised controlled trial of three different treatments for mild-to-moderate impetigo in children ($49,410)

John Windsor (General Surgery)- Lymphogenic basis for insulin resistance in obesity ($12,174)

Fei Xiong and Helen Pilmore (Renal Services)- The investigation, management and outcomes of patients with CKD after an acute coronary syndrome in New Zealand ($13,900)

A+ Trust Summer Student Grants

Ivan Bergman (Anaesthesia)- A retrospective audit of PONV and pain in ADHB bariatric patients

Amy Chan (Pharmacy) and Dennisa Davidson (IMental Health)- Retrospective Study of Antipsychotic use and Hypersexuality

Gary Cheung (Mental Health Services for Older People) - Socio-demographic and disease-related predictors of caregiver burden in dementia.

Tim Cutfield and Steve Ritchie (Infectious Diseases) - Has pathway development reduced unnecessary Cellulitis admissions at ADHB?

Kevin Ellyett (Respiratory Physiology)- Incidence of flow limitation during exercise in healthy adolescent males and its association with perceived dyspnoea on exertion

Craig Jefferies (Paediatric Endocrinology)- The incidence and epidemiology of Acute Kidney Injury in children with Type 1 diabetes

Mike Nicholls (Adult Emergency Department)- Staff wellbeing in an urban Emergency Department in Aotearoa New Zealand

Tim Short (Anaesthesia)- Sarcopenia assessment in the older preoperative surgical co-morbid patient in the anaesthetic assessment clinic: A prospective observational pilot study

Helen Wihongi (He Kamaka Waiora)- Māori were the most physically perfect race living on the face of the earth- turning the curve on diabetes

Michelle Wise (National Women's Health)- Patient satisfaction with two methods of induction of labour

Auckland Academic Health Alliance Collaboration Fund

The Auckland Academic Health Alliance formalises a research, teaching and clinical delivery relationship spanning almost five decades between the Auckland District Health Board and the University of Auckland.

Shuan Dai (Ophthalmology) and Steven Dakin (University of Auckland)- to investigate developing a rapid, objective and automated means of measuring misalignment of the eyes. Misalignment is one of the main causes of amblyopia or 'lazy eye', which affects 3 per cent of children ($85,000)

Lalit Kalra (Reablement Services) and Cathy Stinear (University of Auckland)- for 'TWIST', a prospective, single-site, assessor-blind, observational study to validate the 'Time to Walk Independently after Stroke' algorithm. Stroke is a common cause of adult disability, and being able to walk independently is an important rehabilitation goal. The study will provide an opportunity for a physiotherapist to complete a Master's degree, building Allied Health research capacity within Auckland DHB ($70,000)

Arend Merrie and Greg O'Grady (General Surgery) - for a double-blind placebo-controlled trial of a novel intervention (prucalopride) to prevent post-operative ileus after elective colectomy. Reducing ileus improves patient experience and shortens the hospital stay for patients undergoing this surgery ($42,500)

Giuseppe Sasso (Oncology) and Beau Pontre (University of Auckland)- for developing a non-invasive treatment alternative for atrial fibrillation (AF). The proposed alternative is cardiac radiotherapy with real-time magnetic resonance imaging target-tracking. AF is the most common sustained cardiac rhythm disorder - affecting 2.5- 4% of adults. It is associated with a twofold increase in mortality compared to people with a normal heart rhythm ($85,000)

Sheridan Wilson (Oncology) and Annette Lasham (University of Auckland)- to investigate monitoring of plasma RNA levels during chemotherapy treatment for metastatic breast cancer. This project is expected to generate data that will inform the development of a larger validation trial. It will add to a growing body of research exploring blood-based nucleic acids as early and accurate biomarkers of response during treatment for metastatic breast cancer ($60,000)

Auckland Medical Research Foundation

Cynthia Farquhar (National Women's Health) – Sir Harcourt Caughey Award: Core Outcomes Measures for in Infertility Treatments COMMIT Project ($14,127)

Cynthia Farquhar (National Women's Health) – Sir Douglas Robb Memorial Fund: Verbal histories: Early Medical Women in New Zealand ($1,338)

Johanna Montgomery, Jesse Ashton, Kirsten Finucane (Paediatric and Congenital Cardiac Service), Martin Stiles, Bruce Smaill, Julian Paton- Characterising the role of cardiac neurons in heart rhythm ($154,539)

Marie-Louise Ward, Sarbjot Kaur, Nicholas Kang (Cardiothoracic Surgical Unit), Peter Ruygrok (Cardiology)- The role of Epac in diabetic heart disease ($155,688)

John Windsor (General Surgery), Jiwon Hong- Novel treatment for acute pancreatitis ($159,266)

Australian and New Zealand College of Anaesthetists

Brian Anderson, Jacqueline Hannam (Paediatric Intensive Care Unit) Development of pharmacokinetic models for antibiotics prophylaxis in paediatric cardiac surgery ($Aus25,804)

Alan Merry, Simon Mitchell (Anaesthesia and Perioperative Medicine) – Harry Daly Research Award. A bundle for anaesthetists to reduce postoperative infection: the Anaesthetists Be Clean (ABC) Study ($Aus70,000)

Cure Kids

Cass Byrnes (Starship Respiratory Department) HOPE: Hospitalised pneumonia with extended treatment in young children to prevent long term complications ($103,688)

Stuart Dalziel (Children's Emergency Department) Prevention of admission for bronciolitis ($106,253)

Andy Wood (Paediatric Oncology) Developing and characterising models of a mutated gene responsible for acute myeloid leukaemia (AML) with the aim of improving treatment and survival

Professor Stuart Dalziel

Bronciolitis - What is the problem and who does it affect?

Bronchiolitis is a viral infection of the lower respiratory tract, and the most common reason for New Zealand children under one year of age being admitted to hospital. Maori and Pasifika children, as well as children from lower socioeconomic backgrounds, are overrepresented in these figures.

Aside from its direct effect on the children presenting with the condition, bronchiolitis is a significant drain on scarce resources. It follows that, to improve children's outcomes and reduce wasteful spending, a reduction in admissions is a good place to start.

What does this research aim to achieve?

Dr Stuart Dalziel from Starship Children's Hospital is undertaking a project which will assess the effectiveness of using a combination of nebulised adrenaline and oral dexamethasone – a corticosteroid – to treat children who present with symptoms consistent with bronchiolitis to the Emergency Department.

Previously researchers in Canada undertook a comprehensive placebo-controlled trial which showed adrenaline and corticosteroids on their own are ineffective. However, a more surprising finding was the success of the drugs when taken together; there was a 35% decrease in hospital admissions compared to the placebo group.

These findings have informed the development of a similar trial here. Dr Dalziel and his team will enrol 300 children under one year of age, half of which will receive the combination of drugs, and the other half, an identical – in smell, taste, look, colour & weight – placebo. Together with sites in Australia and Canada, 1616 infants will be enrolled across the three countries resulting in the largest ever trial in bronchiolitis, and providing clinicians with robust information to inform clinical care for this very common condition.

The trial will take place over three years allowing the team to recruit sufficient numbers of children to ensure they have confidence in the outcomes. If the findings are commensurate with the previous trial, this would present a compelling argument for changing current treatment guidelines. A positive result will also contribute directly to reducing inequality. *(Article courtesy of Cure Kids)*

Cancer Research Trust

Gemma Aburn (Paediatric Palliative Care) – Clinical Fellowship -Paediatric Palliative Care, Starship Children's Hospital, Auckland ($98,096)

Green Lane Research and Education Fund

The Green Lane Research & Educational Fund was established at Green Lane Hospital in 1971 and incorporated under the Charitable Trusts act in 1976. Its aims then and now are to advance research and education within the departments of Cardiology, Cardiothoracic Surgery, Paediatric Cardiology and Surgery, Cardiothoracic Anaesthesia and Respiratory Medicine, within the Auckland District Health Board.

The Fund supports a Senior Research Fellowship, annual large and small project grants on a merit contested basis, a PhD Scholarship, conference support for nurses and technical staff and salary support for specified research positions. The Fund hosts an annual Scientific Session followed by the Green Lane Dinner, at which a past member or members' professional achievements are honoured.

John Beca (Paediatric Intensive Care Unit) Nitric Oxide on cardio pulmonary bypass in congenital heart disease – A randomized controlled multi-center trial ($50,000)

Tom Gentles (Paediatric and Congenital Cardiac Service) - A feasibility study to examine fetal regional blood flow and oxygen consumption in the normal fetus. ($7,100)

Malcolm Legget (Cardiology) Multi Ethnic New Zealand Study of Acute Coronary Syndromes – MENZACS ($49,104)

Nigel Lever (Cardiology) Ovine models for lead extraction ($50,000)

Rachael Parke (Cardiothoracic and Vascular Itensive Care Unit) A Multi-centre, Open Label, Randomised Controlled Trial to Compare a Conservative Fluid Management Strategy to Usual Care in Participants after Cardiac Surgery ($100,000)

Jithendra Somaratne (Cardiology) Improving treatment of left ventricular mural thrombus: An ANZACS-QI study ($50,000)

Ryan Welch (Respiratory Physiology) Exercise induced dyspnea caused by ventilatory limitation to exercise: A normal process for adolescents? ($105,000)

Nigel Wilson (Paediatric and Congenital Cardiac Service) – New Zealand Rheumatic Heart Disease Registry ($19,802)

Health Research Council of New Zealand

Frank Bloomfield (Newborn Services)- Reducing inequity through timely detection of critical congenital heart disease ($1,184,577)

Michael Collins (Rebal Services)- The BEST-Fluids study: Better evidence for selecting transplant fluids ($549,035)

Elana Curtis, Peter Jones (Adult Emergency Department) - Examining emergency department inequities: do they exist? ($899,943)

Stuart Dalziel (Children's Emergency Department) – Prevention of asthma ($4,993,727)

Eileen Gilder (Cardiothoracic and Vascular Itensive Care Unit)- To suction or not to suction- that is the question ($250,000)

Colin McArthur (Department of Critical Care Medicine)- Bacteraemia antibiotic length actually needed for clinical effectiveness-BALANCE ($1,191,322)

Shay McGuinness (Cardiothoracic and Vascular Intensive Care Unit) - Improving outcomes after cardiothoracic surgery ($85,000)

Shay McGuinness (Cardiothoracic and Vascular Intensive Care Unit

Continued page 18

+++NEWSFLASH!+++NEWSFLASH!+++NEWSFLASH!+++

Can 'live coaching' parents help children with conduct disorder?

