

Hospital Advisory Committee Meeting

Wednesday, 16 October 2019

1.30pm

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

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Published 10 October 2019

Agenda

Hospital Advisory Committee

16 October 2019

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

Time: 1.30pm

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

Please note that agenda times are estimates only

- 1.30pm **1. Attendance and Apologies**
Members:
Senior Staff: Joanne Gibbs, Barry Snow, Michael Stewart, Mark O'Carroll
- 2. Register and Conflicts of Interest**
Does any member have an interest they have not previously disclosed?
Does any member have an interest that may give rise to a conflict of interest with a matter on the agenda?
- 1.35pm **3. Confirmation of Minutes 04 September 2019**
- 4. Action Points**
- 1:40pm **5. PERFORMANCE REPORTS**
5.1 Provider Arm Operational Performance – Executive Summary
5.2 Provider Arm Scorecard
5.3 Adult Medical Directorate
5.4 Child Health Directorate
5.5 Commercial Services
5.6 Community Long Term Conditions Directorate
5.7 Māori Health Services
5.8 Mental Health and Addictions Directorate
5.9 Patient Management Services
5.10 Provider Arm Financial Performance Report
- 2.25pm **6. RESOLUTION TO EXCLUDE THE PUBLIC**

Next Meeting: Wednesday, 27 November 2019 at 1.30pm A+ Trust Room, Clinical Education Centre Level 5, Auckland City Hospital, Grafton
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Attendance at Hospital Advisory Committee Meetings

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

Conflicts of Interest Quick Reference Guide

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

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

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

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

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

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

IMPORTANT

If in doubt – declare.

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

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

Register of Interests – Hospital Advisory Committee

Member	Interest	Latest Disclosure
Jo AGNEW	Professional Teaching Fellow – School of Nursing, Auckland University Casual Staff Nurse – Auckland District Health Board Director/Shareholder 99% of GJ Agnew & Assoc. LTD Trustee - Agnew Family Trust Shareholder – Karma Management NZ Ltd (non-Director, majority shareholder) Member – New Zealand Nurses Organization [NZNO] Member – Tertiary Education Union [TEU]	30.07.2019
Michelle ATKINSON	Director – Stripey Limited Trustee – Starship Foundation Contracting in the sector Contracting Role – Shea Pita and Associates Chargenet, Director & CEO – Steve West - Partner	10.06.2019
Doug ARMSTRONG	Shareholder - Fisher and Paykel Healthcare Shareholder - Ryman Healthcare Shareholder – Orion Healthcare Trustee – Woolf Fisher Trust Trustee- Sir Woolf Fisher Charitable Trust Daughter – Partner Russell McVeagh Lawyers Member – Trans-Tasman Occupations Tribunal	18.09.2018
Judith BASSETT	Shareholder - Fisher and Paykel Healthcare Shareholder - Westpac Banking Corporation Husband - shareholder of Westpac Banking Corporation	29.03.2019
Lee MATHIAS	Chair – Medicines New Zealand Director/shareholder - Pictor Limited Director Pictor Diagnostics India Private Limited Director - Lee Mathias Limited Director - John Seabrook Holdings Limited Trustee - Lee Mathias Family Trust Trustee - Awamoana Family Trust Trustee - Mathias Martin Family Trust Member – New Zealand National Party Chair – Collective Hospitality Limited Shareholder/Director – Project XYZ Ltd	12.08.2019
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 – Manaiaikalani 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	30.09.2019

	Director – Ports of Auckland Ltd Board Member – Counties Manukau DHB Chair – Counties Manukau Audit, Risk and Finance Committee Board Member – Kainga Ora – Homes and Communities Board	
Gwen TEPANIA-PALMER	Board Member - Health Quality and Safety Commission Chair - Ngati Hine Health Trust Life member – National Council of Maori Nurses Director - Hauora Whanui Limited Alumnus – Massey University Member – Lottery Waikato Community Committee Member – Board of Fire and Emergency New Zealand	12.09.2019



Minutes Hospital Advisory Committee Meeting 04 September 2019

Minutes of the Hospital Advisory Committee meeting held on Wednesday, 04 September 2019 in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton commencing at 1:30pm

<p>Committee Members Present Judith Bassett (Chair) Jo Agnew Michelle Atkinson (Deputy Chair) Doug Armstrong Dr Lee Mathias Gwen Tepania-Palmer (Deputy Board Chair)</p>	<p>Auckland DHB Executive Leadership Present Ailsa Claire Chief Executive Officer Margaret Dotchin Chief Nursing Officer Joanne Gibbs Director Provider Services Chris Hutton Acting Chief People Officer Meg Poutasi Chief of Strategy, Participation and Improvement Sue Waters Chief Health Professions Officer</p> <p>Auckland DHB Senior Staff Present Duncan Bliss General Manager Surgical and Perioperative Services Jo Brown Funding and Development Manager Hospitals Ian Costello Director of Clinical Support Services Kimmo Karsikas-Genet Personal Assistant Bruce Levi General Manager of Pacific Health Services Deirdre Maxwell General Manager for Cancer and Blood Mr Arend Merrie Director Surgical Services Dr Michael Stewart Director Cardiovascular Marlene Skelton Committee Secretary Dr Robert Sherwin Director Women's Health</p> <p>(Other staff members who attend for a particular item are named at the start of the respective minute)</p>
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1. APOLOGIES

That the apology of the Board Chair, Pat Snedden be received.

That the apologies of Executive Leadership Team members Shayne Tong Chief Digital Officer, Rosalie Percival, Chief Financial Officer and Dr Margaret Wilsher, Chief Medical Officer be received.

That the apologies of senior staff Suzanne Corcoran, Director Participation and Insight, Barry Snow Director Adult Medical and Richard Sullivan, Director Cancer and Blood and Deputy Chief Medical Officer 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 24 JULY 2019 (Pages 8 - 45)

Resolution: Moved Jo Agnew / Seconded Lee Mathias

That the minutes of the Hospital Advisory Committee held on 24 July 2019 be approved.

Carried

4. ACTION POINTS (Pages 46)

All actions were either complete or in progress.

5. PERFORMANCE REPORTS (Pages 47 - 131)

5.1 Provider Arm Operational Performance – Executive Summary (Pages 47 - 49)

[Secretarial Note: Items 5.1 and 5.2 were considered as one item]

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

- The winter pressures on the hospitals continue and the Adult and Children Emergency Departments have had another very busy month due to high patient numbers which is also indicated on the Scorecard.
- The new Office Suite has been opened and staff are moving in this week. This will vacate the old admin suite for the build of the Integrated Stroke Unit.

Resolution: Moved Judith Bassett / Seconded Gwen Tepania-Palmer

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

Carried

5.2 Provider Arm Scorecard (Pages 50 - 52)

See above.

5.3 Cancer and Blood Directorate (Pages 53 - 62)

Deirdre Maxwell, General Manager asked that the report be taken as read highlighting the following points:

- There is a continued increase in demand for service particularly within Radiation Oncology.
- Focus remains on the Local Delivery of Oncology with the next extension being on breast cancer chemotherapy.

The following points were covered in the discussion:

- It was advised that the Auckland DHB is paying approximately \$0.5M for matched unrelated donor fees and this money generally goes outside of New Zealand.
- Dr Lee Mathias wanted to know if there had been any feedback on the New Zealand

Cancer Action Plan 2019-2029. Deirdre Maxwell advised that the feedback received had been cautiously optimistic and that there is a sense that the plan covers the right areas although not a lot of detail had been released as yet.

- Gwen Tepania-Palmer was advised that a successful recruitment process had been run for the radiation therapy service allowing recruitment of staff to run 2 additional late shifts to bring the wait list down. The first shift would commence on 6 January 2020 and the second one month later. The applicants were generally from overseas.
- Judith Bassett commented that the Greenbelt Faster Cancer Treatment project had successfully provided a dramatic reduction in DNA for Maori and Pacific, from 30% to 15% and asked how that had been achieved. Deirdre Maxwell and Jo Gibbs advised that it was as a consequence of the Psychosocial Support team telephoning patients, explaining why they needed to attend a particular appointment and providing support. It was not simply a transactional telephone call, but much more personal than that.

5.4 Cardiovascular Directorate (Pages 63 - 72)

Dr Michael Stewart, Director of Cardiovascular asked that the report be taken as read, highlighting the following points:

- A lot of work has been done across the Directorate to try and improve equity and access with one recent example including a team of medical and nursing staff taking service to a community environment to ensure important diagnostic tests were offered to families close to their home.
- The Electrophysiology lab build commences 12th August which will improve the quality of clinical environment for the patients.

The following points were covered in the discussion:

- Judith Bassett commented on how important it is to identify gaps in the Service to ensure more effective coverage, as well as improve access to care and health outcomes.
- Gwen Tepania-Palmer commended the efforts taken to ensure services are taken to communities for patient groups that would significantly benefit from this.

5.5 Clinical Support Services (Pages 73 - 81)

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

- The performance against the MRI target has improved despite the shortage of technicians and continues on a trajectory for recovery.
- New hazardous substances regulations have prompted an audit to be undertaken across LabPlus and Anatomical Pathology. Corrective action plans have been developed and the progress will be monitored through the Directorate's Health and Safety Governance Committee. A full report will be provided to the next Hospital Advisory Committee meeting.

The following points were covered in the discussion:

- Michelle Atkinson felt that the recent health and safety site visit provided a significant briefing on hazardous substances providing a lot of new information which should be more widely disseminated. She herself learnt a lot from the session. Sue Waters undertook to ensure that all related material would be published in the Boardbooks resource library.
- Gwen Tepania-Palmer asked if there were any other concerns to be highlighted. Ian Costello replied that the MIT shortage is a major risk area, as well as managing the increasing demand, increasing acuity and urgency of imaging.

Action:

The Hazardous Substances site visit material and documents be published in the Boardbooks resource library.

5.6 Perioperative Services Directorate (Pages 82 - 90)

Duncan Bliss, General Manager Surgical and Perioperative Services asked the report be taken as read, highlighted areas as follows:

- Perioperative Services celebrated its second Recognition Awards ceremony. There were 202 nominations across 12 categories. The Awards were started in response to the results of the previous Staff Engagement Survey as a way to celebrate and recognise the achievements and dedication of all Perioperative staff.
- There has been a very positive movement on the utilisation of the Greenlane Surgical Unit (GSU) from 68% to 75%.
- The second recruitment drive in the UK is showing good initial results with 20 offers being made.

There were no questions.

5.7 Pacific Health Services (Pages 91 - 97)

Pulotu Bruce Levi, General Manager of Pacific Health Services asked the report be taken as read, highlighting as follows:

- The Kapasa policy framework in engaging with Pacific people at all levels was being pursued.
- Delegates from Auckland and Waitemata District Health Board Pacific Directorate met representatives from the College of Health. This was a significant step followed by formalising an agreement with short, medium and long-term outputs and outcomes to advance Pacific educational and wellbeing interests.
- Inaugural symposium of Pacific Allied Health Association NZ was held in August to support the initiatives in lifting the numbers of Pacific peoples in Allied Health roles.

The following points were covered in the discussion:

- Judith Bassett commented that the material within the report showed that the service is working on all fronts and particularly around recruitment. A brief discussion ensued around what the right age was to engage with school pupils to raise an awareness of the health sector as an area that could be taken through to

tertiary level.

- Gwen Tepania-Palmer wanted to acknowledge the whole team for the concentrated effort and deep commitment to building relationships across the region and to building the required workforce pipelines.

5.8 Surgical Services Directorate (Pages 98 - 108)

Arend Merrie, Director Surgical Services asked that the report taken as read, highlighting as follows:

A retrospective look at the way the financial year ended, with a significant unfavourable financial variance; reveals that there was a clear under delivery of planned surgery and a significant impact felt from the strikes. A more optimistic position is held for this next financial year.

The following points were covered in the discussion:

- Judith Bassett commented on the progress that had been made at the Greenlane Surgical Unit (GSU). This is clearly a successful strategy and results are beginning to be seen. Arend Merrie agreed but commented that it had been hard work to get that 5% increase in utilisation in Greenlane Theatre use up to 75%. Local anaesthetic skin cases which were being done in the theatres are now done elsewhere freeing up critical theatre time.
- A brief conversation was had with Doug Armstrong around the divisor used to calculate the % of operating room utilisation with both Arend Merrie and Jo Gibbs advising that it was a complex calculation but that 6.5 hours per day Monday to Friday were offered for elective surgery at Geeenlane.

5.9 Women's Health Directorate (Pages 109 - 117)

Dr Robert Sherwin, Director Women's Health and Deborah Pittam, Director of Midwifery asked that the report to be taken as read, highlighting as follows:

- Successful recruitment of the General Manager role
- Fertility Services have been recertified
- Ward 96 has been reopened

There were no questions.

5.10 Provider Arm Financial Performance Report (Pages 118 - 131)

Joanne Gibbs asked that the report to be taken as read.

The following point was covered in the discussion:

- Attention was drawn to page 118 of the agenda and a question asked as to what "outsourced other" encompassed with information being provided that it could be other contracts held i.e. healthAlliance & the NRA.

Resolution: Moved Lee Mathias / Seconded Gwen Tepania-Palmer

That the Provider Arm performance reports for the month of August 2019 be received.

Carried

6. RESOLUTION TO EXCLUDE THE PUBLIC (Pages 132 - 135)

Resolution: Moved Michelle Atkinson / Seconded Gwen Tepania-Palmer

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:

Carried

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	N/A	N/A
2. Conflicts of Interest	As per that stated in the open agenda	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3. Confirmation of Confidential Minutes 24 July 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]
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 Workforce Strategy - Presentation – Cecilia Lynch(NRA)		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]
Change and Sustainability Programme – Verbal Update/ Presentation	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]
5.3 Directorate A3 Plans 2019/20 - Verbal Update	N/A	
6.1 Auckland Cardiology Electrophysiology Services Oversight 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)]s Prejudice to Health or Safety Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.2 Clinical Support Oversight Report – MRI Capacity	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 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	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]

	be prejudiced by publication at this time.	
6.3 Head and Neck Oversight Report	<p>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)]</p> <p>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.</p>	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.4 Perioperative Services – Shortage of Perioperative Workforce Oversight Report	<p>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)]</p> <p>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.</p>	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.5 Radiotherapy Workforce Oversight Report	<p>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)]</p> <p>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.</p>	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.6 Security for Safety	<p>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)]</p> <p>Prejudice to Health or Safety Information about measures</p>	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act

	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.	2000]
6.7 Women's Health – Midwifery Recruitment and Retention Oversight Report	Commercial Activities Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] Prejudice to Health or Safety Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.1 Clinical Quality and Safety Service Report	Commercial Activities Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] Prejudice to Health or Safety Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.2 Policies and Procedures (Controlled Document Management)	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]

The meeting closed at 3.42pm.