Can conduct problems in children be resolved with parents wearing an earpiece and being coached by an expert on what to say to their child? This is one of the defining features of a parent training programme that's been running in Auckland since 2010. The programme known as Parent-Child Interaction Therapy (PCIT) has been shown to work overseas, but until now has not been robustly evaluated for its effectiveness here.

Now, thanks to a $119,570 Foxley Fellowship grant from the Health Research Council of New Zealand (HRC), Auckland District Health Board clinical psychologist and PCIT practitioner Dr Melanie Woodfield can finally test if the programme 'sticks' with those families who have tried it.

Melanie feels investment into effective, timely interventions like PCIT is vital. "It's incredibly heart-warming to be given the time and space to do this research and the grant shows that children's mental health is up there with other priorities for funding."

PCIT is designed for children aged 2.5 – 7 years with conduct problems and other complex needs. "Some children have challenging behaviour that lasts beyond the 'terrible twos' and begins to have serious consequences, with difficulties that continue into adulthood," says Melanie. The PCIT programme originated in the United States and is widely used there, but in New Zealand it is only available through a handful of services, including a clinic established by Melanie and a colleague in 2013 within Auckland's Kari Centre. As it stands, the service is only accessed by those referred to Auckland District Health Board's Child and Adolescent Mental Health Services.

Melanie aims to determine the effectiveness of the programme by following up families

Dr Melanie Woodfield

that have completed it, as well as exploring how more families can access this unique intervention. As part of the programme, parents wear an earpiece and interact with their child in a specific way while a highly-trained clinician provides live support and immediate feedback from behind a one-way mirror. Towards the end of treatment, the clinician accompanies the parent and child on a public outing (with the parent wearing the earpiece discretely) to encourage skills to generalise beyond the clinic. Siblings are also included in later sessions, to help parents manage the relationship between their children.

Another thing that sets PCIT apart from other parenting programmes, says Dr Woodfield, is that parents can only move to the second part of the programme if they have reached 'mastery' of the first components.

Dr Woodfield hopes to explore ways to modify the programme so it can be accessible to more families. Childhood conduct problems have been shown to lead to a wide spectrum of adverse adult mental and physical health outcomes. "Early intervention could be the key to preventing major adult psychiatric disorders," she says. She also notes that interventions for young children are a lot less costly and more successful than interventions for older adults, where treatment becomes more complex. "A small investment in young children with challenging behaviour can pay significant dividends in later years – for the child, their family and for society."

HRC Chief Executive Professor Kath McPherson says early interventions that actually do help 'early' are key to reducing the burden on families and whānau at such a key time for childhood development, as well as reducing the burden on mental health services in New Zealand. "We need to respond to the current and future needs of our population. New Zealand is now very aware of the crucial importance of mental health and wellbeing and innovative measures like these warrant good investigation and attention."

(Article courtesy of the Health Research Council

National Heart Foundation

Nigel Lever (Cardiology) Pacemaker and Defibrillator Lead Extraction Project ($88,370)

Nigel Wilson (Paediatric and Congenital Cardiac Service) - The Establishment of the New Zealand Rheumatic Heart Disease Registry s ($131,040)

Dr Nigel Wilson

A new Rheumatic Heart Disease Registry will provide important information to improve care for the mostly Māori and Pacific patients living with rheumatic heart disease (RHD), caused by rheumatic fever.

Led by Associate Professor Nigel Wilson at Starship Hospital, the registry has received a $130,000 grant from the National Heart Foundation.

"RHD is the most common 'acquired' heart disease in young people in NZ, affecting them when they should be at the prime of their life, but instead they are dealing with a chronic heart disease of inequity," says Wilson. "In many ways New Zealand leads the world in understanding acute rheumatic fever but when it comes to the heart disease it is responsible for – which can lead to premature death, heart failure, heart surgery, strokes or heart valve infections – we have very little NZ data.

"We are looking for improvements for both the patients and health services, it's back to the basics of can we get ourselves better organised?"

During the project's first phase, researchers will establish the numbers of Kiwis living with RHD and how they are affected by it, gathering information from existing databases and hospital admissions. The second phase will determine the quality of RHD medical and surgical care and investigate any inequalities of care.

"There are inequalities because currently Māori and Pacific are the groups that are getting rheumatic fever and therefore severe RHD, we want to understand the extent of these and how we can minimise them. We don't have hard data for RHD like we do for acute rheumatic fever.

"We also know that because a lot of people with RHD tend to be more socially disadvantaged they are more likely to fall through the cracks and not attend health clinics. That is our impression but again, we need better data."

Qualitative studies are also part of the whole picture as Wilson says they are learning that families see their RHD in very different ways than health professionals do. He wants to get input into how health services can evolve to meet the needs of families and patients. (Article Courtesy of the National Heart Foindation)

Royal Australasian College of Physicians

Michael Collins (Renal Services) – Jacquot Research Establishment Fellowship ($90,000)

Royal Society Te Apārangi- Marsden Fund

Leo Cheng, Peng Du, Gregory O'Grady (General Surgery) - An Atlas of the Gut: A Framework for Integrating Structure to Function ($950,000)

Starship Foundation Clinical Research Fund

9.5

Starship Child Health and the Starship Foundation share a vision to create, at Starship, an environment of world-class research, training and innovation that will better the lives of kiwi kids faster. In 2016, that vision took an important step forward with the announcement of a significant new investment in paediatric clinical research. Since then, over $1.2m has been committed by the Starship Foundation to projects now underway.

This investment enables our national children's hospital even greater ability to lead the way in evidence-based care and improved health outcomes for New Zealand's children. The Starship Foundation is proud to fund projects that save and extend lives, lift spirits and reduce discomfort, ensure better outcome, faster recovery and less invasive treatments, and are focused on equity and prevention to accelerate the pace of change at our national children's hospital.

The Foundation's support for clinical research includes a pre-eminent research grant named in memory of Athlae Lyon, a long standing supporter of Starship through her involvement in the Starship Foundation. The Athlae Lyon Starship Research Trust has been a foundational supporter of clinical research at Starship, previously funding senior research fellowships. In 2017, the trustees chose Dr Hiran Thabrew's research as the recipient of the Athlae Lyon Starship Clinical Research Award for 2018.

Clinical Research Project Grants awarded in 2017

- Dr Stuart Dalziel (Children's Emergency Department) – Prevention of admission for bronchiolitis
- Professor Cameron Grant (General Paediatrics) – Randomised controlled trial of vitamin D to reduce acute respiratory infection health care visits with the next 12 months
- Dr Hiran Thabrew (Consult Liaison) – Starship Rescue: An e-therapy solution to treat anxiety in young people with long-term physical conditions (awarded the Athlae Lyon Starship Clinical Research Award for 2018)
- Julie Scott (Children's Emergency Department) – Simulation use in paediatric emergency nursing skills education
- Dr James Recordon (Paediatric Orthopaedics) – A decade on: a perspective comparison of Ponseti versus surgical treatment od clubfoot in New Zealand
- Dr Cia Sharpe (Paediatric Neurology) – Neurodevelopment outcome study of neonates with hypoxic iscemic encephalopathy and seizures from the NEOLEV2 trial
- Dr Rachel Webb and Dr William Wong (Paediatric Infectious Diseases and Paediatric Nephrology) – Post-streptococcal glomerulonephritis in New Zealand children: new insights into an old disease

Other Clinical Research Projects underway thanks to the generosity of supporters of the Starship Foundation

- Dr Gina O'Grady (Paediatric Neuroservices) - Genomic technologies for diagnosis and gene discovery in paediatric neurogenetic disease (The Athlae Lyon Starship Clinical Research Award for 2017)
- Katie Bach (Starship Oral Health Service) and Prof Cameron Grant (General Paediatrics)- Oh to be able to open wide and smile

- Hiran Thabrew (Starship Consult Liaison)- Acceptability and utility of electronic screener YouthCHAT for young people with long-term physical conditions attending Starship and Year 9 Tamaki High School students and its comparison with HEEADSSS assessment
- Dr Paul Baker (Starship Paediatric Anaesthesiology) - A randomised controlled clinical trial of using Transnasal Humidified Rapid-Insufflation Ventilatory Exchange (THRIVE) to ventilate paediatric patients undergoing microlyngoscopy and bronchoscopy
- Dr Tom Gentles (Paediatric and Congenital Cardiac Services)- Pulse oximetry screening for the detection of critical congenital heart disease in newborn infants: a study assessing feasibility of a national screening programme
- Dr Anusha Ganeshalingham (Paediatric Intensive Care Unit)- The importance of mean arterial blood pressure in the development of brain injury in infants requiring cardiac surgery
- Dr Sarah Missen (National Metabolic Service)- A retrospective audit of patients diagnosed with Mitochondrial Disease in New Zealand from 2000 to 2015

Celebrating Our People 2017

Welcome *Haere Mai* Respect *Manaaki* Together *Tūhono* Aim High *Angamua*

AUCKLAND DISTRICT HEALTH BOARD *Te Toka Tumai*

CELEBRATING OUR PEOPLE

Auckland DHB Research Excellence Award

This award, offered annually in conjunction with ADHB Healthcare Excellence Awards, recognises lead authors of significant, original research papers published in the preceding year. Applications are judged by a panel of top researchers for contribution to new knowledge, potential to inform best practice, stakeholders and clinical decision making, and potential to improve healthcare delivery.

2017 Winner

Jane Alsweiler and team (Newborn Services)

Prophylactic Oral Dextrose Gel for Newborn Babies at Risk of Neonatal Hypoglycaemia: A Randomised Controlled Dose-Finding Trial (the Pre-hPOD Study).

Research excellence prizewinners Drs Jane Alsweiler and Joanne Hegarty at the 2017 Health Excellence Awards Ceremony

Project team: Jane Alsweiler, Joanne Hegarty, Jane Harding, Gregory Gamble, Caroline Crowther, Richard Edlin.

Reference: PLoS Medicine 13(10): e1002155. doi:10.1371/journal.pmed.1002155

Low blood sugar level (hypoglycaemia) is common soon after birth, with 30% of all babies born at risk, and hypoglycaemia developing in half of these at-risk babies. Babies who develop hypoglycaemia are at risk of neurodevelopmental impairment, including developmental delay and poor school performance. Despite clinical guidelines recommending that prophylactic measures should be taken in babies at risk, there currently are no effective strategies for preventing hypoglycaemia.

Oral dextrose gel is effective for treating neonatal hypoglycaemia, but it was unknown if this could be used to prevent babies developing it. This was the first trial to demonstrate an effective strategy to reduce the incidence of neonatal hypoglycaemia, which could therefore help reduce NICU admissions and neurodevelopmental impairment.