Signed as a true and correct record of the Hospital Advisory Committee meeting held on Wednesday, 04 September 2019

Chair: _____ Date: _____
Judith Bassett

Action Points from Previous Hospital Advisory Committee Meetings

As at Wednesday, 16 October 2019

Meeting and Item	Detail of Action	Designated to	Action by
13 Jun 2018 Item 5.11	Site Visits That a site visit for the Hospital Advisory Committee to view the improvements achieved from the co-location of Mental Health and Addictions and Community and Long Term Conditions teams at the Point Chevalier site be scheduled.	K Lalit, A Schofield	TBA in 2019 when build is complete
24 July 2019 Item 6.4	DNA's Children's Health to provide a progress report on DNAs by 27 th November 2019	John Beca/Michael Shepherd	27 November 2019
4 September 2019 Item 5.5	Hazardous Substances The Hazardous Substances site visit material and documents be published in the Boardbooks resource library	M Skelton	Completed

Provider Arm Operational Performance – Executive Summary

Recommendation

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

Prepared by: Joanne Gibbs (Director Provider Services)

Endorsed by: Ailsa Claire (Chief Executive)

Glossary

Acronym/term	Definition
ED	Emergency Department

1. Executive Summary

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

- The Adult and Children Emergency Departments (EDs) have had another very busy month due to high patient numbers, and are not meeting the 6 hour target.
- Workforce and recruitment issues continue to be a challenge in a number of specialty areas, notably Perioperative, Midwifery, Radiation Oncology (Medical Radiation Therapists) and Radiology (Medical Imaging Technicians).

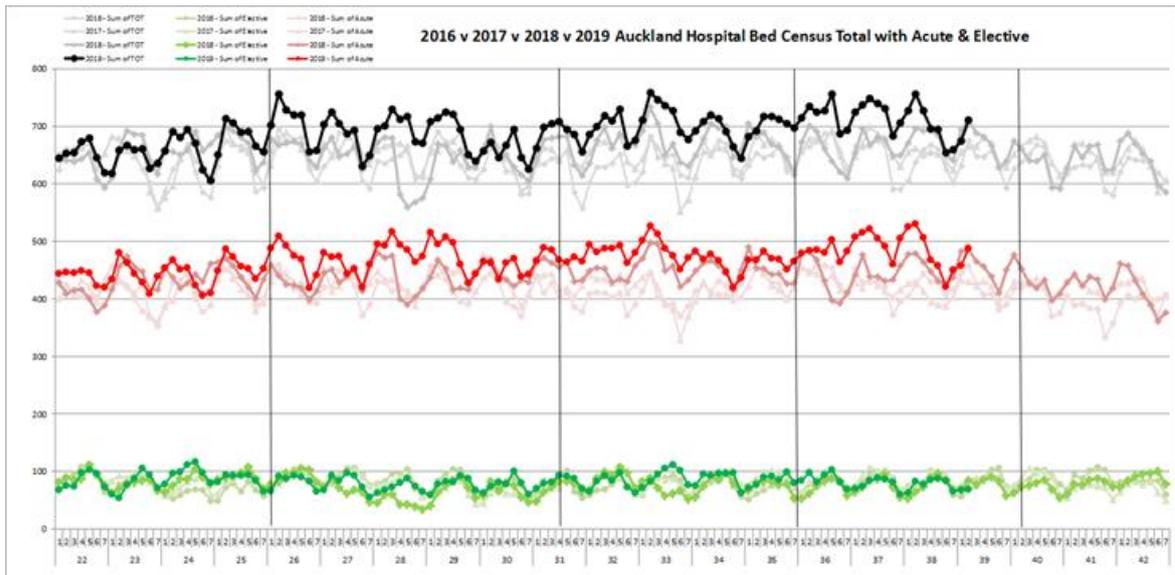
2. Progress/Achievements/Activity

- The target was not met by Adult and Children EDs during August 2019 (83.1% and 86.73% respectively). While ongoing work continues to improve whole of hospital function including ED, it is likely that this problem will persist given both patient numbers and available resources.
- The hospitals have continued to be extremely busy recently with a late surge in presentations for this time of year. The adult hospital has been at or near capacity most days throughout August and September 2019. Each month throughout winter new occupancy records have been broken. An incident management team was established through September to support clinical services for the day and actions were quickly implemented to enable patient flow throughout the hospital.

In order to manage patient flow and prevent cancellation of planned patients, flex capacity was opened earlier than planned and continues to remain open. Patient flow from the acute floor (Level 2) will have been impacted due to the high numbers of inpatients and the lack of available beds. A daily focus on hospital capacity is occurring and teams are working to ensure that patients are transferred to the most appropriate environment as soon as possible. Community services are available and have capacity to support patients closer to home.

Over 50 planned patients have had their procedures postponed as a result of high acute presentations in the last month – either due to a lack of bed capacity or to create theatre capacity for acute patients. However, the teams have worked hard to minimise the impact to

planned patients. This includes utilising Greenlane Clinical Centre operating rooms and beds where possible.



- Performance against the MRI target of 95% of referrals completed within six weeks has deteriorated in August 2019 to 65.3% (65.6% general and 58.8% for Cardiac MRI) compared to performance in July 2019 of 66%. The department currently has a significant number of Medical Imaging Therapist vacancies which is starting to significantly impact capacity. The majority of new recruits are recent graduates who require a further six months post-graduate training to be able to perform MRIs. Locum MIT's are being sought to support the increased demand.
- Work continues to respond to current budget pressures through eliminating unnecessary waste, making the best use of resources, and finding smarter ways to do the things that matter most.
- **Fix it Fast** - Employees were asked to submit small to medium problems that get in the way of effective work. All the ideas were triaged by a small Fix it Fast team. Over a four week period 78 suggestions were received ranging from help with printing to how we manage our chemotherapy prescriptions. Out of the ideas received 34 are closed; 17 of the suggestions had a successful implementation of the intended fix it fast suggestion, 8 are now in a work stream as a larger piece of work or had alternative fix it fast solutions agreed. 9 weren't able to be fixed for a number of reasons, this included work already planned to solve these in the future, unintended consequences or they needed significant investment to fix. The team is still working on the remaining 44 ideas.
- Progress continues in the three work streams focused on length of stay in hospital, elective surgery, and outpatients programme. This work is focused on identifying improvements to the service we provide for our patients that also benefit our financial position. Early outputs include:
 - **Length of stay in hospital:** The Clinical Decision Unit and Short Stay Inpatient Unit merger has been successful reducing handovers and improving patient experience. Sprints have been completed on improving the use of the Chronic Obstructive Pulmonary Disease pathway and improving access to the Rapid Community Access Team to allow a faster and safe discharge. The team are now looking at reducing length of stay for Uteroscopy patients.

- **Planned care (electives):** Removal of skin lesions has successfully moved into a procedure room. Other procedures are still being identified. Work is underway to allocate operating room capacity created by moving skin lesions to procedure rooms, to other services. The implementation of Medirota has been accelerated, with a view to have greater visibility of operating room allocation and availability. The next focus area is looking at how we increase available operating hours to eight hours for all operating rooms at Greenlane Surgical Unit.
- **Outpatients – pathways and equity:** Work is underway to look at better management of follow-up appointments in Cardiology, Vascular and Orthopaedics. This includes a review of overdue follow-ups and establishing options for follow ups to reduce unnecessary in-person appointments. These include patient-directed follow-ups, virtual appointments and telehealth. Other areas of work include establishing standard business rules and ways of working to manage referrals, including triage and use of Clinical Pathways. Negotiations are currently underway with external providers to manage the acute demand for access to MRI. Stakeholders are meeting in October 2019 to develop a medium to long-term approach. Work is also starting to look at better use of telephone interpreters.
- The tender process for the Ward 51 (Integrated Stroke Unit) is nearing completion, with final negotiations being undertaken with the preferred Main Contractor, including options to accelerate construction. Construction of the new office suite has been completed and staff have decanted from the future Ward 51 (ISU) build area. The Integrated Operations Centre (IOC) is expected to be handed over in early November 2019. Impact on the Ward 51 (ISU) opening date is being assessed and mitigation plans will be developed to address this impact.

Auckland DHB - Provider

HAC report for August 2019

5.2

Equitable - equity is measured and reported on using stratification of measures in other domains				
Safety				
Metric		Actual	Target	Previous
Number of reported incidents	PR083	1,648		1,644
Number of reported adverse events causing harm (SAC 1&2)	PR084	6	<=12	6
Central line associated bacteraemia rate per 1,000 central line days	PR087	0	<=1	0
Healthcare-associated Staphylococcus aureus bacteraemia per 1,000 bed days	PR088	0.3	<=0.25	0.31
Healthcare-associated bloodstream infections per 1,000 bed days - Adult	PR089	1.39	<=1.6	1.74
Healthcare-associated bloodstream infections per 1,000 bed days - Child	PR090	0.53	<=2.4	1.06
Falls with major harm per 1,000 bed days	PR095	0.03	<=0.09	0.03
Nosocomial pressure injury point prevalence (% of in-patients)	PR097	2.14%		3.41%
Rate of HO-CDI per 10,000 bed days (ACH)	* PR143	1.52	<=4	2.22
Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	PR185	2.73%		2.99%
% Hand hygiene compliance	PR195	84.15%	>=80%	85.02%
Unviewed/unsigned Histology/Cytology results >= 90 days	PR290	152	Lower	132
Patient-centred				
Metric		Actual	Target	Previous
% DNA rate for outpatient appointments - All Ethnicities	PR056	9.24%	<=9%	9.61%
% DNA rate for outpatient appointments - Māori	PR057	18.58%	<=9%	20.67%
% DNA rate for outpatient appointments - Pacific	PR058	18.38%	<=9%	20.3%
% Very good and excellent ratings for overall inpatient experience	# PR154	84.56%	>=90%	86.38%
Number of CBU Outliers - Adult	PR173	592	<=300	671
% Patients cared for in a mixed gender room at midday - Adult	PR175	26.48%	Lower	27.21%
Breastfeeding rate on discharge excluding NICU admissions	# PR099	77.47%	>=75%	75.68%
Discharge Transition Planning – Inpatient and Community	PR766	44.12%	>=95%	39.06%
% hospitalised smokers offered advice and support to quit	PR129	97.02%	>=95%	94.09%

Timeliness				
Metric		Actual	Target	Previous
(MOH-01) % AED patients with ED stay < 6 hours	PR013	83.1%	>=95%	83.66%
(MOH-01) % CED patients with ED stay < 6 hours	PR016	86.73%	>=95%	88%
% of inpatients on Reablement Services Wait List for 2 calendar days or less	PR023	89.14%	>=80%	91.12%
(ESPI-2) Patients waiting longer than 4 months for their FSA	PR038	0.19%	Lower	0.71%
(ESPI-5) Patients given a commitment to treatment but not treated within 4 months	PR039	8.05%	Lower	8.67%
Cardiac bypass surgery waiting list	PR042	68	<=115	61
% Accepted referrals for elective coronary angiography treated within 3 months	PR043	98.7%	>=90%	100%
% Urgent diagnostic colonoscopy compliance	PR044	100%	>=90%	100%
% Non-urgent diagnostic colonoscopy compliance	PR045	54.4%	>=70%	47.77%
% Outpatients and community referred MRI completed < 6 weeks	PR046	65.29%	>=95%	65.97%
% Outpatients and community referred CT completed < 6 weeks	PR047	85.35%	>=95%	87.93%
31/62 day target - % of non-surgical patients seen within the 62 day target	PR181	92.86%	>=90%	93.75%
31/62 day target - % of surgical patients seen within the 62 day target	PR182	98.31%	>=90%	97.87%
62 day target - % of patients treated within the 62 day target	PR184	95.65%	>=90%	95.79%
% Chemotherapy patients (Med Onc and Haem) attending FSA within 2 weeks of referral	PR508	76.05%	100%	73.26%
% Radiation oncology patients attending FSA within 2 weeks of referral	PR509	45.31%	100%	42.19%
Effectiveness				
Metric		Actual	Target	Previous
28 Day Readmission Rate - Total	# PR078	11.11%	<=6%	11.41%
Mental Health - 28 Day Readmission Rate (KPI Discharges) to Te Whetū Tāwera	PR119	5.63%	<=10%	14.58%
Efficiency				
Metric		Actual	Target	Previous
HT2 Elective discharges cumulative variance from target	PR035	0.94	>=1	0.96
Elective day of surgery admission (DOSA) rate	PR048	68.55%	>=68%	72.38%
% Day Surgery Rate	PR052	51.93%	>=70%	46.79%
Inhouse Elective WIES through theatre - per day	PR053	127.52	>=99	120.36
Average LOS for WIES funded discharges (days)	PR074	2.68	<=3	2.93
Mental Health Average LOS (KPI Discharges) - Te Whetū Tāwera	PR120	28.5	<=21	32.4

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

Amber	Variance from target not significant enough to report as non-compliant. This includes percentages/rates within 1% of target, or volumes within 1 value from target.
#	Actual is the latest available result prior to August 2019
*	Quarterly

PR143 (Quarterly)

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

Adult Medical Directorate

Speaker: Barry Snow, Director

Service Overview

The Adult Medical Directorate is responsible for the provision of emergency care, medical services and sub specialties for the adult population. Services comprise: Adult Emergency Department, Short Stay Inpatient, Clinical Decision Unit, Department of Critical Care Medicine, General Medicine, Infectious Diseases, Gastroenterology, Respiratory, Neurology and Renal.

The Adult Medical Directorate is led by:

Director:	Barry Snow
General Manager:	Dee Hackett
Director of Nursing:	Brenda McKay
Director of Allied Health:	Cheryl Orange

Directorate Priorities for 2019/20

In 2019/20 our Directorate will contribute to the delivery of the six Provider Arm work programmes. In addition to this we will also focus on the following Directorate priorities:

1. Ensuring that our services are equitable and fair to all
2. Ensuring our staff are well trained and supported to work at the top of their scope and enabled to do their life's best work
3. Developing innovative models of care to improve how we manage patients
4. Delivering care in functional and up to date facilities
5. To effectively manage risk across the directorate
6. Effectively managing our resources and ensuring we are able to sustain the directorate income.

Adult Medical Services

A3 owner: Dr Barry Snow, Director

Te Toka Tumai Provider Directorate Plan 2019/20

Date: June 2019



Ngā whāinga : Our priorities	Kei hea tātou ināianei? Where are we now?	Ki hea te tihi o te hiahia? Where do we want to be?
1 – Equity. Ensuring that our services are equitable and fair to all	<ul style="list-style-type: none"> Large disparities in Did Not Attend (DNA) rates for our Māori and Pacific patients Models of care that don't provide for (or attract or appeal to) Māori and Pacific College of Emergency Medicine consultation on Manaaki Mana Facilities that form a block to access (e.g. dialysis units far removed from patients' place of residence) Low numbers of Māori health care workers 	<ul style="list-style-type: none"> A focused programme of work across the directorate dedicated to understanding and subsequently increasing Māori and Pacific First Specialist Assessments and follow-ups (face to face or virtual) Dialysis units closer to the clients home and community Representative numbers of Māori and Pacific health care workers Active participation in the Māori model of care review Meet KPIs for: Stroke, FCT and Bowel Screening Self-directed Care, Goals of Care, Advanced Care Plans
2 – People. Ensuring our staff are well trained and supported to work at the top of their scope and enabled to do their life's best work	<ul style="list-style-type: none"> Each service implementing action plans developed post employee engagement survey Development of extended skills for the workforce Exploring new roles to support care delivery People Strategy Multi-Employer Collective Agreement requirements to address fatigue 	<ul style="list-style-type: none"> Supported staff who are able to perform at their highest level and feel empowered and supported Trial and evaluation of new roles such as Ward Housekeepers across medical wards Senior Medical Officer (SMO) rosters take into account the effect of overnight sleep disruption Implementation of 'Just Culture' Supporting the Nurse Endoscopist to continue to deliver and develop their skills. Lists would be made available Implementation of a Wellness Committee to improve health for staff Effective systems and processes in place to identify, capture and respond to risk and safety issues
3 – How we work and care. Developing innovative models of care to improve how we manage patients	<ul style="list-style-type: none"> General Medicine regularly exceeds its capacity causing inefficiencies in the model of care Developing care pathway approach for renal and stroke patients Nursing resource often does not match demand Patients do not have control of their care and often are unable to determine the care they want and need The Sleep Service is fragmented and inefficient Adult Emergency Department (ED) struggles to maintain flow Review of intensive Care Unit strategy in DCCM 	<ul style="list-style-type: none"> Develop new model of care for General Medicine with increased bed capacity Increased number of patients dialysing independently The number of patients having a partial sleep study has increased and there is a robust criteria for a full sleep study implemented Adult ED will have a POD system with a RAATS model of care which is staffed to ensure patient flow Developed model of care for patients requiring Mental Health care presenting to Adult ED Implementation of DCCM strategy Development and implementation of family violence screening in Adult ED
4 – Physical estate/fit for purpose. Delivering care in functional and up to date facilities	<ul style="list-style-type: none"> Developing new community renal unit in Tamaki Designing new capacity for rehabilitation and integrated stroke care (ARISU) Refurbishing run down areas on level 2 and Neurophysiology Development of home haemodialysis house at Carrington site Re provision of endoscopy capacity, which is currently occupying space at GCC marked for new surgical theatres 	<ul style="list-style-type: none"> Renal community build delivered L2 facilities refurbished and changed to support delivery of new models of care and also to adapt current spaces including specific space for Mental Health Delivered ARISU - fully functional Neuro day stay adhere to hand hygiene guidance fully Delivery of home haemodialysis house Re provided endoscopy capacity at GCC
5 – Managing Risk. To effectively manage risk across the directorate	<ul style="list-style-type: none"> All service have been undergoing intensive education to deliver service risk registers Risk registers need more maturity Mitigation for risk not adequately managed or reported on Data from incidents not used to predict risk factors in clinical environments 	<ul style="list-style-type: none"> Each service has a robust risk register Directorate Risk Register accurately reflects the Service registers, and severe risks escalated to corporate Robust mechanism for measuring mitigations to effectively manage the risk Monthly review of service and directorate risks Whole directorate adopting a risk culture Consistent and accurate use of CDDM to ensure Safe Staffing Regular triangulation of incidents and SACs to review service risks
6 – Managing our resources and finances. Effectively managing our resources and ensuring we are able to sustain the directorate income	<ul style="list-style-type: none"> Limited cost reduction plan Limited budgetary knowledge at service level when finances are tight and robust processes are required Variable authorisation process for overtime and bureau resource for both nursing and administration Variable mitigations of managing Price Volume Schedule (PVS) 	<ul style="list-style-type: none"> Cost reduction plans across directorate Budget oversight by operational managers is promoted Robust authorisation for all staff undertaking overtime across directorate Developed and implemented PVS delivery plans

#	Me pēhea tātou e tae ki reira? How are we going to get there?	Te Kaitohutohu : Owner	Due by
1	Understanding of why our Māori and Pacific patients DNA to different services. Each service has a differing DNA rate and needs further exploration	Service SCDs	Q1
	Review of the DNA project of 2016	Ops Managers	Q1
	Delivery of community renal unit and home dialysis home	Renal SCD	Q4
2	Delivery of service specific action plans following the employee engagement survey	Service SCDs	Q1
	Trial of new roles/ward housekeeper	Ops Manager	Q3
	SMO roster review and change	Service SCDs	Q1
	Implementation of 'Just Culture'	Specific service individuals	Q3
3	Implementation of a Wellness Committee	HR Manager and AH Director and Nurse Director	Q1
	Implementation of General Medicine model of care	Gen Med SCD, Ops Manager, NUM	Q2
	Sleep study project completed and implemented	Respiratory SCD	Q3
	Adult ED new models of care implemented	Adult ED SCD	Q1
	Mental Health model of care and purpose built Adult ED facility	Adult ED SCD	Q1
	Implementation of the DCCM strategy	DCCM SCD	Q3
4	Delivery renal and home dialysis house	Renal SCD	Q4
	Level 2 fully refurbished	Adult ED SCD	Q1
	Adult Rehabilitation and Integrated Stroke Unit build completed	Clinical Lead for stroke	Q4
	Neuro day stay facilities upgraded	Ops Manager	Q1
5	Extra capacity for endoscopy completed prior to bowel screening go live	BFTF	Q4
	Robust risk register across whole directorate with greater understanding of risk and mitigations		Q1
	Triangulation of incidents and risks at monthly service meetings		Q3
6	Adherence to all PVS delivery plans to ensure income delivery	SCDs	Q4
	Implementation of robust overtime authorisation across directorate services	Ops Managers and NUMs	Q1

#	He pēhea te āhua o te angitu? What does success look like?	Current (end 2018/19)	Target (2019/20)
1	Māori DNA Rate (Adult Medical)	18.1%	9%
	Pacific DNA Rate (Adult Medical)	16.0%	9%
2	Dialysis delivered closer to patients' homes	Travel to Point Chev	Developing GI Unit
	Representative Māori workforce	5%	6%
3	Representative Pacific workforce	7%	9%
	Implementation of the housekeeper role	In development	Delivered and evaluated
4	Implementation of 'Just Culture'	In development	Fully delivered
	Reduce outliers of General Medicine with extra capacity	Average 12 per day	0
5	Full implementation of General Medical new model of care	In development	Fully delivered
	Criteria and mode of care for partial sleep study	In development	Delivered and evaluated
6	95% 6 hour target achieved with implementation of POD system for Adult ED discharges	93.5%	95%
	Improved access for Mental Health patients within Adult ED with implementation of new model of care and facility	Currently planning new environment	Design and CAMP paper submitted
7	Consistent and accurate use of CDDM to ensure Safe Staffing across all Adult medical wards	75%	100%
	Development and implementation of family violence screening in Adult ED	Development of steering group	Implementation
8	Development of stroke and rehab unit ready for building completion	20 work streams in preparation for opening 2020	Completion of 20 work stream work
	Neuro day stay adhere to hand hygiene guidance fully	Lack of hand wash basins in neuro day stay	Fully functional hand washing facilities that allow neurophysiology care to meet IC guidance
9	New endoscopy delivery model to be developed for BSP	Current fixed capacity sufficient	Exploration of expanding use of fixed capacity
	Fully functional risk register	Developed risk register	Fully functional risk register

Glossary

Acronym/term	Definition
ARISU	Adult Rehabilitation and Integrated Stroke Unit
ED	Emergency Department

Q1 Actions

- Weekly team and monthly directorate meetings are working well.
- Monthly meetings with each service reviewing priority plans, finance information, Human Resources information, risks and service scorecards. Each service is developing a new performance scorecard specific to service.
- Directorate leads attending Just Culture training days.
- Renal build continuing. Resource consent application submitted.
- Integrated Stroke Unit progressing. Building consent submitted.
- Level 2 building projects - short stay inpatient refurbishment continuing. The mental health area and an area for patients with challenging behaviours are being developed. Architects have been engaged and are reviewing the Adult ED footprint.
- Urgent & Surveillance target met for Gastroenterology/Colonoscopy. Recovery and sustainability plans for the Routine waiting list are being implemented and is monitored weekly. Full target achievement if forecast for October 2019.
- Neuro day stay refurbishment continuing with stage two. Stage one completed.
- Other project work for quarter one completion has been delayed whilst the directorate manages the winter pressures.

Scorecard

Auckland DHB - Adult Medical Services

HAC report for August 2019

Equitable - equity is measured and reported on using stratification of measures in other domains				
Safety				
Metric		Actual	Target	Previous
Medication errors with major harm	PR215	0	Lower	0
Nosocomial pressure injury point prevalence (% of in-patients)	PR097	2.3%		3.8%
Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	PR185	1.5%		1.8%
Number of falls with major harm	PR199	0	Lower	0
Number of reported adverse events causing harm (SAC 1&2)	PR084	1	Lower	1
Unviewed/unsigned Histology/Cytology results >=30 days	PR596	20	Lower	28
% Hand hygiene compliance	PR195	83.13%	>=80%	96.83%
Central line associated bacteraemia rate per 1,000 central line days	PR087	0	<=1	0
Patient-centred				
Metric		Actual	Target	Previous
% Patients cared for in a mixed gender room at midday - Adult	PR175	33.13%	Lower	32.76%
% Patients cared for in a mixed gender room at midday - Adult (excluding Level 2)	PR196	33.13%	TBC	32.76%
Number of CBU Outliers - Adult	PR173	226	Lower	300
% hospitalised smokers offered advice and support to quit	PR129	97.06%	>=95%	93.41%
% DNA rate for outpatient appointments - Māori	PR057	24.76%	<=9%	25.45%
% DNA rate for outpatient appointments - Pacific	PR058	24.01%	<=9%	26.12%
% DNA rate for outpatient appointments - All Ethnicities	PR056	11.83%	<=9%	12.43%
% DNA rate for outpatient appointments - Deprivation Scale Q5	PR338	17.82%	<=9%	20.31%
% Very good and excellent ratings for overall inpatient experience	# PR154	82%	>=90%	82.9%
% Very good and excellent ratings for overall outpatient experience	# PR179	87%	>=90%	88.78%
% Very good and excellent ratings for coordination of care after discharge	# PR493	65.2%	>=90%	65%
% Response rate to ADHB patient experience inpatient survey	# PR315	18%	>=25%	16%
Timeliness				
Metric		Actual	Target	Previous
(MOH-01) % AED patients with ED stay < 6 hours	PR013	83.09%	>=95%	83.66%
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Pacific	PR330	0	Lower	0
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Total	PR328	0	Lower	0
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Deprivation Scale Q5	PR332	0	Lower	0
% Urgent diagnostic colonoscopy compliance	PR044	100%	>=90%	100%
% Non-urgent diagnostic colonoscopy compliance	PR045	54.4%	>=70%	47.77%
% Surveillance diagnostic colonoscopy compliance	PR183	76.19%	>=70%	80.65%

Effectiveness				
Metric		Actual	Target	Previous
28 Day Readmission Rate - Māori	# PR079	12.99%	<=6%	10.85%
28 Day Readmission Rate - Pacific	# PR080	18.35%	<=6%	15.12%
28 Day Readmission Rate - Total	# PR078	12.97%	<=10%	13.78%
28 Day Readmission Rate - Deprivation Scale Q5	# PR322	12.33%	<=6%	14.33%

Efficiency				
Metric		Actual	Target	Previous
Average LOS for WIES funded discharges (days) - Acute	PR219	3.3	TBC	3.7

Equitable:	Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.
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Timeliness:	Reducing waits and sometimes harmful delays for both those who receive and those who give care.
Effectiveness:	Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
Efficiency:	Avoiding waste, including waste of equipment, supplies, ideas, and energy.

Actual is the latest available result prior to August 2019

Scorecard Commentary

- A pressure injury in renal dialysis which occurred in the community and was initially a Grade 3 and subsequently assessed as a Grade 2.
- Reducing mixed gender: this is on the releasing time to care (RTC) work plan with workshops being developed along with plans to trial in general medicine.
- Co-ordination of care after discharge: various pathways being developed including chronic obstructive pulmonary disease and chronic heart failure and Stroke. Future SPRINT focus on discharge.

Key achievements in the month

- Managing increased acute winter demand across directorate particularly Adult ED and general medicine.
- Submission to council of the building consent for ward 51 Adult Rehabilitation and Integrated Stroke Unit (ARISU).
- Met urgent and surveillance targets for colonoscopy.
- Progressing with Colonoscopy recovery plan and delivering to recovery plan target. Urgent and surveillance target met in August 2019.
- Developing ARISU. Working group established with 18 work streams identified. FFE list complete.
- Good progress with the delivery of Regional Out of Hours Stroke Service. Excellent engagement with St John's and Counties Manukau DHB.

- Developing the model of care to inform the design of a mental health area in Adult ED and an area for patients who have behaviours that are challenging.
- Continuing to develop a robust risk culture within the Directorate. Each individual service now has their own risk register and all risks are thoroughly discussed at the priority plan meetings. A Directorate risk register is also being developed and is reviewed and discussed at the weekly Senior Leadership Team meeting. Training is being planned to support directorate leadership to manage service risks on the Safety Management System (Datix).
- Establishment of a steering group and working group for the bed realignment project.

Areas off track and remedial plans

- Routine colonoscopy target still not met. Progressing with recovery plan and predicted routine target achievement is forecast in October 2019. We have been treating the patients waiting the longest first and meet weekly to monitor recovery plan performance.
- Adult ED target off track. Very busy period with increased attendance. New money to support increase in medical staff but phased funding throughout year.
- Mental health admissions delay due to in patient bed capacity.
- NASO negotiations – complexity with numerous issues.

Key issues and initiatives identified in coming months

- Recovery and sustainability plan for the endoscopy waiting list is being implemented and is monitored weekly by the Executive Leadership Team and Gastroenterology. Continuing to book the longest waiter first but should reach routine target by October 2019 as planned.
- Winter volumes in both Adult ED and General Medicine.
- Developing and using our risk register to effectively mitigate our risk.
- Development of ward 61 HASU, ASU, Neurology and General Medicine. Working group and Steering group established – opening date November 2019.
- A key focus is the quality of nursing care in General Medicine, the cover for General Medicine Nurse Unit Manager and the long term plan for that position.
- Continue to progress the community dialysis provision and working collaboratively with Tāmaki Regeneration Company, Social Investors and the Kidney Society for future provision of capacity.
- Monthly priority plan and service performance meetings continuing with good engagement.
- Continuing with Neurology, Gastroenterology and Respiratory capacity and demand planning and maintaining organisational targets. Meeting weekly to ensure ESPI 2 targets are being met and the right patients are being booked.
- Continuing with the delivery of the Regional Hyper Acute Stroke Service for stroke and clot retrieval that went live across all metro on 3 September 2018.
- The Directorate level Health & Safety strategy plan will be finalised with input from Health & Safety representatives and leadership.
- Security and safety actions being progressed within Adult ED. Seed funding secured for a behavioural assessment area, review of triage and a mental health area. Action plan developed following a review.
- Continuing with the development of the ARISU planning.