The investigators conducted a multicenter, randomised controlled trial of prophylactic oral dextrose gel in babies at-risk of developing neonatal hypoglycaemia to determine an effective dose to reduce the incidence of this condition.

416 at-risk babies were randomised to receive either a standard (200mg/kg) or high (400mg/kg) dose of dextrose gel or placebo, either once or followed by three more doses before feeds. It was found that 200 mg/kg of 40% dextrose gel was the most effective dose. Overall, dextrose gel reduced the incidence of hypoglycaemia by over a third, and may also reduce NICU admission.

This research has the potential to improve outcomes for many babies, both in New Zealand and overseas. If long term outcomes are also improved (study in progress), this simple and inexpensive intervention could become the standard of care for up to 30% of all babies born.

Finalist:

Katie Groom and team (National Women's Health)

The EPPI Trial: Enoxaparin for the prevention of preeclampsia and intrauterine growth restriction in women with a prior history – a randomised trial.

Project team: Katie Groom, Lesley McCowan, Peter Stone, Claire McLintock

Reference: Serological and clinical outcomes of horizontally transmitted chronic hepatitis B infection in New Zealand Maori: results from a 28-year follow-up study. American Journal of Obstetrics and Gynecology, http://dx.doi.org/10.1016/j.ajog.2017.01.014- Article was Editor's Choice

The EPPI Trial

Enoxaparin for the Prevention of Preeclampsia and Intrauterine growth restriction – a pilot open-label randomised controlled trial

The EPPI trial was a multicentre, randomised trial exploring a potential therapy for the prevention of ttwo of the major complications of pregnancy, preeclampsia and fetal growth restriction. The idea being that using a daily injection of low molecular weight heparin may help the placenta to function better and therefore reduce the risk of those complications.

At the end of six years we completed recruitment to the study and just in the last year we've been able to look at the results. These have not shown that the injections decreased the risk of these conditions, which, while disappointing, really is great news for us as clinicians as we can move further forward in our understanding; its great news for women that they don't need to be subjected to unnecessary injections every day during their pregnancy. Its good news for Auckland DHB that we can lead an international clinical trial.

One of the really important things in clinical medicine is not using unproven therapies which can be dangerous, so research is not just finding out that something is great, its also about showing something isn't great. We want to be mindful of the health economics of the treatments we give, and we need to be sure that the treatments we prescribe for women are safe for women, they are cost-effective for their healthcare and they are of proven benefit." Dr Katie Groom – EPPI study lead investigator

The EPPI trial was presented in the prestigious opening plenary session at the USA Society of Maternal Fetal Medicine Annual Meeting, January 2017; ranked 5th of 2115 submitted abstracts. It was invited for fast track review with the American Journal of Obstetrics and Gynaecology and was selected as 'Editors Choice', March 2017. Results will be used in future meta-analysis and strongly support the growing body of evidence that Low Molecular Weight Heparin does not reduce the risk of recurrence of preeclampsia and IntraUterine Growth Restriction. Women should not be unnecessarily exposed to this intervention.

Finalist:

Peter Jones and team (Adult Emergency Department) – Impact of a national time target on ED length of stay on patient outcomes.

Project team: Peter Jones, Alana Harper, James Le Fevre, Susan Wells, Elana Curtis, Joanna Stewart, Papaarangi Reid, Shanthi Ameratunga

Reference: Impact of a national time target for ED length of stay on patient outcomes. New Zealand Medical Journal, 12 may 2017, Vol 130, No 1455.

"We were looking at whether the Shorter Stays in ED target, which is a target looking at how long people stayed at the Emergency Department and whether this affected their quality of care.

We had some pretty interesting results. Fewer people died in the emergency department after the targets were implemented, fewer people left without having been seen. Patients were spending less time in the emergency department, especially those patients who were being admitted to hospital. When people who are due to be admitted to hospital spend longer than they should in the emergency department this blocks up the emergency department so we can't look after the new people coming in. It also means that the quality of care for those patients being admitted is impaired. We found the target achieved its aim of reducing the time that those patients spent in hospital".

Dr Peter Jone, study lead investigator

"We had a huge commitment to this research and aligning it with a Treaty of Waitangi perspective for Māori and also undertaking it with a Kaupapa Māori methodological approach, i.e. getting the research right for Māori, as well as for the whole of New Zealand".

Dr Elana Curtis, study investigator

Awards for outstanding Emergency Department research paper

Congratulations to Adult Emergency Department researchers Drs Peter Jones, Alana Harper and James Le Fevre for being awarded the Australasian College of Emergency Medicine's Edward Brentnall Award for 2017.

This award was made in recognition of their publication in the New Zealand Medical Journal "Impact of a national time target for ED length of stay on patient outcomes", which was judged the most significant in the field of public health or disaster medicine in 2017 by the college. In an extraordinary double, the College also awarded the team the John Gilroy Potts Award for 2017 Best Paper. The researchers collaborated with members of the University of Auckland's School of Population Health on the Health Research Council funded "Shorter Stays in the Emergency Department" project, which has produced nine other publications and reports in the media, including in the New Zealand Herald. The study demonstrated that implementation of the 6-hour time target drastically reduced Emergency Department length of stay and time to admission to a ward. introduction of the target was associated with a substantial 50 per cent reduction in the number of patient deaths in Emergency Departments – that's about 700 fewer deaths than predicted if pre-target trends had continued.

Best Research Posters

Auckland DHB Celebration Week (final week of November) was the occasion, and ACH Level 5 Atrium was the venue, for the 2017 Research Poster Competition displays. Continuing the success of previous years, over 60 posters were on display, showcasing the commitment of our staff to research, and our expertise across a diverse range of disciplines and topics. Winners for the four judging categories are below;Health Professions (Allied, Scientific, Technical)

Health Professions (Allied, Scientific, Technical)

Winner:

Iris Fontanill and Liz Painter
(Cardiac Transplant Team)

Runner Up:

Marian Smith (LabPlus Microbiology)

Medical

Winner:

Nicola Culliford-Semmens
(Paediatric and Congenital Cardiac Service)

Runner Up:

Stephen Ritchie (Infectious Diseases Department)

Nursing

Winner:

Alison Burge (Starship Community Services

Runner Up:

Junel Padigos (Department of Critical Care Medicine)

Starship Best Children's Reseach Poster

Winner:

Anna Mulholland
(Starship Respiratory Department)

Runners Up:

Moira Nelson (Starship Community Services) and **Alison Burge** (Starship Community Services).

We gratefully acknowledge the continued support of this competition by the Starship Foundation.

Health and Development at School Entry:
Are We Setting Tamariki Up To Fail?

A Burge, M Nelson, A van Meygaarden, F Mahony, B Kool, and A Leversha on behalf of the Welcome to School Team, and R Burt, T Nua and A Burke on behalf of Maniakalani Community of Learning, Tamaki.
Starship Community, University of Auckland and Manaiakalani Community of Learning.

Starship Children's Health
cure kids

Introduction

Health and educational outcomes are inextricably linked. Health and education systems, however, tend to operate in silos with little sharing of information of collaboration.

The introduction of school health clinics in low decile schools has provided the impetus and opportunity for health and education to work differently together.

The **Welcome to School** Project is a cross-sector collaboration between Starship Community and schools in the Manaiakalani Community of Learning in Tamaki. Principals reported many children were starting school at a developmental age of 3-4 years of age without the skills required to participate in learning. In addition, they were concerned the children had significant health issues.

Aim

The aim of this project was to determine the prevalence of health, developmental, and social needs among new entrants in Tamaki.

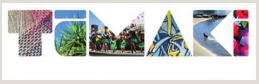
Methods

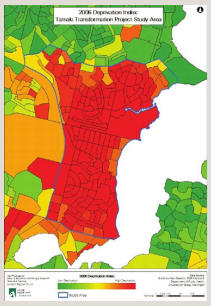
Eligible children were 5 year old tamariki starting school in one of 9 primary schools in the Manaiakalani Community of Learning, Tamaki. There was a 2-stage consent process: Stage One consent for the research nurse to contact the family was obtained by teachers and Stage 2 was obtained by the nurse after the project had been explained to whanau.

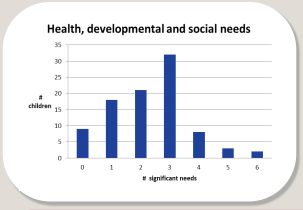
Data: Compiled using a standardised questionnaire with the primary caregiver: demographic data, health history, developmental concerns, parental developmental status (PEDS), strengths and difficulties questionnaire (SDQ), housing, and standardised questions about measures of deprivation. A brief clinical assessment: height, weight, BMI, general assessment of skin health, dental health, and a formal developmental screen using the Ages and Stages Questionnaire (ASQ). Care and protection concerns were identified using parental report, the presence of a child protection alert in ADHB, and cross check with the Oranga Tamariki database. Before School check (B4SC) data were obtained from DHB data.

Significant needs: Defined as meeting the threshold for further assessment or intervention for PEDS, SDQ, 2 or more abnormal domains on the ASQ (<2.5th centile), known to Oranga Tamariki, requiring dental extraction under GA or being overweight or obese.

Ethics approval: 127862-398561

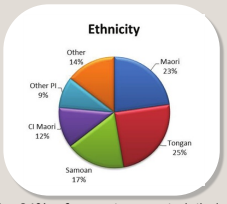






Results

Study Population: 100 children and whanau participated during the 12-month study period. 90% students were Pacific or Māori.



Health: 84% of parents reported their child had excellent or very good health. 33% children were obese, and 22% overweight. 23% required dental extractions under GA for significant dental decay.

Development: 23% parents reported significant concerns about their child's development (PEDS pathway A).

Social: Whanau reported significant levels of disadvantage: 77% in social housing, 25% had their power disconnected and 88% had received assistance from community agencies for food parcels, clothes or money in the preceding 12 months.

38% of children were known by Oranga Tamariki and an additional 7% had a contact record, mostly for Family Violence, but had not met the threshold for formal care and protection involvement.

Multiple Needs: Only 7% of children had no health, developmental or social needs. The remainder of children had multiple significant needs requiring further assessment / intervention: 71% had 2 or more significant needs. 48% had 3 or more significant needs (see below).

Very few children had been identified by existing health, education or social services prior to school entry and even less had received appropriate intervention.

Conclusions

- Children starting school in Tamaki have high levels of health, developmental and social concerns which have not been identified by the B4SC, parents, or ECEC providers prior to school entry
- Our current model of delivering health, education and social services equally is accepting a lesser deal for disadvantaged children and is increasing inequity.