Financial Results

STATEMENT OF FINANCIAL PERFORMANCE							Reporting Date Aug-19		
<i>Adult Medical Services</i>									
(\$000s)	MONTH			YEAR TO DATE (2 months ending Aug-19)					
	Actual	Budget	Variance	Actual	Budget	Variance			
REVENUE									
Government and Crown Agency	285	278	7 F	560	556	4 F			
Funder to Provider Revenue	16,798	16,798	0 F	33,915	33,915	0 F			
Other Income	651	653	(2) U	1,171	1,306	(136) U			
Total Revenue	17,734	17,729	5 F	35,646	35,777	(131) U			
EXPENDITURE									
Personnel									
Personnel Costs	10,655	10,646	(9) U	21,158	21,281	123 F			
Outsourced Personnel	89	93	4 F	174	187	13 F			
Outsourced Clinical Services	21	50	29 F	58	100	42 F			
Clinical Supplies	2,365	2,328	(36) U	4,723	4,695	(28) U			
Infrastructure & Non-Clinical Supplies	326	289	(37) U	641	578	(63) U			
Total Expenditure	13,456	13,408	(48) U	26,755	26,841	86 F			
Contribution	4,278	4,322	(44) U	8,891	8,936	(45) U			
Allocations	3,318	2,987	(330) U	5,901	5,870	(31) U			
NET RESULT	960	1,334	(374) U	2,990	3,066	(76) U			
Paid FTE									
	MONTH (FTE)			YEAR TO DATE (FTE) (2 months ending Aug-19)					
	Actual	Budget	Variance	Actual	Budget	Variance			
Medical	219.5	216.8	(2.7) U	221.0	216.8	(4.1) U			
Nursing	657.5	630.5	(27.0) U	660.7	630.5	(30.2) U			
Allied Health	56.1	51.3	(4.8) U	56.3	51.3	(4.9) U			
Support	6.1	6.0	(0.1) U	6.1	6.0	(0.1) U			
Management/Administration	71.1	66.2	(4.9) U	68.8	66.2	(2.7) U			
Total excluding outsourced FTEs	1,010.3	970.8	(39.5) U	1,012.9	970.8	(42.0) U			
Total :Outsourced Services	3.8	4.4	0.6 F	3.4	4.4	0.9 F			
Total including outsourced FTEs	1,014.1	975.2	(38.9) U	1,016.3	975.2	(41.1) U			

Comments on Major Financial Variances

The result for the year to date is close to budget and is an unfavourable variance of \$76k.

Volumes: After updating the coding in August the overall volumes are 100 % of contract.

Full-time Equivalent (FTE) – 41 FTE unfavourable of which Adult ED is 39 FTE unfavourable. A meeting has been held that has explored the FTE variance. Contributing factors include PA's requests, extended Adult ED stays, Adult ED nursing sickness and opening up Adult ED capacity which is unfunded. These all need further analysis and are being investigated to be fully understood.

Child Health Directorate

Speakers: John Beca, Director of Child Health (Surgical) and Michael Shepherd, Director of Child Health (Medical and Community)

Service Overview

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

Surgical Child Health: Paediatric and Congenital Cardiac Services, Paediatric Surgery, Paediatric ORL, Paediatric Orthopaedics, Paediatric Intensive Care, Neonatal Intensive Care, Neurosurgery and Starship Operating rooms

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

The Child Health Directorate is led by:

Director (Surgical):	Dr John Beca
Director (Medical and Community):	Dr Michael Shepherd
General Manager:	Emma Maddren
Director of Nursing:	Sarah Little
Director of Primary Care:	Dr Barnett Bond

Directorate Priorities for 2019/20

In 2019/20 our Directorate will contribute to the delivery of the Provider Services strategic programmes. In addition to this we will also focus on the following Directorate priorities:

1. Clinical Excellence
2. Service and Facility redesign to deliver improved equity and effectiveness
3. Wellbeing of our people
4. Starship @ (standardised national service delivery)
5. Financial sustainability

Ngā whāinga : Our priorities	Kei hea tātou ināianei? Where are we now?	Ki hea te tahi o te hiahia? Where do we want to be?
1 – Clinical Excellence	<ul style="list-style-type: none"> Clinical Excellence programme active across all of services with a strong focus on safety and quality Clinical outcome measures are not consistently measured, reported and used for improvement Clinical pathways in several services 	<ul style="list-style-type: none"> Co-ordinated quality and safety improvements across our Directorate Measurement, reporting and improvement of clinical outcomes, with demonstration of equity (including across Māori, Pacific, and other ethnicity; socio-economic status; and geographic location). Patients are managed on clinical pathways that deliver maximum value and improved experience
2 – Service and Facility redesign to deliver improved equity and effectiveness	<ul style="list-style-type: none"> Community services are redesigned and improving equity in some areas but not in first 1000 days Inpatient and outpatient systems design are not optimally supporting priority whānau Service design in some areas does not promote effectiveness (e.g. Plastics, Pain, Vascula Access) Facilities in some areas do not allow for safe and effective care 	<ul style="list-style-type: none"> Community services are optimally designed to deliver equity of outcomes across whole age range Those with most need are appropriately supported; to access outpatient care and while in hospital Services are designed optimally for effective care Facilities are fit for purpose and help to deliver a great patient and whānau experience
3 – Wellbeing of our people	<ul style="list-style-type: none"> Staffing which does not always match demand We have a capable and motivated workforce with generally high levels of engagement, experiencing increasing challenges through clinical and service complexity Pockets of wellbeing associated work in various services 	<ul style="list-style-type: none"> Robust process that matches staffing FTE, staff mix and skill mix to our patients needs, including embedded use of Trendcare and Care Capacity Demand Management (CCDM) methodology Coordinated programme for staff wellbeing and embedding of 'Just Culture' Engaged, healthy and productive workforce that is culturally competent and supported by skilled leadership and robust workforce planning
4 – 'Starship @'	<ul style="list-style-type: none"> We have a range of off site activity that is not very well planned, funded or visible Some of our services delivered in off-site locations are without the same links to quality, resources and support as Auckland DHB delivered services 	<ul style="list-style-type: none"> Our non-Auckland DHB service delivery is well coordinated and funded Our services delivered in off-site locations are at least as good as those delivered in Starship Children's Hospital and have the same clinical governance
5 – Financial sustainability	<ul style="list-style-type: none"> Significant financial challenges particularly related to tertiary services and community services 	<ul style="list-style-type: none"> Sustained financial position which supports best clinical practice, sustainable services and equitable service access across New Zealand

#	Me pēhea tātou e tae ki reira? How are we going to get there?	Te Kaitohutohu : Owner	Due by	#	He pēhea te āhua o te angitu? What does success look like?	Current (End 2018/19)	Target (2019/20)
1	Clinical pathways established in all services	Directors	Q4	1	Quality and safety metrics established across our services	Services with metrics	Further development of clinical outcome metrics
	Measure, report, benchmark and improve clinical outcomes	Directors	Q4		Equity measures (including across Māori, Pacific, and other ethnicity; socio-economic status; and geographic location)	Some clinical outcomes include equity	Systematic reporting of equity for all clinical outcomes
	Equity focus for Clinical Excellence and Outcome measures	Directors	Q4		Functioning clinical pathways	Few	Every service has at least 1
Develop further equity focused community model - first 1000 days	Nurse Director	Q4	Acute Flow metric		93%	95%	
2	Patient focused booking implementation with effective Was Not Brought response	General Manager	Q4	2	Community redesign programme	Redesigned but gaps exist	Service further developed to include first 1000 days
	Priority whānau project focused on inpatients with social complexity	General Manager	Q4		Pain service model	Model reviewed and developed	Implemented
	Plastic surgery pathway and service development together with Counties Manukau Health (CMH)	Director Surgical	Q4		Was Not Brought rate	>10%, with significant inequity	<10%, with reduced inequity
3	Pain service model review and improvement	Directors	Q4	3	PICU and atrium project	Initiate and plan	Design and build
	Implement the facilities programme for safety, patient experience and long term planning, including PICU expansion and atrium development	General Manager	Q4		Plastic surgery service	Proposal developed, CMH engaged	New model implemented
	Ensure Trendcare and CCDM is fully implemented within inpatient wards/departments with appropriate response	Nurse Director	Q3		Staff Wellbeing	Measured - highs and lows identified	Action plans completed and some actions initiated
4	Develop Directorate and service level wellbeing plans and actions	HR Manager	Q4	4	'Starship @' performance measures	Few	Developed and reported
	Improved programme of research, innovation and training for all our staff	Directors	Q4		5	Meet revenue and expenditure targets	Budget not met. Revenue opportunities identified
5	Develop a standardised model of delivery ('Starship @') of procedural and outreach support in non-Starship Children's Hospital facilities to ensure equity of quality, outcomes and efficiency	Directors	Q4				
	Measure and report the performance of 'Starship @' services	Directors	Q2				
5	Sustained and effective financial management across financial years with balanced cost/revenue emphasis	General Manager	Q4				
	Seek national position on adequate funding mechanism	Directors	Q4				

Glossary

Acronym/term	Definition
ACHD	Adult Congenital Heart Disease
CCDM	Care Capacity Demand Management
ESPI	Elective Services Patient Flow Indicator
FTE	Full-time Equivalent
PICU	Paediatric Intensive Care Unit
WIES	Weighted Inlier Equivalent Separation
WNB	Was Not Brought

Q1 Actions – 90 day plan

Priority	Action Plan	Commentary
1	Clinical pathways established in all services	Clinical Pathways are under development in most child health services. A standardised methodology to design clinical pathways has been developed and is currently being tested in multiple services. Information technology applications are being identified and analysed as enablers to outcome data capture and standardising of clinical management.
1	Measure, report, benchmark and improve clinical outcomes	Reporting on patient safety measures is established and incorporated into directorate and service level clinical excellence scorecards. Patient Safety Culture Score is incorporated into directorate and service level clinical excellence scorecards. Some services have begun benchmarking and reporting on improvement activity with an emphasis on clinical outcomes. Pilot completed of National Paediatric Toolkit (Fabio the Frog) as a mechanism to capture children’s feedback to influence future improvement initiatives. Starship Community and Children’s Emergency Departments are progressing with service survey development.
1	Equity focus for Clinical Excellence and outcome measures	The development of an outcomes measurement and reporting framework is commencing with the intention of creating a continuous improvement environment within pathways and services. Where possible data is stratified by ethnicity. A summary of child health equity initiatives is provided in this report.
2	Develop further equity focused community model - first 1000 days	Starship Community does not have sufficient Full-time Equivalent (FTE) to implement the first 1000 days approach. The service has reviewed FTE allocation and our well child cases to intensify visiting for our priority families. We have aligned this to our locality based model with geo-hubs to define a geographical area of visiting. We are currently working on what seamless integration for intensive home visiting model would look like.
2	Patient Focused Booking (PFB) implementation	<ul style="list-style-type: none"> Patient Focused Booking (PFB) has rolled out in Endocrinology, Diabetes, Respiratory, Gastroenterology,

Priority	Action Plan	Commentary
	with effective Was Not Brought (WNB) response	<p>Immunology and Neurology.</p> <ul style="list-style-type: none"> • Early impacts on Was Not Brought (WNB) rates in the first few months (first 3 services - Endocrinology, Diabetes, Respiratory) is encouraging, with WNB rates and rescheduling rates already reducing. • There has been successful WNB-avoidance as a result of the PFB process, when parents have called to make an appointment they have identified barriers to being able to attend which have been overcome e.g. appointment time, transport issues, other parental reassurance. • Delays to roll out has been due to healthAlliance prioritisation and communication about the Invite to Contact letter being set up.
2	Priority whānau project focused on inpatients with social complexity	<p>A one year project (funded by Starship Foundation) to effect sustainable change and improve outcomes for priority whānau and tamariki across Starship. Key actions include:</p> <ul style="list-style-type: none"> • Providing assistance, support and intervention in partnership with priority whānau for identifying complexity, vulnerability and risk. • Early, effective and skilled responses to housing needs for priority whānau. • Development of effective multidisciplinary and multiagency communication and processes which are geared to active and timely collective decision making and intervention. • Effective and consistent implementation of the published medical neglect guidelines. • Clear and consistent escalation pathways in relation to at risk patients and whānau and addressing staff wellbeing. <p>Completed activity since March 2019 includes:</p> <ol style="list-style-type: none"> 1. Memoranda of understanding regarding specific roles with external agencies. Information/training to communicate these to teams. 2. Legal opinion obtained and process in development regarding information sharing and documentation between agencies. 3. Agreed implementation of the Neglect of Medical Care Guidelines 4. Psychosocial assessment tool identified for implementation. 5. Commenced escalation pathways, including multiagency focus. 6. Alignment to Starship-wide staff wellbeing initiatives. 7. Engaging effectively with Māori – sessions well - attended. Planned sessions through to end 2019.
2	Plastic surgery pathway and service development together with Counties Manukau Health (CMH)	<p>The aim is to develop an integrated, one-service, two-site model for paediatric plastic surgery to achieve centralisation of services at Starship for children where:</p> <ul style="list-style-type: none"> • Subspecialty support will enhance care • Outcomes will be improved <p>This work will focus on:</p>

Priority	Action Plan	Commentary
		<ul style="list-style-type: none"> • Providing equitable, sustainable service • Aligning to existing surgical services at Starship <p>The service will be supported by clinicians from both organisations and developed using a phased approach to ensure smooth transition. Work on this model has commenced in close discussions with clinicians and leaders from Counties Manukau DHB.</p>
2	Pain service model review and improvement	This work will take place during Q3 and Q4.
2	Implement the facilities programme for safety, patient experience and long term planning, including PICU expansion and atrium development	<p>Day Stay refurbishment, complete – July 2019</p> <p>Phlebotomy refurbishment, complete – July 2019</p> <p>Outpatients refurbishment, in progress – completion October 2019</p> <p>PICU expansion project, in progress – concept design complete</p> <p>Atrium development (enable PICU expansion), in progress – concept design complete.</p>
3	Ensure Trendcare and Care Capacity Demand Management (CCDM) is fully implemented within inpatient wards/departments with appropriate response	Child Health CCDM Steering group established. All activities on track. Starship prepared for Variance Indicator System (VIS) go live for October 2019. FTE calculations in line with organisational timeframes. FTE calculations are complete in oncology and medical specialties, however there are difficulties meeting new FTE requirements due to registered nurse workforce shortages.
3	Develop Directorate and service level wellbeing plans and actions	The majority of services have developed and advanced their action plans. In line with the Directorate focus on wellbeing, all services have been asked to include at least one action related to wellbeing. At a directorate level a Wellbeing A3 plan has been shared for feedback and a Wellbeing steering group is being formed.
3	Improved programme of research, innovation and training for all our staff	<p>Clinical Trial Infrastructure is a key priority for continued growth in our capacity and capability to deliver excellent research in our child populations. Initiatives include:</p> <ul style="list-style-type: none"> • A new clinical trial management tool (EDGE) for operational oversight in respect of real time data collection, performance metric review, and financial management. Current trial in progress. • Approved central resource operations hub structure to support Investigator teams Directorate wide. Flexible infrastructure comprised of biostatistician, clinical trial administration and research practitioner increasing research activity across clinical specialties. • Increasing commercial trial capacity through partnership with ACS in the delivery of commercial trials in children and adolescents. New child and parent friendly space built. Starship and ACS combined responsibility for delivery, budget and sponsor liaison. Two new early phase trials in set up.
4	Develop a standardised model of delivery ('Starship @') of procedural and outreach support in non-Starship	This work will align quality of service, resources and support delivered in off-site locations with those delivered at Starship. A review of clinic optimisation, patient accessibility, equity and cost effectiveness has highlighted the benefits of repatriating some clinics. A plan is being developed to repatriate clinic

Priority	Action Plan	Commentary
	Children's Hospital facilities to ensure equity of quality, outcomes and efficiency	activity in early 2020.
4	Measure and report the performance of 'Starship @' services	This action will be targeted in 2019/2020 following development of the standardised Starship@ model.
5	Sustained and effective financial management across financial years with balanced cost/revenue emphasis	Child Health experiences on-going financial challenges particularly in relation to tertiary services where there is a reliance on service capacity and capability regionally and nationally. In-year financial performance is on track, taking into account unreported revenue. Inpatient WIES year to date is 24% higher than last year and 13% higher than contract.
5	Seek national position on adequate funding mechanism	This is being discussed and an approach agreed with the executive leadership team.

Scorecard

Auckland DHB - Child Health

HAC report for August 2019

5.4

Equitable - equity is measured and reported on using stratification of measures in other domains				
Safety				
Metric		Actual	Target	Previous
Medication errors with major harm	PR215	0	Lower	0
Nosocomial pressure injury point prevalence (% of in-patients)	PR097	7.7%		3.6%
Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	PR185	4.58%		4.25%
Number of falls with major harm	PR199	0	Lower	0
Number of reported adverse events causing harm (SAC 1&2)	PR084	1	Lower	1
Unviewed/unsigned Histology/Cytology results >=30 days	PR596	10	Lower	9
% Hand hygiene compliance	PR195	93.09%	>=80%	94.13%
Central line associated bacteraemia rate per 1,000 central line days	PR087	2.14	<=1	1.11
Number of Central line associated bacteraemia reported	PR600	2		1
Medication/Fluid Errors causing moderate/severe harm	PR486	0		1
Medication and Fluid Error rate reported per 1,000 bed days	PR415	11.04		11.4
Good Catches	PR334	15		13
Unexpected PICU admissions	PR374	27		21
Paediatric Code Blue Calls	PR335	7		3
% PEWS score documented	PR355	R/U	>=95%	93.75%
Patient-centred				
Metric		Actual	Target	Previous
% DNA rate for outpatient appointments - Māori	PR057	19.16%	<=9%	19.91%
% DNA rate for outpatient appointments - Pacific	PR058	19.84%	<=9%	21.93%
% DNA rate for outpatient appointments - All Ethnicities	PR056	10.58%	<=9%	11.74%
% DNA rate for outpatient appointments - Deprivation Scale Q5	PR338	16.52%	<=9%	18.66%
% Very good and excellent ratings for overall inpatient experience	# PR154	74.79%	>=90%	87.59%
% Very good and excellent ratings for overall outpatient experience	# PR179	87.63%	>=90%	91%
% Very good and excellent ratings for coordination of care after discharge	# PR493	59.76%	>=90%	71.84%
% Response rate to ADHB patient experience inpatient survey	# PR315	16%	>=25%	16%
Electronic Discharge Summary completion – Child Health	PR439	97.4%	>=95%	97.61%
Child Health Nursing Family Feedback	PR376	R/U	>=90%	95.15%

Timeliness				
Metric		Actual	Target	Previous
(MOH-01) % CED patients with ED stay < 6 hours	PR016	86.73%	>=95%	88%
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Māori	PR329	6	Lower	3
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Pacific	PR330	4	Lower	4
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Total	PR328	14	Lower	21
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Deprivation Scale Q5	PR332	8	Lower	7
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Māori	PR323	12	Lower	12
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Pacific	PR324	6	Lower	6
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Total	PR327	42	Lower	40
(ESPI-5) Number of patients given a commitment to treatment but not treated within 4 months - Deprivation Scale Q5	PR326	13	Lower	9
Median acute time to theatre (decimal hours) - Starship	PR034	5.27		4.97
Effectiveness				
Metric		Actual	Target	Previous
28 Day Readmission Rate - Māori	# PR079	N/A	<=10%	7.86%
28 Day Readmission Rate - Pacific	# PR080	N/A	<=10%	8.68%
28 Day Readmission Rate - Total	# PR078	N/A	<=10%	8.18%
28 Day Readmission Rate - Deprivation Scale Q5	# PR322	N/A	<=10%	6.38%
Efficiency				
Metric		Actual	Target	Previous
Elective day of surgery admission (DOSA) rate	PR048	60%	TBC	71.11%
% Day Surgery Rate	PR052	53.31%	>=52%	49.23%
Average LOS for WIES funded discharges (days) - Acute	PR219	4.03	<=4.2	5.13
Average LOS for WIES funded discharges (days) - Elective	PR220	1.81	<=1.5	1.13
% Adjusted Session Theatre Utilisation	PR198	76.61%	>=85%	80.06%
Average Occupancy	PR444	93.48%	90%	94.29%
Inpatient Median LOS	PR437	2.14		2.43
Inpatient LOS over 30 days (discharged)	PR438	21		24
FSA to FU Ratio – Child Health	PR440	0.3		0.3
Laboratory cost per bed day (\$) - Child Health	PR441	98.09		70.41
Radiology cost per bed day (\$) - Child Health	PR442	108.84		87.1
Antibiotic cost per bed day (\$) - Child Health	PR443	19		21.67
% of patients discharged on a date other than their estimated discharge date	PR375	20.35%		16.82%
PICU Exit Blocks	PR333	R/U	Lower	9

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

Amber	Variance from target not significant enough to report as non-compliant. This includes percentages/rates within 1% of target, or volumes within 1 value from target.
#	Actual is the latest available result prior to August 2019
R/U	Result Unavailable

Child Health Nursing Family Feedback

% PEWS score documented

PICU Exit Blocks

Results Unavailable

Health equity

Starship Child Health acknowledges the significant health inequities for Māori and Pacific patients and whānau and the need to commit to systemic and sustainable change which result in improved access and outcomes for these populations. A programme of work is in progress with actions specific to health equity and these include:

- **Engaging effectively with Māori.** This three-part training programme provides participants with the knowledge and skills to more effectively engage with Māori. To date 500+ staff and people working closely with Starship have participated in at least one 3 hour workshop.
- **Clinical excellence programme.** This programme measures clinical outcomes for patients, with stratification used to determine equity of outcomes. Service and directorate wide improvements are then developed to improve clinical outcomes including seeking to eliminate inequity.
- **Improving outcomes for priority whānau and tamariki.** This project (supported by funding from the Starship Foundation) is focused on specific actions across the wider system of care that result in improved engagement with Māori , more effective multidisciplinary and inter-agency working and early and active supports around housing and broader social complexities which many whānau experience.
- **Patient focused booking.** This project (supported by funding from the Starship Foundation) provides whānau with an invitation to contact services to negotiate a time to attend appointments. This is closely aligned with other initiatives such as Was Not Brought. Early data indicates encouraging rates of whānau engagement and decreased re-schedule rates and fewer non attended appointments.
- **Was not brought (WNB).** This work is addressing the significant rates of Starship patients not being brought to appointments. Specific actions include accurate reporting for individual services and clinic locations, greater understanding of the factors which prevent whānau from

attending appointments, specific interventions for patient groups, close alignment to patient focused booking, accurate information on whānau we work with and a Was Not Brought scheduler to engage with and support whānau to attend appointments when there are challenges. Transport, clinic locations and inter-DHB work are important areas of focus also.

- **Puawaitahi** – Work to implement the recommendations of the Puawaitahi review is continuing including implementation of detailed recommendations from a comprehensive needs assessment. A five year strategic plan has been drafted; Health – Oranga Tamariki escalation pathways are being reviewed; and a pilot for intra-building referrals is in development. Work continues to develop a Business Case for dedicated Kaiāwhina roles, and formulate detailed recommendations for access to therapeutic services.
- **Workforce.** Starship Child Health is participating in the wider Auckland DHB efforts to increase Māori and Pacific staff in all clinical and non-clinical roles.

Scorecard Commentary

Elective performance

Elective surgery performance continues to be a central focus for the Child Health Directorate; with 100% compliance achieved for the majority of services for Elective Services Patient Flow Indicator (ESPI) 1 and 2. There are residual challenges in ESPI 2 and 5 for some sub-specialties.

- ESPI 1 (acknowledgement of referral): Compliant
- ESPI 2 (time to First Specialist Assessment): 0.68% non-compliant, 17 breached in total (5 paediatric ear nose and throat, 10 paediatric surgery, 2 adult congenital heart disease).
- ESPI 5 (time to surgery): 5.04% non-compliant, 40 cases breached in total (24 Electrophysiology and Pacing, 8 Paediatric Cardiac, 1 Paediatric Ear Nose and Throat, 5 Paediatric Orthopaedics and 2 Paediatric Surgery). Contributing factors include spinal surgery constraints, acute demand, intensive care bed capacity and acute demand. Mitigations include re-allocated theatre sessions and insourced sessions.

The Child Health Directorate achieved 79% of the target for Auckland DHB discharges at the end of August 2019. Recovery plans include additional Clinics and operating sessions.

Health and safety

The Child Health directorate has a well-established health and safety structure and representation. There is now an opportunity to extend health and safety activity through the following priorities set out in the health and safety strategy for 2019/20:

Key priorities	Where we are now	Where we want to be
1. Governance and leadership	<ul style="list-style-type: none"> • Directorate Health and Safety Strategy is not well described and is only partially aligned with Auckland DHB Health and Safety Strategy. • Safe365 and Deloitte Health and Safety Audit in late 2018 highlighted areas of improvement required including development of a strategy. • Varying levels of manager capability, with lack of visibility of manager 	<ul style="list-style-type: none"> • Strategy developed and well described, including aligned to ADHB strategy. • Safe365 self-assessment results show that areas currently amber status are now at least green compliant level. • All managers have competent understanding and capability

Key priorities	Where we are now	Where we want to be
	training and knowledge of risk management.	to manage Health and Safety in their area.
2. Worker engagement and participation	<ul style="list-style-type: none"> Health and Safety Representatives (HSRs) have inconsistent understanding regarding the role and responsibilities with lack of time to undertake the role and low morale. 	<ul style="list-style-type: none"> HSRs have a good understanding of the importance of their role, are competent in health, safety & wellbeing knowledge with high morale and are supported. HSRs and managers are working together to implement Starship Health and Safety.
3. Risk management	<ul style="list-style-type: none"> Inconsistent knowledge of hazard identification and risk management, lack of visibility at Service or Directorate level. Inconsistent identification and management of key Health and Safety risks <ul style="list-style-type: none"> Blood and Body fluid accident Lone worker Workplace violence Inconsistent recording and completion of induction process. 	<ul style="list-style-type: none"> Managers and HSRs have a good understanding of hazards and risks in their area. Directorate key hazards and risks, currently identified as workplace violence, lone worker and needle sticks have adequate control plans implemented and are reviewed regularly. Health and Safety hazard & risk registers (Datix) are in place at service and directorate level.
4. Staff wellbeing	<ul style="list-style-type: none"> Incidents, literature and staff feedback have highlighted Wellbeing as an important issue for staff. Starship has pockets of excellent activity and some developing pieces of work in this area but does not have a systematic or comprehensive approach. 	<ul style="list-style-type: none"> Wellbeing strategy and action plan developed and implemented. Improved mind health and general wellbeing of staff. Staff better equipped to deal with the environment we work in.

Nursing commentary

- Good catch handovers have improved the early detection of / or potential for medication errors, especially for infusions.
- Pressure injuries identified in intensive care areas with extreme medical and physiological comprise. The Child Health Pressure Injury Steering group continues to lead best practice for pressure prevention and is currently focusing on the associated bundle of care.
- Nursing continues to achieve well above local and national hand hygiene targets (80%), currently achieving 93% audited compliance.
- Paediatric Early Warning Sign targets have been set high within Child Health. We consistently perform over 90%. Currently we are 92% for documented and 95% for actioned. The PaR nursing team has a visible presents in wards and may reflect lower compliance rates.

- Nursing receives consistently high family feedback scores. The aggregated totals for Family feedback for nursing range from 92 -100%. This is commendable as there have been significant demands over the winter period with hospital occupancy running over capacity at 95 -105% since early May.
- CCDM and trendcare are on track for FTE calculations in line with the organisational timeframes. This should assist in ameliorating overtime and bureau utilisation with nursing FTE meeting actual care delivery and capacity requirements. This will also aid nursing staff wellbeing by reducing overtime demands and increase the ability of staff to take annual leave.

Key achievements in this reporting period

- Safe services provided across Starship during a time of high volume and acuity across the wider system of care. During August PICU experienced the highest ever number of number of admissions to PICU in August (129), the second highest number of retrievals (34) and occupancy exceeded 100% nearly continuously during the month (25 days).
- A clear pathway and process for non-resident elective patients who access investigations and treatment at Starship has been developed and implemented. This work will help guide clinicians to plan care and the associated costs to improve cost recovery for this patient group.
- A significant milestone was reached on 1 August with the discharge of a long term patient from PICU to a community setting. This is a great outcome for this child and their family and the efforts from all involved are acknowledged. There are currently five children within the community across New Zealand on long term ventilation.

Areas off track and remedial plans

- Critical care demand in Starship continues to exceed resourced capacity. Neonatal intensive care occupancy has been at or exceeding 100% for much of 2019. This has placed considerable demands on the clinical team and has been exacerbated by neonatal capacity pressures regionally and nationally. Paediatric Intensive Care has experienced high occupancy during the winter months and elective surgery cancellation rates have been impacted by lack of post-operative beds.
- Recruitment challenges resulting in recruitment delays and a limited volume of candidates for nursing roles. This has contributed to overtime and bureau costs year to date and has continued throughout 2019.
- On-going and significant risk related to the provision of allergy safe meals for patients. This has been investigated thoroughly with Compass and a range of immediate mitigations have been put in place.
- Significant risk related to the unreliable function of the link lift 2. This is the sole lift required for safe transfer of patients from the Paediatric Cardiac Ward (23b) to PICU, Theatre and Radiology. Contingency plans are in place for patient transfer. The replacement is currently scheduled for November 2019.
- Delays completing the installation of the air handling unit and associated facilities upgrade to ensure the paediatric cardiac investigation unit is able to function at theatre standard. Facilities and Development has commissioned remedial work but this is not yet finalised.
- Funding for Rheumatic fever prevention has ceased and further investment in Auckland DHB child health community services has not occurred. It has also become clearer that significant

unmet need is present in Auckland DHB child health population and science has evolved to make it even clearer that investing in the first 1000 days of life is critical to lifelong health.

Key issues and initiatives identified in coming months

- Re-development of Paediatric Intensive Care to increase physical bed capacity in line with current and future demand. This is a significant project which will be staged to ensure safe and appropriate care is maintained throughout.
- Development of the service-level clinical excellence groups and finalisation of the service-level outcome measures.
- National funding proposals for ACHD and Cardiac Inherited Diseases Group services have been submitted for consideration nationally. These proposals follow a successful submission for phase one funding in 2015 and were an agreed outcome of the earlier submission.
- Development of a two-site model of Plastics in close collaboration with Counties Manukau Health with an emphasis on providing plastics care for children in the setting which supports the best clinical quality and patient outcome.