Implications

- Collaboration between health and education has provided valuable data to examine how well current systems are working for children in Tamaki. Business as Usual is not enough.
- Health and education services need to have an equity focus and be delivered with proportionate universality: services and interventions which are universal, but with a scale and intensity that is proportionate to the level of disadvantage.
- The screening tools used in the WCTO schedule and B4SC are not working for disadvantaged populations. Starship Community is now using the ASQ as an additional developmental screen and are reintroducing a new entrant check linking school nurses with children/whanau. Information is being fed into the WCTO review.

AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai
TĀMAKI REGENERATION
MINISTRY OF EDUCATION Te Tāhuhu o te Mātauranga
Joyce Fisher Charitable Trust
a+Trust
THE UNIVERSITY OF AUCKLAND NEW ZEALAND

Alison Burge's prizewinning poster describes the Welcome to School health and education collaboration in Auckland's low decile schools

AWARDS

Clarivate Analytics Highly Cited Researchers 2017 – a repeat performance!

Congratulations to **Professors Ed Gane** (NZ Liver Transplant Unit) and **Harvey White** (Cardiology) who made it onto Clarivate Analytics Highly Cited list for the second year running. Only a handful of New Zealanders made it onto the international list of 3539 highly cited researcher. The pair were also the two highest ranked New Zealanders, with Professor Gane appearing in the list in 703rd place, and Professor White at 955th.

New Zealand Society of Gastroenterology Young Investigator Award

Congratulations to Ibrahim Hassan, a registrar with the Liver Transplant Unit, who won the 2017 New Zealand Society of Gastroenterology's Hepatology Young Investigator Award at the Society's annual meeting in November.

Ross Craig Award 2017 – Newmarket Rotary Charitable Foundation

Congratulations to Auckland DHB medical oncologist **Dr Rosalie Stephens**, who was awarded the Ross Craig Oncology award. The award is targeted towards Auckland medical, surgical and pathology registrars who treat patients with cancer. It provides an opportunity for these mid-career doctors to step out of clinical life and undertake first-hand research into the genomic abnormalities that underlie cancer. Dr Stephens' project aims to identify non-invasive disease biomarkers in metastatic melanoma patients in order to improve patient outcomes by detection of relapse, earlier than current tests.

Young Physicist Investigator Competition

Congratulations to **Suzanne Lydiard** (Oncology Physics) for being chosen as Runner Up in the John R Cameron Young Investigator Competition at the Annual American Association of Physicists in Medicine Conference, held in Denver in July/August 2017. Her abstract "First Cardiac Radiosurgery MLC Tracking Results" was one of 10 chosen as a finalist out of over 350 entries and then the top 3 winners were chosen by the score from their Oral presentations.

Summer Students Awards 2017

Student researchers work at Auckland DHB during the summer months each year. These studentship projects are well regarded as being one of the best ways to utilise local talent to find out things Auckland DHB is interested in knowing, and for a very small investment. The A+ Trust supports Auckland DHB staff to devise projects which will answer important clinical question by funding stipends for student workers. Ten of these projects were active in the summer of 2017-2018. The scheme runs under the auspices of the Auckland Academic Health Alliance, with the Faculty of Medical and Health Sciences administering the grants. The end-of-project reports prepared by the students were recently assessed for scientific quality by an expert panel. The winner and runner up of the 2017 A+ Trust Summer Studentship prize for best students' reports were;

- **Thalia Babbage** (winner), supervised by **Kevin Ellyett** (Respiratory Physiology) "*Incidence of flow limitation during exercise in healthy adolescent males and its association with perceived dyspnoea on exertion*"
- **Robert Gow** (runner up), supervised by **Timothy Cutfield and Stephen Ritchie** (Infectitious Diseases) "*Has pathway development reduced unnecessary Cellulitis admissions at ADHB?*"
- **Rachel Basevi** (runner up), supervised by **Tim Short** (Anaesthesia) "*Sarcopenia assessment in the older preoperative surgical co-morbid patient in the anaesthetic assessment clinic: A prospective observational pilot study*"

2017 A+ Trust student prizewinners Robert Gow, Thalia Babbage and Rachel Basevi at the awards ceremony

9.5

NEW RESEARCH

NEW RESEARCH UNDERWAY

Auckland DHB researchers are instigators and leaders of projects in almost all clinical and support services of the organisation. Many participate in international, collaborative, multi-centre studies, and in commercially funded clinical trials of pharmaceuticals and medical devices. ADHB also provides essential resources and partnerships for researchers from other organisations.

Below is presented a snapshot of nearly 300 new research projects that commenced at Auckland DHB in 2017, along with the lead investigator.

Allied Health – Audiology, Nutrition, Pharmacy, Physiotherapy, Social Work, Speech & Language:

Cherie Appleton - Field Education Enhanced - does the application of E Portfolio pedagogy embolden transformational learning in social work field placement, if so how?

Tayla Bowers - Investigation into the effects of e-prescribing on antimicrobial stewardship at Auckland DHB

Joanne Beachman - End of line spectroscopic verification of five intravenous oncology drugs, for hospital pharmacy compounding

Kim Brackley - Visual Thinking Strategies - using art to support the development of critical thinking in pharmacy technicians

Stella Friedlander - Retrospective audit of zinc and Vitamin D status of eating disorder inpatients newly admitted to Starship since 2009

Chandini Gadhvi - In-patient physiotherapy management of #NOF (Neck of femur fracture) patients at Auckland City Hospital: are we meeting current clinical care standards?

Dale Sheehan - From Theory to Practice. The application of workplace learning theory to inform the development of a clinical placement for Medical Imaging Technology Students

Megan Tennant-Humphreys - The role of physiotherapy in the management of frail elderly patients in the Admissions and Planning Unit (APU), Auckland City Hospital

Ricky Wan - Retrospective audit of the use of prokinetics in critically ill patients at Auckland District Health Board (ADHB) and Counties Manukau District Health Board (CMDHB)

Anaesthesia – Adult, Cardiothoracic, National Women's and ORL:

Ivan Bergman - A retrospective audit of PONV and pain in ADHB bariatric patients

Doug Campbell - Validation and extension of a multivariable prediction model of perioperative mortality in a national perioperative dataset: the Surgical Outcome Risk Tool New Zealand study

Karen Day - What risk information do patients want when considering high risk surgery?

Carolyn Deng - 13-year trend in acute and elective surgery for patients aged 60 and above at Auckland District Health Board

Kaveh Djamali - Audit of perioperative management of diabetes on Level 8 Theatres by anaesthetists

Philip Guise - Continuation of new oral anticoagulants for cataract and vitreoretinal surgery: an audit

Jack Hill - Measuring haemoglobin concentration in obstetric patients using Sysmex XE 2100 and point-of-care ABL800/FLEX: a comparison of methods

Alan Merry - Linking days alive and out of hospital with surgical site infection: the 'LASSI' feasibility study

Leesa Morton - A pilot randomized controlled trial of two interventions to manage dry mouth pre-operative elective surgical patients: I AM DRY

EeMei Soo - Audit of the Efficacy of External Cephalic Version (ECV) in Patients with Breech Presentations

Andrew Wilson - The 2nd Sprint National Anaesthesia Project (SNAP2): Epidemiology of Critical Care provision after Surgery

Anaesthesia (Starship):

Paul Baker – A randomised controlled clinical trial of using Transnasal Humidified Rapid-Insufflation Ventilatory Exchange (THRIVE) to ventilate paediatric patients undergoing microlaryngoscopy and bronchoscopy

Amanda Dalton - Prospective Evaluation of emergency red bell calls and adverse events in Starship Theatres

Jacqueline Hannam - An audit and simulation study of current compliance with antibiotic dosing protocols at Starship Children's Hospital

Michael Tan - An audit of humidified high flow nasal prong oxygen usage in Starship PACU

Elsa Taylor - Opioid prescriptions at the postoperative anaesthesia care unit in Starship Children's Health

Elsa Taylor - Paediatric postoperative vomiting (and nausea) incidence and prophylaxis

Cardiology (Adult):

Sheila Bacus - Fasting before an elective coronary Angiogram and AngioplaSTy. (FAAST)

Aleisha Easton - The Utility of Balloon Mitral Valvuloplasty in Pregnancy for Severe Symptomatic Mitral Stenosis: A retrospective Study of Outcomes

Benjamin Liu - Retrospective audit of ST elevation myocardial infarction associated left ventricular thrombosis and its complications in Auckland region

Martyn Nash - Biomechanical analyses of myocardial disease: a pilot study

Peter Ruygrok - Biochemical and Molecular Analysis of Novel Neurohumoral Factors Derived from Failing Cardiac Tissue

Ralph Stewart - Improving outcomes of patients with atrial fibrillation in primary care. B-SAFE trial

Marie-Louise Ward - Exploration of mitochondrial dynamics in the contractile dysfunction of diabetic heart disease

Mark Webster - A Prospective, Randomized, Controlled, Multi-Centre Study to Establish the Safety and Effectiveness of the SAPIEN 3 Transcatheter Heart Valve in Low Risk Patients who have Severe, Calcific, Aortic Stenosis Requiring Aortic Valve Replacement

Mark Webster - Prospective, Multi-Center, Single Arm Study of the Medeon Biodesign XPro™ Suture-Mediated Vascular Closure Device System

Mark Webster - The genetics of spontaneous coronary artery dissection

Cardiology (Starship):

Jessee Fia'ali'i - A qualitative exploration of the psychosocial impacts of cardiac inherited diseases in Pasifika and Maori people

Tom Gentles - 30 years of surgery for congenital heart disease - time related outcomes

Jascha Kehr - Impact of timing of the Glenn operation on Fontan outcomes

Claire O'Donovan - A cross sectional study investigating the psychological sequelae of cardiac inherited diseases experienced by individuals listed on the New Zealand Cardiac Inherited Diseases Register

Claire O'Donovan - People's experiences of Cardiac Inherited Diseases in the year after referral for investigation

Kathryn Rice - Fontan Conversion surgery at Starship Children's Hospital - a retrospective study of the outcomes of a modified anti-arrhymthmia surgical technique which aims to preserve the sinus

Jon Skinner - Exercise in Cardiovascular Disease: LIVE-HCM / LIVE-LQTS

Jon Skinner - Genome wide investigation in cardiac inherited diseases

Jon Skinner - Outcomes in Timothy Syndrome

Nigel Wilson - The New Zealand Rheumatic Heart Disease Registry

Cardiothoracic Surgical Unit:

Andrei Belyaev - Inflammatory biomarkers in acute cholangitis

Anita Fitzgerald - An investigation of infection rates in patients receiving implantable cardiac devices

Giridhar Hariprasad - Thoracoscopic Left Ventricular lead placement for Cardiac Resynchronisation Therapy: an audit of outcomes

David Haydock – Dissections audit

Cardiothoracic and Vascular Intensive Care Unit:

Paul Drury - Dysphagia after cardiothoracic surgery

Paul Drury - Re-admissions to CVICU - a retrospective audit

Shay McGuinness - A pilot multicentre blinded randomised controlled clinical trial of cryopreserved platelets vs. conventional liquid-stored platelets for the management of post-surgical bleeding. The CLIP study

Shay McGuinness - Improving Outcomes after Cardiothoracic Surgery

Shay McGuinness - IV iron for Treatment of Anaemia before Cardiac Surgery; The ITACS Trial

Shay McGuinness - REACTOR: A multi-centre, phase II, randomised, open label, clinical trial comparing combined prophylactic intravenous paracetamol and early targeted physical cooling for fever with standard temperature management in mechanically ventilated adult

Shay McGuinness - The Intensive Care Unit Randomised Trial Comparing Two Approaches to OXygen therapy: The ICU-ROX trial

Rachael Parke - An Australia and New Zealand-wide point prevalence study to determine ECMO-related infection rates and cannulae dressing and securement practices in patients receiving extracorporeal membrane oxygenation

Rachael Parke - The Extended Study of Prevalence of Infection in Intensive Care III (EPIC III)

Rachael Parke- The Intensive Care Unit Randomised Trial Comparing Two Approaches to Oxygen therapy: Translating Research into Practice Study

Community Services

Andrew Jull - A randomized controlled trial of wool-derived keratin dressings for venous leg ulcers. Keratin4VLU

Critical Care Medicine

Junaid Beig - Survival Outcome of Admissions in Critical Care unit with Gastrointestinal Bleeding

Andrew Jull - Sleep Quality of Non-mechanically Ventilated Patients and the Affecting Factors in the Intensive Care Unit

Colin McArthur - Plasmalyte 148 versus saline study (PLUS)

Colin McArthur - Randomised, Embedded, Multifactorial Adaptive Platform for Community Acquired Pneumonia (REMAP-CAP)

Rachael McConnochie - Delayed defecation and the impact on brain injured critically ill patients

Lynette Newby - A prospective multicentre observational study of aneurysmal subarachnoid haemorrhage in Australasian intensive care – PROMOTE-SAH

Dermatology (Adult):

Lydia Chan - Characteristics of lichenoid drug reactions at ADHB from 2006-2010

Denesh Patel - Cost and loss of productivity of hospital-based phototherapy: an Auckland, New Zealand perspective

Denesh Patel - Ethnic Skin- Defining inequalities to accessing public funded dermatology service

Dermatology (Starship):

Diana Purvis - Long term outcomes of methotrexate treatment for childhood and adolescent eczema

Diabetes Service (Adult):

Sarah Gray - Northern Regional Diabetes-related lower limb amputation audit

Manish Khanolkar - Audit on young adults (<40 years) with type 2 diabetes (T2D) registered at Auckland Diabetes Centre (ADC)

Simon Speight - The Three Great Pathologies of diabetic foot disease

Fiona Wu - The Fenofibrate And Microvascular Events in Type 1 diabetes (FAME 1) Eye

Emergency (Adult):

Stephanie Mackie - Does videolaryngoscopy improve Emergency Medicine registrars' success rates? An observational study in an urban, tertiary centre

Charlotte May - Retrospective validation of a risk stratification tool developed for management of patients with blunt chest wall trauma

Anil Nair - Assessing the relationship between actual and perceived waiting times in a metropolitan emergency department

Mike Nicholls - Staff wellbeing in an urban Emergency Department in Aotearoa New Zealand

Emergency (Starship):

Stuart Dalziel - Australian Paediatric Head Injury Rules Study: Assessing the gap prior to implementation: APHIRST Gap

Stuart Dalziel - How are we managing acute asthma in children? A PREDICT study

Endocrinology (Starship):

Wayne Cutfield - Is usage of antibiotics in early childhood related to obesity?

Paul Hofman - A phase 3, open-label, randomized, multicentre, 12 months, efficacy and safety study of weekly MOD-4023 compared to daily Genotropin therapy in pre-pubertal children with growth hormone deficiency

Craig Jefferies - The incidence and epidemiology of Acute Kidney Injury in children with Type 1 diabetes

Craig Jefferies - Preventing diabetic ketoacidosis in new patients with type 1 diabetes - the NO-DKA Study: New-Onset Diabetes Ketoacidosis

Gastroenterology (Adult):

Wayne Bai - Validation of Baveno IV criteria to identify cirrhotic patients not requiring endoscopic surveillance for varices

Maggie Ow - Colonoscopy in the elderly

David Rowbotham - A Long-Term Extension Study to Evaluate Filgotinib in Subjects with Crohn's Disease

David Rowbotham - A Long-Term Extension Study to Evaluate the Safety of Filgotinib in Subjects with Ulcerative Colitis

David Rowbotham - Combined Phase 2b/3, Double-blind, Randomized, Placebo-Controlled Studies Evaluating the Efficacy and Safety of Filgotinib in the Induction and Maintenance of Remission in Subjects with Moderately to Severely Active Ulcerative Colitis

David Rowbotham - Combined Phase 3, Double-blind, Randomized, Placebo-Controlled Studies Evaluating the Efficacy and Safety of Filgotinib in the Induction and Maintenance of Remission in Subjects with Moderately to Severely Active Crohn's Disease

Gastroenterology (Starship):

Helen Evans - Pediatric intestinal transplant listing criteria - a multicenter validation study

Helen Evans - Retrospective single-centre comparison of innovator vs generic tacrolimus in de novo paediatric liver transplant patients

Reena Ho - An audit of reported drug allergy amongst Starship hospital inpatients, with development of a clinical guideline for those reporting allergy to penicillins, with post implementation re-audit

Genetics Service

Kimberley Gamet - Implementing mainstreaming of genetic testing of women with ovarian cancer: evaluation of a training programme for oncology health professionals

Russell Snell - The molecular basis of Autism Spectrum Disorder (ASD) and other neurodevelopmental disorders (NDDs)

Haematology (Adult):

Leanne Berkahn - A Phase II/III, Randomized, Multicentre Study of Bendamustine with MOR00208 versus Bendamustine with Rituximab in Patients with Relapsed or Refractory Diffuse Large B-Cell Lymphoma (R-R DLBCL) who are not eligible for high-dose chemotherapy (HDC) and autologous stem-cell transplantation (ASCT)

Leanne Berkahn - A Phase 3, Randomized, Double-blind, Placebo-controlled, Multicenter Study of Bendamustine and Rituximab (BR) Alone Versus in Combination with Acalabrutinib (ACP-196) in Subjects with Previously Untreated Mantle Cell Lymphoma

Leanna Berkahn - A Phase III, Randomized, Open-label, Clinical Trial to Compare Pembrolizumab with Brentuximab Vedotin in Subjects with Relapsed or Refractory Classical Hodgkin Lymphoma

Leanne Berkahn - Obinutuzumab with Idasanutlin and Venetoclax in Lymphoma

Peter Browett - A phase 2 open-label proof of concept study to assess the efficacy, safety, and pharmacokinetics of ACH-0144471 in untreated patient with paroxysmal nocturnal hemoglobinuria (PNH)

Peter Browett - A phase II study of dasatinib followed by imatinib in newly diagnosed, previously untreated patients with chronic phase CML

Peter Browett - A Phase 3, Multicenter, Randomized, Double-blind, Double-dummy, Active-controlled Study to Assess the Efficacy and Safety of Maribavir Compared to Valganciclovir

Peter Browett - A Screening Study for the ACH471 100 Treatment Study in Patients with Untreated Paroxysmal Nocturnal Hemoglobinuria

Peter Browett - Stopping TKI therapy in Chronic Myeloid Leukaemia - an audit of patient outcomes in the Auckland region

Nicole Chien - Rapid diagnosis of acute promyelocytic leukaemia (APML) in Auckland DHB - is PML protein localisation assay useful?

Haematology/Oncology (Starship):

Ruellyn Cockcroft - ASSET; Acute Lymphoblastic Leukaemia Subtype and Side-Effects

Nyree Cole - COG AAML1531 - Acute myeloid leukemia in Down Syndrome

Lochie Teague - ALL SCTped 2012 FORUM: Allogenic Stem Cell Transplantation in Children and Adolescents with Acute Lymphoblastic Leukaemia

Lochie Teague - A phase 3, randomised, adaptive study comparing the efficacy and safety of defibrotide vs best supportive care in the prevention of hepatic veno-occlusive disease in adult and paediatric patients undergoing haematopoietic stem cell transplant. Jazz_15-007

Karen Tsui - International Diffuse Intrinsic Pontine Glioma (DIPG) Registry and Repository

Mark Winstanley – Ewing 2008

Mark Winstanley - Prognostic value of the Curie Score in children with high-risk neuroblastoma undergoing immunotherapy treatment

Andrew Wood - High risk neuroblastoma study 1.7 of SIOP-Europe (SIOPEN): HR-NBL-1.7/SIOPEN

He Kamaka Waiora:

Helen Wihongi - Maori were the most physically perfect race living on the face of the earth - turning the curve on diabetes

Infectious Diseases (Adult):

Tim Cutfield - Has pathway development reduced unnecessary Cellulitis admissions at ADHB?

Mitzi Nisbet -What is the additional benefit from three screening sputums versus two for diagnosing smear negative, culture positive pulmonary Tuberculosis?

Infectious Diseases (Starship):

Emma Best - Invasive Staphylococcus aureus infections and hospitalisations (ISAIAH)

Emma Best - Non type B Haemophilus influenzae invasive disease in childhood in the Auckland region DHBs 1995-2016

Emma Best - Pre-school Osteoarticular Infection (POI) Study

Diana Lennon - Is a rheumatic fever register the best surveillance tool to evaluate rheumatic fever control in the Auckland region?