Financial results

STATEMENT OF FINANCIAL PERFORMANCE						
<i>Child Health Services</i>						Reporting Date Aug-19
(\$000s)	MONTH			YEAR TO DATE (2 months ending Aug-19)		
	Actual	Budget	Variance	Actual	Budget	Variance
REVENUE						
Government and Crown Agency	983	1,046	(62) U	1,662	1,909	(247) U
Funder to Provider Revenue	21,520	21,520	0 F	42,586	42,586	0 F
Other Income	1,113	1,295	(181) U	2,446	2,773	(327) U
Total Revenue	23,616	23,860	(243) U	46,694	47,268	(573) U
EXPENDITURE						
Personnel						
Personnel Costs	14,382	14,298	(84) U	28,353	28,402	49 F
Outsourced Personnel	180	130	(50) U	362	260	(102) U
Outsourced Clinical Services	227	238	11 F	472	476	4 F
Clinical Supplies	3,216	2,890	(326) U	6,416	5,720	(696) U
Infrastructure & Non-Clinical Supplies	490	442	(48) U	949	884	(64) U
Total Expenditure	18,495	17,998	(497) U	36,552	35,743	(809) U
Contribution	5,122	5,862	(740) U	10,142	11,524	(1,382) U
Allocations	1,304	1,067	(237) U	2,197	2,088	(110) U
NET RESULT	3,818	4,795	(977) U	7,945	9,437	(1,492) U
Paid FTE						
	MONTH (FTE)			YEAR TO DATE (FTE) (2 months ending Aug-19)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	290.2	271.0	(19.1) U	285.2	271.0	(14.2) U
Nursing	764.2	750.0	(14.2) U	763.6	750.0	(13.7) U
Allied Health	210.2	204.8	(5.4) U	210.2	204.8	(5.4) U
Support	0.3	0.3	0.0 F	0.3	0.3	0.0 F
Management/Administration	105.7	99.9	(5.7) U	107.6	99.9	(7.6) U
Total excluding outsourced FTEs	1,370.5	1,326.0	(44.5) U	1,366.9	1,326.0	(40.9) U
Total :Outsourced Services	14.4	3.9	(10.5) U	13.6	3.9	(9.7) U
Total including outsourced FTEs	1,384.9	1,329.9	(55.0) U	1,380.5	1,329.9	(50.6) U

Comments on major financial variances

The Child Health Directorate reported position is \$1.492M unfavourable Year to Date.

August Year to Date revenue is reported as \$573k unfavourable with total expenditure variance at \$919k unfavourable.

However actual August revenue position is not reflected in the financial statements for the directorate at this point.

Inpatient Weighted Inlier Equivalent Separation (WIES) for the month is 23% higher than last year and 7% higher than contract.

Inpatient WIES for Year to Date is 24% higher than last year and 13% higher than contract.

Year to Date FTE for Employed/Contracted Employees is 50.6 FTE unfavourable.

Key factors impacting on the 2019/20 Year to Date performance are as follows:

1. Revenue \$573k unfavourable:

- Funder to Provider revenue is recognised at budget. However the underlying activity is equivalent to approximately \$3.0M additional revenue which will be recognised in future months. There are significant long stayer discharges in the year to date reported volumes.
- Other revenue streams are \$573k unfavourable to budget overall. Non-resident revenue (\$404k unfavourable); ACC revenue (\$180k unfavourable) and sub-contracts (\$120k unfavourable) all contributed to that position.

2. Expenditure \$919k unfavourable:

- Personnel costs \$49k favourable. This was primarily medical costs (\$437k favourable) due to 8.3% favourable cost/FTE, whilst nursing was \$230k unfavourable, due to a 14 FTE unfavourable FTE position. Other employee groups were also unfavourable (\$160k unfavourable); however the majority of this was funded through additional revenue. These overall favourable price variances (3.2% favourable cost/FTE) offset the significant volume variance that related to the total 41 FTE unfavourable position.
- Clinical supply costs are \$696k unfavourable (112% of budget). This compares to over-delivery of 113% so overall costs are tracking in line with activity. These variances are mainly evident in high blood costs (\$240k unfavourable); and high instrumentation costs (\$285k unfavourable). We will pay close attention to these costs to ensure they do not exceed volume adjusted expectations.

3. FTE: 50.6 FTE unfavourable:

- Year to Date employed FTE was 41 unfavourable and total FTE, including outsourced, was 50.6 unfavourable.
- Approximately 20 FTE of that variance relates to additional funded roles, either from donation funding or unbudgeted Ministry of Education funding. Excluding the funded roles brings the unfunded variance to approximately 30 FTE unfavourable.
- Resident Medical Officer FTE is approximately 8.0 FTE unfavourable with the majority of the FTE through over-appointments or overstated payroll FTE which will be corrected next month.
- Nursing is 13.8 FTE unfavourable – primarily in Ward 25AB, due to increased recruitment of Health care assistants, and on-going high occupancy and pressure on nursing FTE.
- Admin FTE net of funded roles is approximately 8.0 FTE unfavourable, which is primarily unmet vacancy assumptions of 5.3fte and 2.3 FTE of unbudgeted roles.

The focus for 2019/20 will be pathway development, clinical supply cost containment and productivity. In addition on-going oversight of employee costs, including vacancy and recruitment processes, and leave management will continue to be managed tightly in order to mitigate cost pressures.

Commercial Services

Speaker: Kieron Millar, General Manager

Service Overview

Commercial Services is responsible for service delivery and management of Linen and Laundry, Car Parking, Motor Vehicle Fleet, Staff Shuttle, Property Leases, Retail Space Management, Delivery Dock Management, Commercial Contracts, Clinical Education Centre, Sustainability, Mailroom, Food and Nutrition, Health Alliance Procurement and Supply Chain (including New Zealand Health Partnerships Ltd, PHARMAC and Ministry of Business Innovation and Employment).

The Directorate has four core service groups with a single point of accountability for each function. These are as follows:

- Commercial Services Business Improvement
- Commercial Contracts Management
- Procurement and Supply Chain
- Sustainability

The Commercial Services Directorate is led by:

General Manager:	Kieron Millar
Operations Manager Business Improvement:	Kieron Millar
Commercial Manager Contracts :	Shankara Amurthalingam
Sustainability Manager:	Manjula Sickler
Finance:	Tut Than

Directorate Priorities for 2019/20

In 2019/20 our Directorate will contribute to the delivery of the Finance and Business Support Services long term plan with a focus on the following key priorities:

1. Proactively manage and develop partnerships with our key suppliers.
2. Improve our communications and engagement with our customers and partners.
3. Develop and embed the key principles of sustainability.
4. Manage and improve change through improved project and contract management processes.
5. Support and develop our workforce to align with our objectives and goals.
6. Embed best practice Health and Safety across the team.
7. Improve our planning by inclusive planning and engagement with other Directorates.
8. Identification of commercial revenue generation and other value for money opportunities.
9. Develop and improve policies, strategies and guidelines.
10. Identify and develop regional collaborative opportunities.

Glossary

Acronym/term	Definition
ACH	Auckland City Hospital
FPSC	Finance, Procurement and Supply Chain
GHG	Greenhouse gasses
SDGs	Sustainable Development Goals
PIA	Privacy Impact Assessment
CRAT	Cloud Risk Assessment Tool
GETS	Government Electronic Tenders Service

Key achievements in the month

Procurement

healthAlliance Finance, Procurement and Supply Chain (FPSC) have reported the following year to date savings*

OPEX	\$291K
Budgetary	\$224K
Non-Budgetary	\$66K
CAPEX	\$1.04M
Non-Budgetary	\$1.04M

*Noting that reporting has changed to reflect alignment with actual year to date savings rather than annualised savings.

Supply Chain

- In mid-August, healthAlliance FPSC received notification from Universal Specialties Limited (USL) Medical informing us that the Nitrile Non-Sterile Examination Glove supplied to the Northern Region DHBs will be on backorder effective immediately. USL appear to have mismanaged their inventory and failed to order this product, resulting in the shortage.
 - Auckland DHB has managed inventory on over 90% of these gloves so were in a great position to identify current stock on hand immediately. A substitute has been approved and the Supply Chain team continue to monitor this situation closely throughout September and October.
- The supply chain Service level agreement (current state) has now been formalised.
- Responsibility for funding and management of the dock project has been transferred to FIRP.

Security for Safety Programme

- The transition of the Code Black response into business as usual is being planned by the Emergency Management Team. Aiming to be completed for Code Black Firearm, Code Black Offensive Weapon and Code Black Abduction by the end of September; this is dependent on final response plan sign-off by the Security for Safety Steering Group.
- Culture and Performance – the Code Black / Lock Down e-learning will be updated to include information on “Run, Hide, Self-Defend” in the case of a critical incident.
- The Lone Worker Welfare System rollout to off-site lone workers. To-date 338 community workers have been registered and trained in the use of Get Home Safe and the rollout to Mental Health Service workers has commenced. Project communications is focussed on key messages of

welfare and usage. Onsite lone worker evaluation checklist being rolled out with support from the OH&S advisor team.

- CCTV system upgrade continues to be key focus with 2 cameras still remaining and the issues associated with upgrading these cameras are expected to be resolved by end September.
- A new supplier has been appointed for all future Security Systems and Related Services; Transition has commenced and transition is on track to be fully completed by 1 November 2019.
- Planning for security enhancements is now underway starting with Women's and NICU, levels 9 and 10, Auckland City Hospital.
- The focus for the Access Plans development has been the public spaces associated with Cornwall House at Greenlane.
- The Security Staffing and Services transition to in-house Auckland DHB Healthcare Security Officers is on track to be completed by end 2019. Feedback from staff and visitors has been very positive.

Sustainability

- The Sustainable Development Goals (SDGs) project is nearing completion of the first stage with completion of the materiality assessment to determine the priority SDGs. The audit document to obtain formal assurance is being finalised.
- The DHB was announced winner for the Excellence in Climate Change (Large Organisation) award by Enviro-Mark Solutions. This is in recognition of being one of the top carbon reducers and showing exceptional leadership in environmental management.
- The DHB was recognised globally for its sustainability programme and emissions reduction by receiving three gold awards by Green Global Health Hospitals for GHG Reduction; Energy, Climate Resilience and Climate Leadership.
- The DHB was nominated finalist for the 2019 Sustainable Business Network Awards Revolutionising Energy category. The winner will be announced on 27 November 2019.
- Food waste pilot in main kitchen and retail outlets is coming to an end. To date 25 tonnes of food waste has been diverted and converted into high quality compost. A post-pilot review will consider options for a roll out to other high food waste areas.
- A feasibility study is being considered to significantly reduce waste to landfill with waste conversion technology. The Auckland metro DHBs have been approached to consider a regional solution. The funding for the feasibility study is being explored.
- Three EV stations are being planned for Carpark B. This is to provide on-site charging facilities for staff with electric vehicles. The EV stations have been donated by Fisher & Paykel Healthcare as part of its sustainability programme.
- Upcoming events are; Pacific Week Environmental session 7 October; Recycle week 21-25 October; Annual Sustainability Symposium 14 November.

Car Parking

- Car park utilisation continues to be high.
- Installation of safety barriers in carpark B has commenced with completion anticipated in November 2019. To minimise disruption to the site, work is to be undertaken after hours (7.00 pm to 6.00 am).

- A Car Park survey was commenced on 9 September 2019 for a two week duration. The results will help us understand the purpose of visitors to the Auckland City Hospital (ACH) site.

Sustainable Transport

- The Auckland DHB Travel survey was sent out to all staff on 12 September 2019. It will run for up to four weeks. The survey seeks to obtain a wide range of information on staff journeys to and from work, their parking needs, and potential uptake of transport alternatives to private motor vehicles. The results from the survey will help guide initiatives to reduce the number of vehicles coming into the main hospital sites.
- Auckland Transport is staffing stands at ACH and GCC on the week beginning 16 September 2019 to provide information on available public transport options.
- Additional bike parking areas at the ACH site are being reviewed. Initially open racks will be considered in highly visible areas, and access controlled bike shelters will be considered for inclusion in future Capital planning.
- 22 September is World Car Free day. A promotion to encourage staff to not bring a car to work at least one day a week is being reviewed as a follow-up initiative to the travel survey.
- A Car-pooling scheme is under development.

Motor Vehicle Fleet

- The deep dive fleet report is complete and will be submitted to the Executive Leadership Team for consideration. Primary recommendations include changing the fleet management company, moving to online vehicle bookings for all fleet vehicles, and initiating on-line driver training for all drivers of fleet vehicles.
- A review of Capital planning to fund fleet vehicle replacements is under consideration for the next 3-5 years. Currently there are 136 vehicles 8 years and older.

Shuttle Service

The Shuttle service data is as follows:

Monthly Staff Shuttle Figures (Monday – Friday)	No days service	Total trips	Total passengers	Total kilometers
August 2019	22	2904	29,031	12,910

- Reports from regular users indicate that passenger numbers may have increased at peak times. This will be closely monitored over the next reporting period.

Property Leases

- A high level overview of the property market in Auckland CBD follows after an interest in the DHB’s property portfolio at the previous meeting.
- The following is market commentary obtained from Telfer Young Valuers and Colliers International reports which suggest a tight leasing market with vacancies falling.
 - Improving economic drivers across Auckland have resulted in falling vacancy rates over a broad range of commercial property, down to levels below long term averages. In some sub-markets (total market) leasing options have diminished significantly.
 - Auckland CBD’s overall vacancy rate tightened once more to an all-time low of 5.0%, the lowest since we commenced the survey over 20 years ago. The prime vacancy rate fell to

2.8% and the secondary vacancy rate fell to 6.6% compared to 3.5% and 8.1% recorded respectively last year.

Retail

- A Request for Proposal (RFP) for the lease of the vacant Park Road retail shop (previously the Barber Shop) has been loaded on GETS (Government Electronic Tenders Service). The closing date for submissions is 2 Oct 2019.

Contract Management

Projects	Update
Uniforms	<ul style="list-style-type: none"> • Price increase proposal declined, working with supplier to cut back and minimise their operational expenses.
Fuji Xerox	<ul style="list-style-type: none"> • Right of renewal, contract extended for a further 12 months to 24 May 2020.
DX Mail	<ul style="list-style-type: none"> • healthAlliance (FPSC) engaged to review a possible take-over of the mailroom service. • Commercial Services investigating the ability to purchase a tracking system for package delivery on site (Grafton and Greenlane) which will tie into the current dock project long term goals. Currently completing a PIA and CRAT.
Implementation	<ol style="list-style-type: none"> 1. Custom Packs <ul style="list-style-type: none"> • All packs have been reviewed by the respective senior nursing staff. • Proposed changes have been made to the recipes. • All packs with changes have been quoted by REM Systems in conjunction with Medline. • There are two new proposed Ortho packs for level 8 included, quoted and costed against current products used and estimated volume. • hA (FPSC) will negotiate pricing noting that Custom packs will be included by Pharmac in the near future. ADHB have reviewed and revised their packs in preparation for this process. • Both packs have resulted in estimated savings of \$36k annually. 2. Stationery Supply Transition to Office Max <ul style="list-style-type: none"> • Transition scheduled for 1 October 2019. • Communication regarding this transition is planned to be sent out for the 3 weeks prior to 1 October transition date. • Catalogue stationery list is currently being reviewed and finalised. • Projected savings of \$40,000 from this transition with new fleet of 50 delivery trolleys. 3. Pressure Mattress Supplier <ul style="list-style-type: none"> • Supply of pressure mattresses was reviewed and the decision was made to move over to a single supplier. • AH Essential is the part of a Panel agreement and is the preferred supplier of pressure mattresses and related accessories as of 1 September 2019. • Estimated costs savings of \$36,000 from this rationalisation project.

Linen

- The linen supply rate at ACH for August 2019 was 94% (target 98%). The August 2019 utilisation rate was 76% against a target of 85%.

Monthly Sales Figures

	August 2019	
	Sales (\$)	Variance from last period (\$)
Linen	518,961	+4,191
Sterile	147,939	+3,085
Disposables	66,971	+770
Total	733,781	+8,046

Food and Nutrition Services

- Totara Ward Proposal – Feedback from Compass Group on is due on Friday 13 September 2019, which will then be reviewed with the GM Surgical & Perioperative and the Totara Ward team.