Sarah Primhak - Community onset invasive bacterial sepsis in infants under 3 months; experience of a tertiary paediatric hospital over 10 years

Sarah Primhak - Starship Script - an antibiotic prescribing smartphone application for Starship Hospital

LabPlus (Immunology, Microbiology, Pathology, Virology):

Karen Bartholomew - Surgical consent forms in New Zealand – understanding their role in the use of clinical tissue for research

Rexson Tse - A 1-year retrospective study on the changes in post mortem vitreous humour magnesium, sodium and chloride levels in salt water drowning deaths

Liver Transplant Unit:

Wayne Bai - Validation of Baveno IV criteria to identify cirrhotic patients not requiring endoscopic surveillance for varices

Ed Gane - A Follow-up Study to Assess Resistance and Durability of Response to AbbVie Direct-Acting Antiviral Agent (DAA) Therapy (ABT-493 and/or ABT-530) in Subjects Who Participated in Phase 2 or 3 Clinical Studies for the Treatment of Chronic Hepatitis C Virus (HCV) Infection

Ed Gane - A Phase 2, Multicenter, Open-Label Study to Evaluate the Efficacy and Safety of Sofosbuvir/Velpatasvir for 12 Weeks in Subjects with Chronic HCV Infection Who are on Dialysis for End Stage Renal Disease

Ed Gane - A phase IIIb, open-label, multicentre, international randomised controlled trial of simplified treatment monitoring for 8 weeks glecaprevir (300mg)/pibrentasvir (120mg) in chronic HCV treatment naïve patients without cirrhosis

Ed Gane - A Prospective 3-Year Follow-up Study in Subjects Treated in a Preceding Phase 2 or 3 Study with a Regimen Containing Odalasvir and AL-335 With or Without Simeprevir for the Treatment of Hepatitis C Virus (HCV) Infection

Ed Gane - Comparing hepatitis C care and treatment in a primary health care service with a tertiary hospital: a randomised trial

Ed Gane - Phase 1b Study Evaluating the Safety, Tolerability, Pharmacokinetics and Pharmacodynamics of GS-9688 in Patients with Chronic Hepatitis B

Ed Gane - Study of the Safety and Efficacy of Sofosbuvir/Velpatasvir/Voxilaprevir for 12 Weeks in Subjects who Participated in a Prior Gilead Sponsored HCV Treatment Study

Rachael Harry - Improving long term outcomes following paediatric liver transplantation: assessing outcomes from 5 years of the Young Persons Liver Clinic

Rachael Harry - Retrospective analysis of diagnosis, management and outcomes of patients with autoimmune hepatitis (AIH) managed at a specialist clinic at New Zealand Liver Transplant Unit (NZLTU)

Ibrahim Hassan - Assessing long term outcomes following liver transplant for non-alcoholic steatohepatitis (NASH) cirrhosis over the last 18 years

Ibrahim Hassan - Assessing long term outcomes following Trans-jugular Intrahepatic Porto-Systemic Shunts (TIPSS)

Ibrahim Hassan - Assessing long term outcomes of Hepatocellular Carcinoma (HCC) at the Liver Transplant Unit over the last 20 years

David Orr - A Phase 3, Multicenter, Randomized, Double-Blind, Placebo-Controlled Study to Evaluate the Efficacy and Safety of Cenicriviroc for the Treatment of Liver Fibrosis in Adult Subjects with Nonalcoholic Steatohepatitis

David Orr - A Phase 3, Randomized, Double-Blind, Placebo-Controlled Study Evaluating the Safety and Efficacy of Selonsertib in Subjects with Nonalcoholic Steatohepatitis (NASH) and Bridging (F3) Fibrosis GS-US-384-1943

David Orr - A Phase 3, Randomized, Double-Blind, Placebo-Controlled Study Evaluating the Safety and Efficacy of Selonsertib in Subjects with Compensated Cirrhosis due to Nonalcoholic Steatohepatitis (NASH) GS-US-384-1944

David Orr - A randomized, patient and investigator blinded, placebo-controlled, multicenter study to assess the safety, tolerability, pharmacokinetics and efficacy of LMB763 in patients with non-alcoholic steatohepatitis (NASH)

Debi Prasad - Fatty liver / NAFLD (Non Alcoholic Fatty Liver Disease) carries increased risk of HCC (Hepato Cellular Carcinoma) in Chronic Hepatitis B patients

Mental Health (Adult):

Chris Bullen - An open-label randomised-controlled clinical trial to evaluate the effectiveness and safety of combining varenicline with bupropion or nicotine e-cigarettes on smoking abstinence in people with co-existing conditions

Gary Cheung - Socio-demographic and disease-related predictors of caregiver burden in dementia

Trish Du Villier - Dialectical Behaviour Therapy (DBT) groups for cancer patients

Ian Soosay – Audit of management of self-harm in primary care following discharge from ED

Inoka Wimalaratne - A cross-cultural comparison of general hospital specialists' attitudes toward management of psychological/psychiatric problems

Christine Winspear - Metabolic monitoring: a clinical audit and nurses perceptions of monitoring

Richard Worrall - Legal authorities for residents without the legal capacity to consent to care

Mental Health (Starship):

Joanna Appelby - Cross-sector information sharing in youth justice residences

Emily Cooney - Outcome evaluation of the Kari Centre Dialectical Behaviour Therapy Programme

Josephine Stanton - A qualitative study of experiences young people and families report of admission to an acute adolescent mental health inpatient unit

Hiran Thabrew - Acceptability and utility of electronic screener YouthCHAT for young people with long-term physical conditions attending Starship Hospital and Year 9 Tamaki high school students and its comparison with HEEADSSS assessment

Hiran Thabrew - Game for Health Level 2: Development of a Prototype eHealth Intervention to Treat Anxiety in Young People with Long-term Physical Conditions

Tanya Wright - E-screening and clinical decision support for depression in pregnant mothers

National Metabolic Service

Sarah Missen - The NZ Experience of Mitochondrial Disease: 2000-2015

National Women's Health – Fertility Plus, Gynaecological Oncology, High Risk Maternity, Midwifery, Obstetrics and Gynaecology:

Lois Eva - EXCISE – EXcisional treatment Comparison for In Situ Endocervical adenocarcinoma

Lois Eva - Trends in squamous cell carcinoma of the vulva

Lois Eva - Trends in the diagnosis of high grade cervical abnormailities in young women in the post vaccination era

Katie Groom - Antenatal corticosteroids prior to planned caesarean section (CS) delivery from 35+0 weeks gestation; a randomised controlled trial assessing the effects on newborn respiratory morbidity and glycaemic control – participant feasibility study

Diana Lennon - A Phase 3, Randomized, Observer-Blind, Placebo-Controlled, Group-Sequential Study to Determine the Immunogenicity and Safety of a Respiratory Syncytial Virus (RSV) F Nanoparticle Vaccine with Aluminium in Healthy Third-trimester Pregnant Women; and Safety and Efficacy of Maternally Transferred Antibodies in Preventing RSV Disease in their Infants

Michele Lomax - What is the experience for women requiring hospitalisation for an extended time in their pregnancy?

Chris McKinlay - Characteristics of newborns with prolonged hypoglycaemia

Lynn Sadler - A comparison of ethnicity data collections for mothers, and their newborns, who birthed at Auckland and Waitemata DHB maternity facilities

Peter Stone - The Effect of maternal sleep position in small for gestational age pregnancy

Ai Ling Tan - What are the patterns of referral and uptake of BRCA testing of eligible women with ovarian cancer in NZ?

Jeremy Tuohy - An assessment of antenatal corticosteroids in women with Diabetes in Pregnancy; Adherence to protocol, maternal and neonatal glycaemic control

Philippa Walker - Bowel resection rates in patients with ovarian cancer

Michelle Wise - Outpatient balloon induction of labour versus inpatient prostaglandins; a randomized controlled trial. OBLIGE

Neurology (Adult):

Peter Bergin - Open Label Extension Study to ZYN2-CL-03 to Assess the Long Term Safety and Efficacy of ZYN002 Administered as a Transdermal Gel to Patients with Partial Onset Seizures (STAR 2)

Benson Chen - Heidenhain variant of Creutzfeldt-Jakob Disease in the Auckland region: an audit of cases

Jennifer Pereira - Identification of BBB disrupting factors in serum of patients with relapsing remitting multiple sclerosis

Richard Roxburgh - The Motor Neurone Disease Patient Registry

Julia Slark - A retrospective study of patients who have died from stroke in ADHB in January 2016 - January 2017

Julia Slark - A study to identify key points in the pathway of stroke survivor's transfer to aged residential care or private hospital after first ever stroke

Cathy Stinear - A single-site observational study of the recovery of voluntary motor activity and somatosensory function after stroke

Caroline Woon - Oral hygiene in neuroscience nursing

Neurology (Starship):

Gina O'Grady - Genomic technologies for diagnosis and gene discovery in paediatric neurogenetic disease

Neurosurgery:

Abhinav Jain - Outcome analysis of all patients undergoing posterior fossa decompression for Chiari Malformation at Auckland City Hospital

Abhinav Jain - Outcome analysis of all patients undergoing resection of intracranial metastases from Renal Cell Carcinoma at Auckland City Hospital, 2003-2015

Abhinav Jain - Outcome analysis of all patients undergoing surgical resection of intraventricular tumours at Auckland City Hospital, 2003-2016

Abhinav Jain - Outcome analysis of all paediatric patients undergoing surgical treatment for brain Arteriovenous Malformation (AVM) at Auckland City Hospital, 2007-2016

Andrew Law - Creation of the Australasian Shunt registry

Edward Mee - NEWTON 2: Phase 3, Multicenter, Randomized, Double-Blind, Placebo-Controlled, Parallel-Group, Efficacy and Safety Study Comparing EG-1962 to Standard of Care Oral Nimodipine in Adults with Aneurysmal Subarachnoid Hemorrhage

Newborn:

Malcolm Battin - Preventing Adverse Outcomes of Neonatal Hypoxic Ischaemic Encephalopathy with Erythropoietin: A Phase III Randomised Placebo Controlled Multicentre Clinical Trial: PAEAN

Sarah Jane Bellhouse - An audit comparing before and after the use of radio-opaque contrast to check percutaneous intravascular central catheter tip location

Sarah Jane Bellhouse - Audit of feeding practices in an at-risk population in NICU to estimate the need for Donor Human Breast Milk

Anneke de Bie - The Meaning of Milk: opinions of mothers of preterm infants (<32wks gest.) and health professionals working with these infants regarding the milk that these infants receive

Jo Hegarty - Audit of hyperbilirubinemia monitoring in neonates

Toni Shepherd - Pilot of PAT 2.0 (Psychosocial Assessment Tool v.2) in the ACH NICU

Nursing:

Gillian Allen - In situ high fidelity simulation: Clinical Nurse Educators' perspectives

Stephanie Clark - Fever management: current nursing practices in a paediatric inpatient population

Maria Hermoso - Exploring the reasons and aspects of nursing care most commonly missed in nurses caring for cancer patients

Hollie McDonald - Supporting District Health Board managers to implement leadership skills

Erin Ward - Embedding organisational values: Evaluation of a pilot test of an educational intervention

Oncology (Adult):

Reuben Broom - A Randomized, Open-Label, Phase 3 Study of Abemaciclib combined with Standard Adjuvant Endocrine Therapy versus Standard Endocrine Therapy Alone in Patients with High Risk Early Stage Hormone Receptor Positive, Human Epidermal Receptor 2 Negative, Breast Cancer

Vinayak Dev - An investigation into the psychological predictors of physical functioning amongst chemotherapy patients

Sanjeev Deva - A Phase 1b/2, Open-label, Multicenter, Dose-escalation and Expansion Trial of Intratumoral SD-101 in Combination with Pembrolizumab in Patients With Metastatic Melanoma or Recurrent or Metastatic Head and Neck Squamous Cell Carcinoma

Sanjeev Deva - A Phase IIa Open-Label Trial to Investigate the Safety, Tolerability, Pharmacokinetics, Biological, and Clinical Activity of AGEN1884 in Combination with Pembrolizumab in Subjects

Anne Fraser - WINGS: why are indigenous people not getting surgery?

Nuala Helsby - An observational study to assess the ability of the thymine loading test to prospectively categorise patients with gastrointestinal or breast cancer who cannot tolerate fluoropyrimidine treatment (THYmine 2)

Orlaith Heron - Cervical Cancer in Auckland DHB- outcomes of primary definitive chemoradiation for FIGO IB1-IVA Cervical Cancer in the Auckland region 2003-2016

Carmel Jacobs - A Phase 3, Multinational, Randomised, open-label, Parallel-arm study of Avelumab (MSB0010718C) in Combination with Axitinib (INLYTA®) versus Sunitinib (SUTENT®) monotherapy in the first-line treatment of patients with Advanced Renal Cell Carcinoma

Michael Jameson - Outcomes of Patients Managed in New Zealand Blood and Cancer Centres

Louis Lao - A randomised phase 2 trial of nivolumab and stereotactic ablative body radiotherapy in advanced non-small cell lung cancer, progressing after first or second line chemotherapy

Michael Lee - Impact of formalised multidisciplinary meeting on referral rate for neoadjuvant chemotherapy and survival outcomes for muscle invasive bladder cancer: The Auckland Experience

Michael McCrystal - A Phase 3, Double-Blinded, Randomised, Placebo-Controlled Study of Atezolizumab Plus Cobimetinib and Vemurafenib Versus Placebo Plus Cobimetinib and Vemurafenib in BRAFV600 Mutation-Positive Patients with Unresectable Locally Advanced or Metastatic Melanoma

Angela Mweempwa - Audit of patients with clear cell carcinoma of the ovary in the Auckland region

Vikash Patel - Hypofractionated radiotherapy on locally advanced head and neck cancer

David Porter - A Randomized, Double-Blind, Phase III Study of Pembrolizumab (MK-3475) plus Chemotherapy vs Placebo plus Chemotherapy for Previously Untreated Locally Recurrent Inoperable or Metastatic Triple Negative Breast Cancer – (KEYNOTE-355)

Cristin Print - Blood biomarkers for patients with melanoma

Giuseppe Sasso - An international randomised phase II trial of Stereotactic Ablative Radiotherapy (SABR) for treatment of oligometastases to the lung (TROG 13.01 - SAFRON II)

Karen Spells - Patient satisfaction and medication adherence in a nurse led telephone follow up clinic for women taking adjuvant endocrine therapy for breast cancer

Rosalie Stephens - A Phase III, Open-Label, Multicenter, Two-Arm, Randomised study to Investigate the Efficacy and Safety of Cobimetinib Plus Atezolizumab versus Pembrolizumab in Patients with Previously Untreated Advanced BRAF Wild-Type Melanoma

Rosalie Stephens - Compliance with guidelines for BRCA testing in patients with epithelial ovarian, fallopian tube or peritoneal cancer: an audit of 2015 practice

Michelle Wilson - A Phase 1 Study of the Safety, Tolerability, and Pharmacokinetics of MGA012 in Patients with Advanced Solid Tumors

Michelle Wilson - A Phase II, Open-Label, Randomized, Multi-Centre Study, of Neoadjuvant Olaparib in Patients with Platinum Sensitive Recurrent High Grade Serous Ovarian/Primary Peritoneal or Fallopian tube Cancer (The NEO trial)

Michelle Wilson – 30-day mortality post systemic anti-cancer therapy in the Auckland region

Sheridan Wilson - The timeliness of HER2 FISH results on Auckland breast cancer samples

Sheridan Wilson - Use of pertuzumab in HER-2 positive metastatic breast cancer in Auckland District Health Board

Ophthalmology:

Jennifer Craig - Evaluating the impact of chalazia and their treatment on the meibomian glands

Jay Meyer - Prevalence and outcomes of retinal diseases treated at the Auckland District Health Board

Rachael Niederer - Endophthalmitis: retrospective review and ongoing monitoring for endophthalmitis outbreak

Hussain Patel - A retrospective review of Auckland DHB glaucoma patients

Keith Pine - The anatomical and physiological response of the anophthalmic socket to prosthetic eye wear over time

Oral Health:

Katie Bach - Oh to be able to open wide and smile: (Sub-study of Growing Up in New Zealand study)

Liam Moore - Intraoperative O-arm CT assessment of orbital reconstruction

ORL – Head and Neck Surgery:

Richard Douglas - An Exploratory Safety Study of 480 Biomedical Mometasone Furoate Sinus Drug Depot (MFSDD) in Adult Patients with Chronic Sinusitis

Richard Douglas - Effect of probiotic BLIS M18 on the post-radiotherapy oral microbiome

James Johnston - Lemierre's syndrome caused by Citrobacter freundii

Nick McIvor - Preoperative serum calcitonin as a predictor of tumour burden and guide to extent of surgery in Medullary Thyroid Cancer patients

Kevin Smith - Role of PET CT in the head and neck cancer pathway

David Vokes - Laryngeal injury and dysphagia after cardiac surgery

ORL (Starship):

Jeyanthi Kulasegarah - Bonebridge - a new transcutaneous bone conduction hearing device: our experience in children with atresia and microtia

Michel Neeff - The age and quantification of petrous apex pneumatisation in pediatric patients

Orthopaedics (Adult):

Matthew D'Arcy - Synovasure: an independent and local audit

Rushi Penumarthy - Incidence of forearm diaphyseal fracture in the South Auckland population. A study looking at differences from international 'normal' and ethnic differences

Mark Zhu - Wound closure and follow-up after TKA - do they affect the rate of antibiotic prescription?

Orthopaedics (Starship):

Matthew Boyle - Comparison of complication rates in treatment of severe SCFE - Modified Dunn osteotomy vs in situ pinning

Kong Koh Chuan- Comparing infection rate between proud and buried K-wire fixation for paediatric distal humerus supracondylar fractures

Haemish Crawford - Comparison of femoral neck growth after in situ pinning of slipped capital femoral epiphyses with partially threaded screws and fully threaded screws

John Ferguson - Clinical efficacy of bone dust harvested at the time of orthopaedic spinal surgery

Andrew Irving - The effect of wrist arthrodesis on quality of life in patients with Cerebral Palsy

Jenna Salmons - A feasibility assessment of a study protocol measuring the H reflex and muscle strength in children with spastic diplegic cerebral palsy following Chiropractic spinal manipulation

Otis Shirley - Magnetically controlled growing rods in early onset scoliosis

Susan Stott - Pedobarography in pre-operative assessment in children with foot and ankle deformities secondary to cerebral palsy and other paediatric neuromuscular conditions

Nichola Wilson - Comparison of management of paediatric medial epicondyle fractures in Auckland to a multicentre audit in the UK

Paediatrics:

Donna Cormack - Transforming research into child health equity: a 21st Century approach

Phillipa Walker - Time from referral to diagnosis of ASD - audit

Paediatric Intensive Care Unit:

Anusha Ganeshalingham - Influence of late term (39-40 weeks) gestational age on outcomes in neonates admitted to paediatric intensive care units in Australia and New Zealand

Anusha Ganeshalingham - Prevalence, severity and outcomes of severe infections in critically ill children in Australia and New Zealand in the Era of Sepsis-3 : An Observational Study of the Australian and New Zealand Paediatric Intensive Care Registry

Anusha Ganeshalingham - The importance of mean arterial blood pressure in the development of brain injury during cardiopulmonary bypass surgery

Anusha Ganeshalingham - Testing the Accuracy of a Malignant Pertussis Prediction Model

Jacqueline Hannam - An audit and simulation study of current compliance with antibiotic dosing protocols at Starship Children's Hospital

Pain Service

Gwyn Lewis - Who is attending our chronic pain clinics?

Palliative Care (Adult):

Aileen Collier - Exploring motivations for, and experiences of, Advance Care Planning: a qualitative study

Leslie Johney - Measuring a Good Death: validation of a tool for retrospectively measuring quality of death

Mandy Parris-Piper - To explore the challenges faced by medical interpreters and clinicians working with interpreters in the palliative care settings within the Auckland region

Physiology

Kevin Ellyett - Incidence of flow limitation during exercise in healthy adolescent males and its association with perceived dyspnoea on exertion

Hanna Fontinha - Maternal physiological responses to position change during and after pregnancy

Public Health:

Hilary McCluskey - Enhancing collaboration to improve population and individual health outcomes: How do Primary Care and Public Health Practitioners, working with children, collaborate at practice level?

Radiology (Adult):

Rohana Gillies - Measuring the Trochlear Groove- Tibial Tubercle distance (TTTG): A simplified method

Andrew Holden - A 3:1 Randomized Trial Comparing the Boston Scientific RANGER TM Paclitaxel Coated Balloon vs Standard Balloon Angioplasty for the Treatment of Superficial Femoral Arteries (SFA) and Proximal Popliteal Arteries (PPA)

Andrew Holden - EMBO-FIH: Evaluation of a Shape Memory Polymer Foam Embolization Device – A Prospective Multicenter Safety Study

Andrew Holden - Iliac Branch Excluder ReGistry (IceBERG 2): Multi-centre, observational, post-market, real world registry to assess outcomes of patients treated with the Gore® EXCLUDER® ILIAC BRANCH endoprothesis

Andrew Holden - Randomized Study of IN.PACTTM AV Access Paclitaxel-Coated Percutaneous Transluminal Angioplasty (PTA) Balloon vs. Standard PTA for the Treatment of Obstructive Lesions in the Native Arteriovenous Dialysis Fistulae (AVF) (IN.PACTTM AV Access Study)

Andrew Holden - Tack Optimized Balloon Angioplasty Study for the Below The Knee Arteries (TOBA II - BTK)

Andrew Holden - XPEDITE: PaclitaXel-coated Peripherall StEnts useD Iin the Treatment of FemoropoplitEal Stenoses

Jing Li Liu - Intracranial Vertebral Aneurysm Dissection: Management and Outcomes

Reablement Services:

Margaret Dudley - Kaumatuatanga o Te Roro: A Maori approach to the diagnosis and management of dementia

Melissa Evans - Stroke interventions provided by community rehabilitation teams in Auckland

Claire Grey - Power of Push On? A review of wheelchair provision for Motor Neuron Disease (MND) clients within the Auckland DHB wheelchair service

Sean Mathieson - Modernisation of the ACC Non-Acute Rehabilitation service delivery: Case Mix

Peter Sandiford - A Randomised Controlled Trial of the effectiveness of the Reablement from Stroke Obtained via a Rehabilitation and Employment Service (RESTORES) Initiative

Cathy Stinear - Gait retraining in stroke rehabilitation: feasibility of the Re-Link Trainer in acute rehabilitation

Claire Valentine - A retrospective clinical audit of post-stroke mobility and gait retraining on Rangitoto Ward. Is this in line with best practice?