Monthly Sales Figures

	August 2019	
	Sales (\$)	Variance from last period (\$)
Patient Meals	1,045,215	+32,982
MOW	23,589	+557
RMO	234,049	-12698
All Other Costs	77521	-1565
Total	1,380,374	+19,276

Vending Machines

- Vending Direct continues to work with Auckland DHB towards meeting the Ministry of Health's National Healthy Food and Drink Policy. A new version of this policy is expected in the coming months which will again change the scope of what can/cannot be sold in the vending machines.
- Commercial Services are currently investigating extending the contract with our current vending machine supplier.

Financial Results

STATEMENT OF FINANCIAL PERFORMANCE						
Commercial Services				Reporting Date Aug-19		
(\$000s)	MONTH			YEAR TO DATE (2 months ending Aug-19)		
	Actual	Budget	Variance	Actual	Budget	Variance
REVENUE						
Government and Crown Agency	0	0	0 F	0	0	0 F
Funder to Provider Revenue	0	0	0 F	0	0	0 F
Other Income	2,106	1,848	258 F	2,844	2,766	78 F
Total Revenue	2,106	1,848	258 F	2,844	2,766	78 F
EXPENDITURE						
Personnel						
Personnel Costs	299	138	(160) U	418	280	(137) U
Outsourced Personnel	11	11	1 F	16	23	7 F
Outsourced Clinical Services	0	0	0 F	0	0	0 F
Clinical Supplies	0	0	0 F	0	1	0 F
Infrastructure & Non-Clinical Supplies	2,568	2,482	(86) U	5,091	4,964	(127) U
Total Expenditure	2,877	2,632	(245) U	5,525	5,268	(258) U
Contribution	(771)	(784)	13 F	(2,682)	(2,501)	(180) U
Allocations	(1,357)	(1,357)	(0) U	(2,695)	(2,690)	5 F
NET RESULT	585	573	13 F	13	189	(176) U
Paid FTE						
	MONTH (FTE)			YEAR TO DATE (FTE) (2 months ending Aug-19)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	0.00	0.00	0.00 F	0.00	0.00	0.00 F
Nursing	0.00	0.00	0.00 F	0.00	0.00	0.00 F
Allied Health	0.00	0.00	0.00 F	0.00	0.00	0.00 F
Support	0.00	0.00	0.00 F	0.00	0.00	0.00 F
Management/Administration	12.68	14.00	1.32 F	12.34	14.00	1.66 F
Other	0.00	0.00	0.00 F	0.00	0.00	0.00 F
Total excluding outsourced FTEs	12.68	14.00	1.32 F	12.34	14.00	1.66 F
Total :Outsourced Services	2.04	0.00	2.04 U	1.55	0.00	1.55 U
Total including outsourced FTEs	14.72	14.00	0.72 U	13.89	14.00	0.11 F

Comments on Major Financial Variances

Commercial services YTD results to August 2019 were unfavourable to budget by \$176k.

- Unfavourable variance was primarily driven by a retirement gratuity payment arising from a historical obligation to former Auckland DHB employees who were transferred to Compass under the Food Service Agreement.
- Total revenue to YTD Aug-19 was favourable by \$78k due to higher than budgeted car park revenue.

Community and Long Term Conditions Directorate

Speaker: Lalit Kalra, Director

Service Overview

The Community and Long Term Conditions Directorate is responsible for the provision a wide range of adult services.

The services covered are:

- Reablement (inpatient adult assessment, treatment and rehabilitation services)
- Community services (Intermediate Care, locality community teams and Mobility Solutions)
- Specialist Outpatient Services
- Hospital Palliative Care

The Community and Long Term Conditions Directorate is led by:

Director:	Lalit Kalra
General Manager:	Jennie Montague
Nurse Director:	Sheri-Lyn Purdy
Allied Health Director:	Anna McRae
Primary Care Director:	Jim Kriechbaum

Directorate Priorities for 2019/2020

In the 2019/2020 year our Directorate will contribute to the delivery of the Provider Arm work programmes. In addition to this we will also focus on the following Directorate priorities:

1. Services for the frail older adults
2. Responsive intermediate care services
3. Responsive diabetes services
4. Palliative Care services in all settings
5. Health and wellbeing for our people
6. Building Blocks for Sustainability

Adult Community and Long Term Conditions

A3 owner: Dr Lalit Kalra, Director

Te Toka Tūmahi Provider Directorate Plan 2019/20

Date: June 2019



Ngā whāinga : Our priorities	Kei hea tātou ināianei? Where are we now?	Ki hea te tihi o te hiahia? Where do we want to be?
1 – Services for Frail Older Adults	<ul style="list-style-type: none"> We understand the support needs of Age Related Residential Care (ARRC) facilities to manage our complex patients with chronic conditions We have co-designed patient referral pathways with ARRC, Primary Care and St John Ambulance We have developed a new way of working on Level 2 and a business case for an acute inpatient service for frail older adults in line with our frailty model of care 	<ul style="list-style-type: none"> We have specialist nursing support for ARRC facilities in localities Referrals to Intermediate Care are routinely made by ARRC and St John to avoid unnecessary presentation to the Adult Emergency Department Frailty pathways from Level 2 and direct admission to health of older adults services contribute to supporting better outcomes for older adults and managing overall acute patient flow
2 – Responsive Intermediate Care Services	<ul style="list-style-type: none"> There is no process or coordination across Auckland DHB for advance care planning (ACP) or defining goals of care and staff are not able to access ACPs reliably at the point of care delivery We have recruited Allied Health staff to the Rapid Community Access Team (RCAT) and now need to develop single access point and clear criteria for multidisciplinary referral from community and hospital 	<ul style="list-style-type: none"> All our patients in ARRC are supported to make an ACP and documented conversations with our patients about their health goals occur as part of everyday care We have an easy to access Interdisciplinary Intermediate Care Team to support timely transition from hospital and Primary Care referrals for our complex patients in the community
3 – Responsive Diabetes Services	<ul style="list-style-type: none"> We have a traditional clinic based model with high Did Not Attend (DNA) rates for our Māori, Pacific and other priority populations contributing to inequity of outcomes The model and tools for the provision of retinal screening means not everyone who should be screened is, increasing the risk of diabetic eye disease 	<ul style="list-style-type: none"> Existing specialist roles have evolved to work across settings and services to integrate care focused on improved engagement and outcomes for our Māori, Pacific and other priority patients We have the key components of an organised diabetic retinal screening service so that high-quality screening can be provided for everyone at risk of diabetic eye disease, in particular Māori and Pacific
4 – Supportive and Palliative Care Services in all settings	<ul style="list-style-type: none"> The hospital palliative care team is transitioning to improved ways of team working that integrate hospital-based and community services We do not have 24/7 access to specialist palliative care advice in the hospital We have a Palliative Care system of services that does not make the best use of resources available to support our patients and whānau 	<ul style="list-style-type: none"> There is access to 24/7 specialist palliative care advice in all Auckland DHB settings Referrers can identify palliative care needs and there is a single point of access for all specialist palliative care services Lasting, integrated, system-level processes are in place to enable all health professionals to identify and meet the palliative care needs of our patients and whānau in all care settings
5 – Health and Wellbeing of our People	<ul style="list-style-type: none"> Some staff tell us they feel their workloads are high and not distributed fairly Some staff do not feel safe to let us know when things are not right We have a developing wellness group integrated into our Health and Safety governance Recruitment processes are variable and Māori and Pacific staff are underrepresented in our workforce and in our more senior roles A significant proportion of staff do not have annual performance and development plans 	<ul style="list-style-type: none"> Our staff and leaders have the tools to ensure that workloads are manageable, fairly distributed and support a good work life balance All our staff feel able to speak up when things are not right and work with the principles of a 'Just Culture' We use TrendCare effectively to ensure the provision of timely, appropriate and safe nursing care We have standardised recruitment processes and a commitment to increasing our Māori and Pacific workforce Our staff have regular performance conversations supporting personal and leadership development We have effective systems and processes in place to identify, capture and respond to risk and safety issues
6 – Building Blocks for Sustainability	<ul style="list-style-type: none"> Our funding mechanisms are historical and do not reflect changing models of care Our teams do not have access to the right service metrics that accurately reflect performance against patient focused outcomes and are not sensitive to interventions or service change Locality services operate from an overcrowded building at Greenlane Clinical Centre Current services need to be aligned to the Northern Region Long Term Investment Plan (NRLTIP) objectives 	<ul style="list-style-type: none"> Long-term financial sustainability is built into every service delivery model Relevant and sensitive metrics are available and used by each of our services to monitor access, performance, patient outcomes and safety, and service quality We have a well developed community hub at Pt. Chevalier We have aligned services to the evidence based recommendations of the NRLTIP

#	Me pēhea tātou e tae ki reira? How are we going to get there?	Te Kaitohutohu : Owner	Due by	#	He pēhea te āhua o te angitu? What does success look like?	Current (end 2018/19)	Target (2019/20)
1	Establish a health of older adults acute service mid 2020	SCD	Q4	1	The proportion of patients seen on L2 by our frailty team that are not admitted to hospital	42%	50%
2	Develop single access point for Intermediate Care services and clear criteria for referrers	SCD	Q2		The proportion of patients that have a length of stay greater than 21 days in our Reablement wards	26%	22%
3	Put in place processes for recording ACPs and making them accessible, at the point of care delivery	GM	Q4	2	Improved scores from our patient experience survey in the domain of co-ordination of care	78%	95%
3	Establish a rapid access clinic for Diabetes Services	SCD	Q1		DNA rate for Māori in outpatient services	17%	9%
4	Implement Optimize within the retinal screening service	SCD/Ops	Q4	3	DNA rate for Pacific in outpatient services	21%	9%
4	Work with Mercy Hospice to establish 24/7 access to Specialist Palliative Care advice	SCD/GM	Q4		Improved engagement score in the domain of workload	50%	-
5	Support and train leaders to have meaningful performance conversations	GM	Q4				
6	Implement MediRota across all services	GM	Q3				
6	Develop metrics for each service that help us understand our health outcome gaps particularly for our Māori and Pacific patients	Director	Q4				
	Build a directorate and service level knowledge base for staff using Hippo	GM	Q4				

Glossary

Acronym/term	Definition
ACP	Advance Care Plan
ARRC	Age-Related Residential Care
DNA	Did Not Attend
Level 2	Adult Emergency Department, Clinical Decision Unit, Short Stay Inpatient Unit

Q1 – Progress against business plan

1. Better services for the frail older person

Our programme of work to support better services for the frail older person is on track. We have prioritised work streams focused on:

- specialist geriatric management of frail older people throughout Level 2
- avoiding unnecessary hospital presentation of frail older people
- developing the acute geriatrics model due for implementation in May 2020

These workstreams continue our implementation of best practice for providing high-quality care to older people and also towards reducing capacity pressures in the hospital setting, consistent with the strategic vision set out in the Long Term Investment Plan.

Over the last 12 months, the percentage of patients going directly home after being seen by this team has increased. Central to this model is the interdisciplinary team that can coordinate care in the community. We are working on pathways and capacity to admit patients with multidisciplinary needs best met by geriatrics services directly to Reablement wards. We have developed a comprehensive geriatric assessment document that will be visible in our core systems to all clinicians involved with care. We have actively engaged other directorates in this work.

We are building on this success by developing relationships in the community (St John, Age-Related Residential Care (ARRC) and primary care) and working on common pathways to provide a coordinated response to changes in health or minor accidents in frail older patients in the community.

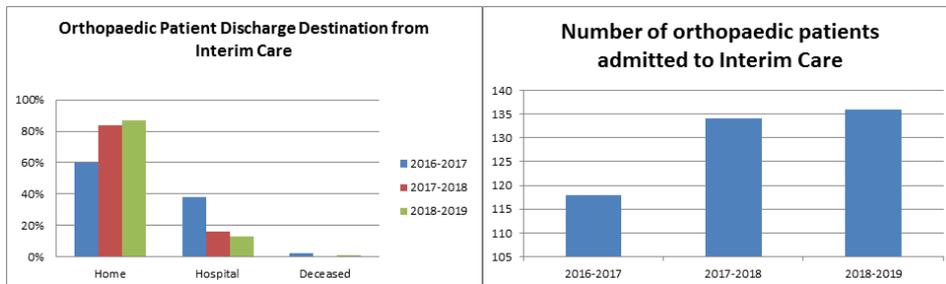
We are moving to an acute geriatrics model which will work in conjunction with the 7-day Senior Medical Officer led service for specialist assessment and management of frail older patients who present to Level 2, within the frailty model of care. The acute model will improve access to specialist management and time-efficient interdisciplinary care for frail older people requiring hospital admission.

2. A responsive intermediate care services

Our goal for our Intermediate Care function is an easy to access interdisciplinary team which supports the timely transition from hospital and care closer to home. We are contributing to the Length of Stay work as the evidence base for a robust intermediate care team is excellent. The critical task is strengthening referrals to the multidisciplinary Rapid Community Access Team to support patient pathways such as cellulitis, chronic obstructive pulmonary disease and chronic heart failure, early supported discharge from Level 2, General Medical, Surgical and Reablement wards.

We are on track for having a single robust point of access in place for Q2.

A recent audit of our interim care patients has demonstrated a sustained change in the benefit of a rehabilitation focus in interim care. The hospital bed-days saved in FY16/17 was 2900 bed-days saved in FY18/19 this had risen to 4600 bed-days saved.



We have prioritised the workaround Advance Care Plans (ACP). An Advance Healthcare Plan detailing patient and whānau preferences for goals of treatment, level of desired care, transfer to hospital and ceiling of care will be completed for residents in ARRC facilities at the time of entry and updated regularly. This initiative has been endorsed by a collaborative group of consumer representation, ARRC facilities, primary care, funding and planning, St John, community and hospital representatives and aligns with the Advance Care Planning and Goals of Treatment programmes endorsed by HQSC.

We now have a process in place for primary care to share ACPs via the eReferrals platform.

3. Responsive Diabetes Services

We have implemented a rapid access clinic in our diabetes clinic. The purpose of the clinic is to provide specialist input for patients care and transition them back to primary care.

We continue to see high non-attendance rates for Māori and Pacific Peoples at our diabetes clinics, for whom there is a higher prevalence of diabetes and diabetic complications. Our health coach role continues to improve engagement with patients. A health coach is person-centred and provides care close to home. Health coaching is a way to help patients build resilience to participate and take an active role in their health care. With this patient group, we have seen improved individual outcomes by working with patients and are looking to see what is scalable as part of the co-design projects with primary care.

We have reviewed our satellite clinics and are changing the model of booking for these clinics to make them more accessible to the community.

4. Palliative Care Services in all settings

There is a real opportunity for a “step change” in the delivery of Specialist Palliative Care services across Auckland DHB to allow the development of a critical mass of professionals to support an integrated service for people with a life-limiting illness. We are working in partnership with the Mercy Hospice and other stakeholders to develop models of care. The goal is to move the focus of palliative care away from selected patients in specialist settings to delivering comprehensive and supportive palliative care in the community.

We have a small steering group reviewing the opportunities to progress towards a more integrated model.

5. Health and Wellbeing of Our People

'Time to hire' for new candidates remains below the Auckland DHB target. It has been challenging to fill some Physiotherapy, Occupational Therapy and some Nursing positions however turnover is at the lowest it has been in the past three years and has dipped below the Auckland DHB target for the first time in the past three years.

There is a greater focus on equity of health outcomes within the directorate. We are in the process of building a Kaupapa Māori Supervision Framework which will be launched to the nurses in our Adult Community Service later in the year. A Māori staff network meeting has also been sponsored in the directorate by the general manager. The directorate has also committed to sending 15 key people to attend the Engaging Effectively with Māori course running in Quarter 2 of the 2019/2020 financial year.