Claire Valentine - A retrospective clinical audit on the incidence and management of post stroke shoulder pain and shoulder subluxation on Rangitoto Ward. Is this is line with best practice?

Renal Services (Adult):

Michael Collins - A Phase 1, Open Label, Single Dose, Parallel Group Study to Evaluate the Pharmacokinetics, Safety and Tolerability of MEDI0382 in Subjects with Renal Impairment

Michael Collins - A Single-dose, Open-label, Parallel-group Study to Assess the Pharmacokinetics of Inclisiran in Subjects with Renal Impairment Compared to Subjects with Normal Renal Function (ORION-7)

Michael Collins - CL010-168 A Randomized, Double-Blind, Placebo-Controlled, Phase 3 Study to Evaluate the Safety and Efficacy of CCX168 (Avacopan) in Patients with Anti-Neutrophil Cytoplasmic Antibody (ANCA)-Associated Vasculitis Treated Concomitantly With Rituximab or Cyclophosphamide/Azathioprinel

Michael Collins - The BEST-Fluids study: Better Evidence for Selecting Transplant Fluids

Elizabeth Curry - Retrospective analysis of the management of renal stone patients within the Auckland District Health Board

Natasha Houghton - Influenza A vaccination rates in the renal transplant population at Auckland City Hospital

Helen Pilmore - Distribution of referrals to ADHB Inpatient Renal Service: 2016

Ashwin Rajan - Rate of seroconversion after routine Hepatitis B vaccination in nonimmune Auckland DHB dialysis patients and rate of loss of immunity in previously immune patients

David Semple - Audit of Home Haemodialysis Patient Admission Rates at ADHB

David Semple - Patient mortality after cessation of home haemodialysis to centre Haemodialysis (technique failure)

Tina Sun - Proposed review of the New Zealand experience with donation after circulatory death (DCD) kidney transplantation 2008 – 2016

Renal Services (Starship):

Jodi Bingley - Addressing disparities in Pediatric Kidney Transplantation: The New Zealand families' perspective

Respiratory Services (Adult):

William Good - Acute lung injury in lung transplantation and the role of generic tacrolimus - a New Zealand perspective

Dominica Horton - A review of access to physiotherapy for Maori and Pacific Island patients with respiratory failure secondary to end stage neuromuscular disease

Sandra Hotu - Pilot Study: Self-management (knowledge), and behaviour during acute exacerbations of chronic airways disease

John Kolbe - Lung Clearance Index: Validating measures of airway dysfunction

Mark O'Carroll - New and effective method for the treatment of cystic fibrosis using nanotechnology

Respiratory (Starship):

Cass Byrnes - LOTUS: long-term follow-up improves clinical care and respiratory outcomes for Indigenous children

Cass Byrnes - Young people's day to day life experience living with bronchiectasis. What matters most?

Rochelle Moss - How does the current transition process of youth with chronic lung disease to adult services impact on health outcomes?

Rheumatology (Adult):

Nicola Dalbeth - Denosumab In Addition To Intense Urate-Lowering Therapy For Bone Erosions In Gout: A Pilot Study

Nicola Dalbeth - Evaluating the health economic impact of ankylosing spondylitis in New Zealand

Alina Krasnoryadtseva - Making information about gout and its treatment more understandable to patients with gout

Trish Morpeth - Development of a patient-reported assessment measure for footwear experience in women with rheumatoid arthritis

Ravi Suppiah - A Randomized, Double-blind, Placebo- and Active-controlled, Multicenter, Phase 3 Study to Assess the Efficacy and Safety of Filgotinib Administered for 52 Weeks in Combination with Methotrexate

Surgery (Adult):

Ian Bissett - A prospective study of the incidence of and risk factors for development of Low Anterior Resection Syndrome in a New Zealand tertiary hospital setting

Ian Bissett - Auckland Rectopexy Mesh Audit (ARMA)

Ian Bissett - International multicentre cohort study for the validation of CLASSIC – Classification of Intraoperative Complications

Ian Bissett - In vivo characterisation of electrical activity in the human intestine using high-resolution electrical mapping

Ian Bissett - The role of health literacy in health outcomes and quality of life in diverticular disease

Hannah Collins - Routine liver biopsy in bariatric surgery: retrospective audit of safety and utility

Andrew Hill - Weight loss outcomes following publicly-funded bariatric surgery in New Zealand - A retrospective review of the years 2010-2014

Alexandra Jacobson - Magnetic tracer versus standard technique for sentinel node biopsy: application of Sentimag at Auckland City Hospital

Jun Lu - Investigation of changes in liver and pancreatic fat after bariatric surgery in relation to diabetes remission and ethnicity

Gregory O'Grady - High-resolution recordings of evoked transsaccral sphincter potentials via magnetic stimulation

Sanjay Pandanaboyana - Spectroscopic assessment of the adequacy of pancreatic perfusion at transection margin before and after Whipples pancreatoduodenectomy: a prospective pilot study

Keith Petrie - The use of a visualisation intervention to improve exercise during recovery from colorectal cancer surgery. ERAS study

Tamasin Taylor - A qualitative exploration of factors affecting preoperative attrition in Pacific clients who are eligible for publically funded bariatric surgery from the perspective of health professionals

Surgery (Starship):

Jenni Perrin - Appendicetomy in children under 3 years of age

Jenni Perrin - Bilateral Wilm's Tumour: comparison of treatments and outcomes

Jenni Perrin - 10 years of paediatric laparoscopic appendicetomy using hook diathermy

Heath Wilms - Value of basic investigations for partially treated appendicitis in paediatric patients

Te Puaruruhau

Patrick Kelly - Health professionals understanding of the Child Protection Alert system: an online survey

Trauma Service

Hannah Collins - Patient attitudes to trauma-related radiation exposure in a public hospital setting

Urology:

Andrew Wilson - Developing a Diagnostic and Prognostic Test for Prostate Cancer Using RNA Biomarkers

Vascular Service

Andrew Hill - A prospective, multi-centre, controlled clinical evaluation of the use of a bioresorbable drug eluting stent (Absorb, Abbott Vascular) in the arterial vasculature below the knee – ABSORB BTK Study

Andrew Hill - Investigation of Femoropopliteal In Situ Valve Formation with the InterVene System (INFINITE-OUS)

PUBLICATIONS

Abnousi, F., Sundaram, V., Yong, C.M., Prats, J., Deliargyris, E.N., Stone, G.W., Hamm, C.W., Steg, P.G., Gibson, C.M., White, H.D., Price, M.J., Généreux, P., Desai, M., Yang, L., Ding, V.Y., Harrington, R.A., Bhatt, D.L., Mahaffey, K.W. (2017). Cangrelor reduces the risk of ischemic complications in patients with single-vessel and multi-vessel disease undergoing percutaneous coronary intervention: Insights from the CHAMPION PHOENIX trial. American Heart Journal, 188, pp. 147- 155.

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Having an excellent programme of research distinguishes great hospitals. Auckland District Health Board – Auckland DHB- is the largest tertiary care centre and the largest clinical research facility in New Zealand. Our research portfolio comprises over 1400 projects and our doctors, nurses, allied health professionals and scientists engage in research that attracts funding, participation and peer esteem both from New Zealand and internationally.

Auckland DHB's hospitals are teaching hospitals and ADHB partners with the University of Auckland in an Academic Health Alliance. Its goals, to deliver research-informed healthcare alongside clinical teaching and training, will fast-track translation of research findings from "bench to bedside", and onwards to communities and families.

Auckland DHB provides a first-class setting for research across the health spectrum. We serve a diverse population (with rapidly expanding migrant population) of over 478,000 as the local provider, and over 1.3 million as regional provider of specialist health services. Acute services are provided together under one roof so researchers can access participants under the care of skilled multidisciplinary teams of specialists with specialist equipment. Auckland DHB's accredited laboratory facility, LabPlus, provides a range of on-site laboratory services for clinical research, including diagnostic and genetic analysis, storage, disposal and shipping to central laboratories worldwide.

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Auckland DHB is committed to preserving our status as a centre of clinical excellence by fostering our involvement in research activity, critiquing health care approaches and investigating new initiatives. We celebrate our contribution to health through research with our annual Auckland DHB Research Excellence Award, Best Research Posters and now the best summer students' reports. Within the diversity, integral to all Auckland DHB research is a desire by our committed staff to build a strong evidence base for our clinical, community and policy work, and ultimately, the good health and well-being of our patients.

This was the Auckland DHB Annual Research Report for 2017.

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Research

Annual Report 2017

Welcome *Haere Mai* | Respect *Manaaki* | Together *Tūhono* | Aim High *Angamua*

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Resolution to exclude the public from the meeting

Recommendation

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

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
1. Apologies		
2. Register of Interest 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 26 September 2018	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3.1 Circulated Resolution – 2018/2019 Auckland DHB Annual Plan	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	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]
3.2 Circulated Resolution – 2017/2018 Auckland DHB Annual Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	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	**Commercial Activities** Information contained in this report is related to commercial activities and	That the public conduct of the whole or the relevant part of the meeting would

Points	Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	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]
4.1 RMO's –Schedule 10	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.1 Risk Management – Board Update	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time [Official Information Act 1982 s9(2)(k)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.1 Chief Executives Confidential Report	**Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)] **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time [Official Information Act 1982 s9(2)(k)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.1 Human Resources Report	**Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section

		9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.1 Finance, Risk and Assurance Committee	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.2 Hospital Advisory Committee	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.1 NRLTIP Governance and Oversight Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	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]
9.2 Regional Information Systems Strategic Plan Update and Proposed Information Systems Governance Arrangements	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.3 Auckland DHB PHO Policy	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]	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]
10.1 Remuneration – Deep	**Commercial Activities** Information contained in this report is related to commercial activities and	That the public conduct of the whole or the relevant part of the meeting would

Dive	Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]	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]