Our Wellness Group is going from strength to strength. The Group has an intranet site for information and events which is regularly updated. It has organised several outdoor activities and has introduced mindfulness sessions within services.

Performance Conversations recorded on Kiosk is an area where there is a significant improvement. The actual figure currently sits at just under 59% this increased from approximately 30 % at the end of the last quarter and 10% at the same time the previous year.

6. Building blocks for sustainability

We have implemented a new scheduling module in community Services which will support our services to work together more effectively with patients.

We have implemented MediRota for our Reablement Service; the Sexual Health service is on track to be online in October.

We have developed easy to reference guidance, using our intranet, for staff across the Provider arm to understand processes relating to Taikura support (DSS funding) and PPP&R. Providing useful information to our staff is part of the work valuing our patients time and reducing the length of stay. When staff have clear information, it improved communication between the clinical team and patients and their whānau.

Scorecard

Auckland DHB - Adult Community & Long Term Conditions

HAC report for August 2019

Equitable - equity is measured and reported on using stratification of measures in other domains				
Safety				
Metric		Actual	Target	Previous
Medication errors with major harm	PR215	0	Lower	0
Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	PR185	4.6%		5.3%
Number of falls with major harm	PR199	1	Lower	1
Number of reported adverse events causing harm (SAC 1&2)	PR084	1	Lower	1
% Hand hygiene compliance	PR195	81.13%	>=80%	R/U
Patient-centred				
Metric		Actual	Target	Previous
% Patients cared for in a mixed gender room at midday - Adult	PR175	14.86%	<=2%	19.63%
% hospitalised smokers offered advice and support to quit	PR129	100%	>=95%	90.91%
% DNA rate for outpatient appointments - Māori	PR057	22.78%	<=9%	33.55%
% DNA rate for outpatient appointments - Pacific	PR058	23.03%	<=9%	26.41%
% DNA rate for outpatient appointments - All Ethnicities	PR056	12.04%	<=9%	13.13%
% DNA rate for outpatient appointments - Deprivation Scale Q5	PR338	16.16%	<=9%	19.19%
% Very good and excellent ratings for overall inpatient experience	# PR154	78%	>=90%	94.7%
% Very good and excellent ratings for overall outpatient experience	# PR179	89%	>=90%	89.8%
Timeliness				
Metric		Actual	Target	Previous
% of inpatients on Reablement Services Wait List for 2 calendar days or less	PR023	89.14%	>=80%	91.02%
% Discharges with Length of Stay less than 21 days (midnights) for Reablement	PR193	74.48%	>=80%	69.23%
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Total	PR328	0	Lower	0
(ESPI-2) Number of patients waiting longer than 4 months for their FSA - Deprivation Scale Q5	PR332	0	Lower	0
Effectiveness				
Metric		Actual	Target	Previous
28 Day Readmission Rate - Māori	# PR079	0%	<=6%	10%
28 Day Readmission Rate - Pacific	# PR080	0%	<=6%	7.14%
28 Day Readmission Rate - Total	# PR078	4.23%	<=6%	5.3%
28 Day Readmission Rate - Deprivation Scale Q5	# PR322	3.03%	<=6%	9.68%

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

Amber	Variance from target not significant enough to report as non-compliant. This includes percentages/rates within 1% of target, or volumes within 1 value from target.
#	Actual is the latest available result prior to August 2019
R/U	Result Unavailable

% Hand hygiene compliance

Results Unavailable

Scorecard Commentary

- There were no medication errors with major harm and two Severity Assessment Code incidents which are currently being investigated and are within AERC timelines.
- Maintaining gender appropriate areas remain a priority, re-orientation of the rooms will occur as soon as it is practical. Consent is gained prior to any patient entering a mixed gender room and patients are reviewed on a shift by shift basis when discharges occur.
- The progress on reducing the Did Not Attend (DNA) rate for outpatient services (particularly the Diabetes Service) remains steady. We have a focus on specifically reducing the DNA rate for Māori over the next 12 months to close the gap for DNA rates.
- Our discharges with a long length of stay has improved but there are further improvements to the complex patient pathway we will be making this year.

Key achievements

- We have introduced the scheduling module within our core clinical system in Community Services. This gives better visibility to activity with patients across the team and supports multidisciplinary working.
- We were planning to move the last of our second locality to Pt Chev in October. This is now a busy site with lots of clinical activity.
- We opened 7 new beds in the Reablement wards which has supported hospital flow this winter.
- Our Health and Safety inductions are now above 95% for both e-learning completing and local inductions. This is the best performance in the Provider arm.
- Use of Volunteers within our service is continuing. Enhancing the patient experience and making better use of the patient’s day to reduce overall length of stay.

Areas off track and remedial plans

- Recruitment for subspecialty medicine Senior Medical Officers has proved challenging. This is specifically a challenge in Immunology where there is a national and international shortage. We have worked with the team to review the service model of care.
- We have a reduced hospital palliative care team but we are seeking support from Mercy Hospice to maintain an acceptable service level.
- Accessable has launched on a new service application platform (aSAP). Unfortunately this has had a significant impact on our ability to order equipment for patients as the implementation has been difficult. We are working regionally with Ministry of Health support to address this issue.

Key issues and initiatives identified in coming months

- We continue our implementation of the frailty model of care both in hospital and in the community.
- The intermediate care team is making changes to support increased referrals and improved clinical governance.
- We are focused remaining within budget and delivering our savings plan.
- The Sexual Health service is working closely with Auckland Regional Public Health Services to monitor and proactively manage the current outbreak of syphilis in Auckland.

Financial Results

STATEMENT OF FINANCIAL PERFORMANCE							Reporting Date Aug-19		
<i>Adult Community and LTC</i>									
(\$000s)	MONTH			YEAR TO DATE (2 months ending Aug-19)					
	Actual	Budget	Variance	Actual	Budget	Variance			
REVENUE									
Government and Crown Agency	1,229	1,184	44 F	2,385	2,369	16 F			
Funder to Provider Revenue	6,749	6,749	0 F	13,643	13,643	0 F			
Other Income	37	18	19 F	55	36	19 F			
Total Revenue	8,015	7,951	63 F	16,083	16,048	36 F			
EXPENDITURE									
Personnel									
Personnel Costs	5,027	4,791	(236) U	9,895	9,556	(339) U			
Outsourced Personnel	64	53	(11) U	146	107	(39) U			
Outsourced Clinical Services	115	112	(3) U	211	223	13 F			
Clinical Supplies	943	973	29 F	2,006	1,964	(42) U			
Infrastructure & Non-Clinical Supplies	148	160	11 F	402	319	(83) U			
Total Expenditure	6,297	6,088	(210) U	12,660	12,170	(491) U			
Contribution	1,717	1,864	(146) U	3,423	3,878	(455) U			
Allocations	668	529	(139) U	1,127	1,035	(91) U			
NET RESULT	1,050	1,335	(285) U	2,297	2,843	(546) U			
Paid FTE									
	MONTH (FTE)			YEAR TO DATE (FTE) (2 months ending Aug-19)					
	Actual	Budget	Variance	Actual	Budget	Variance			
Medical	79.1	74.1	(5.0) U	79.7	74.1	(5.6) U			
Nursing	300.4	288.4	(12.0) U	300.3	288.4	(11.9) U			
Allied Health	142.8	141.2	(1.6) U	144.2	141.2	(2.9) U			
Support	0.0	0.0	0.0 F	0.0	0.0	0.0 F			
Management/Administration	60.9	58.1	(2.8) U	62.5	58.1	(4.4) U			
Total excluding outsourced FTEs	583.2	561.8	(21.4) U	586.6	561.8	(24.8) U			
Total :Outsourced Services	2.2	2.1	(0.1) U	3.5	2.1	(1.4) U			
Total including outsourced FTEs	585.4	563.9	(21.6) U	590.1	563.9	(26.2) U			

Comments on Major Financial Variances

The result for August is \$285k U and the year to date result is \$546k U.

Funder to Provider Revenue volumes are at contract for the year to date and don't include the wash-up for the high volumes.

The main drivers of the \$546k unfavourable variance for the year to date are:-

- \$378k U Personnel including outsourced, predominantly driven by ward rostering for seasonal occupancy/acuity validated by Trendcare; high volumes in key areas especially Dermatology and Sexual Health; FTE for special projects which are finishing shortly and FTE vacancy targets not being achieved due to timing.
- \$73k U high-cost blood products, especially in Dermatology, due to high volumes;
- \$39k U Savings from the use of phone interpreters not achieved.

Volumes

Price Volume Schedule (PVS) volumes are currently estimated at \$0.3M (2.5%) above base contract for the year to date. The wash up will be reflected in the accounts after quarter one.

Forecast

We are forecasting to break even for the year.

Māori Health Services

Recommendation

That the Hospital Advisory Committee:

1. **Receives the Māori Health Services report for October 2019.**
2. **Notes the status and progress of Māori Health Services at Auckland DHB.**

Prepared by: Riki Nia Nia (General Manager, Māori Health)

Endorsed by: Joanne Gibbs (Director, Provider Services)

Māori Led Events in 2020

In 2020 there will be 5 key Māori led events. Namely:

1. Te Tiriti o Waitangi Celebrations
2. Matariki Awards
3. Te Wiki o te reo Māori
4. Kahui Hononga (x2)

We will continue to implement these important events in collaboration with the Auckland DHB Communications team. The events are designed to expose our organisation to Māori health intelligence, best practice, innovation and excellence. The events are also an opportunity for our DHB to champion the importance of Mātauranga Māori and its importance to how we care for whānau within our district. We will share more details on these events with the Board before the end of the year.

Āke Āke APP

The DHB's Āke Āke APP was born out of a desire to raise cultural awareness amongst our healthcare staff, with a view to improving health outcomes for Māori. New Zealand Doctor have shared a video of the App through their website, engaging a wider audience.

<https://www.nzdoctor.co.nz/article/news/health-it/tikanga-Māori-app-breaking-downbarriers-dhb-staff-and-patients>

Recently we upgraded the Āke Āke APP to include:

1. More 'kupu'
2. More 'waiata'
3. More 'karakia'
4. More user friendly functions

The APPs intelligence and contents was endorsed by Dame Naida Glavish (Chief Advisor Tikanga, Auckland DHB). The content is also being used as an integral part of our Level 3 Certificate in Te Reo Māori, which the DHB provides in partnership with Te Wānanga o Awanuiārangi. We have received positive feedback about our APP. For example, one of our staff at Waitemātā DHB said, '*What an innovative, interactive and inclusive way to incorporate the learnings from another culture to improve healthcare outcomes for everyone. Ka kite ano.*' - Ben Bradley

To date the APP has been downloaded over 2500 times and is available free to all New Zealanders on either IOS or Android devices. It can be downloaded at:

The App Store:

<https://apps.apple.com/app/id1435134156?fbclid=IwAR0MmMpq20-XdVORRjP2Jk9vrK2DDLxv6igBvhQGBcYUptRh8mGPaT0pZI>

Google Play:

<https://play.google.com/store/apps/details?id=com.kiwamedia.android.qbook.WTA0001&fbclid=IwAR3U5oFjeoNrfEZm8seLpOLb3No4LIPIVWRO2h3HaMULN2UDcSeQKaghMw>

Model of Care Review – He Kāmaka Waiora

The Model of care review of He Kāmaka Waiora Services has commenced. The objective of the review is to strengthen our approach and the work we do to care for and support whānau who utilise hospital services.

Reviewers have started to look at whānau experience and utilisation data across our hospitals and hospital services. Six wānanga were planned across both our DHBs with Iwi, Kaumātua, our staff, whānau and wider DHB staff. Ethics approval has also been completed. To date five Wānanga have been implemented. These have been with Whānau, wider DHB staff, He Kamaka Waiora staff, Iwi and Kaumātua. Another staff Wānanga is planned.

The methodology for conducting the review is aligned to Kaupapa Māori methodologies. The methodology is trans-disciplinary in that it integrates oral history and custom, wānanga (deliberation), and pūrākau (storytelling). These approaches to the research recognise the need to decolonise methodologies. It attempts to foreground indigenous epistemological constructs, recreating and reaffirming the diversity of Māori experiences within context of the He Kāmaka Waiora service.

A site visit of similar Māori support services at Bay of Plenty DHB, Waikato DHB and Lakes DHB has also been implemented in an endeavour to gain exposure to relevant intelligence in the Māori support service space. The final He Kāmaka Waiora Services review report is due in December 2019.

Preliminary Findings and Actions:

The reviewers have provided systematic reporting of findings as they make process with the review. Given the nature of some the findings, where necessary we have implemented a number of immediate actions to address.

Preliminary Findings	Action
<p>Positive examples of values based service delivery by the team have surfaced. For example; in terms of Manaakitanga: Reviewers have found that staff commitment to patients, whānau and community often goes over and above position descriptions, providing services in own time and resources.</p> <p>In terms of Kawa whakaruruhau: Reviewers have found that staffs endeavour to meet whānau needs as they see them; practices are whānau led and centred.</p> <p>Supporting and growing wider hospital staff cultural</p>	<p>These positive findings of the service will be reinforced and utilised to underpin the refreshed model of care.</p>

<p>practice and accountability also takes place regularly.</p> <p>Service Enablers not fully in place. For example, there are policy gaps, and a very low level of IT support is provided to the service. For example the service does not receive real time reporting of Māori patient admissions to any of the DHBs hospitals as they occur.</p>	<p>A 6 month service development plan has been developed and endorsed by the GM Māori Health and Chief Advisor Tikanga. He Kāmaka Waiora Quality Forum was established in August and TOR posted to the Waitematā DHB Controlled Documents web page in September. The main focus of the forum in the first instance will be the finalisation of the services core policies and procedures. An updated He Kāmaka Waiora Risk register has been developed and approved. This will be monitored by the Corporate Divisional Meeting at Waitematā DHB.</p>
<p>There are significant limitations in the way the service reports its performance. The current approach needs to be strengthened and better enabled by technology.</p>	<p>A conversation has commenced with IT to identify ways to:</p> <ol style="list-style-type: none"> 1. Enable real time reporting to the service of Māori patient admissions 2. To apply more SMART capability to the services reporting functions 3. A process has commenced to look at strengthening service level reporting, both quantitative and qualitative.
<p>He Kāmaka Waiora services are expected to see 65% of Māori inpatients(<55) and 95% of Kaumātua inpatients(>55). Based on the data received this requires the team of 12 staff to see approximately 17300 people per annum across 4 hospitals, between 830am and 430pm on week days. A rigorous process of prioritisation needs to be implemented.</p>	<p>The review will provide informed comment on the prioritisation of the services target population in the future.</p>
<p>Staff wellness, training and development should be a priority for the service. Because of the huge demands on the team it appears investment in the development of the team’s capability has not been prioritised. Staff wellness has also been identified as a priority.</p>	<p>All staff will be supported to complete the Takarangi Competency Training Framework and Portfolio development program over the next 6-12 months. The Leading Quality Healthcare training programme provided at Waitematā DHB will be implemented with the services Site Leaders and Team leader before the end of the year.</p> <p>A staff wellness plan in being developed.</p>
<p>Service Coverage at ADHB</p> <p>He Kāmaka Waiora services endeavour to visit the following areas on a daily basis:</p> <p>Star Ship Hospital - Oncology (27A&B), Neurology (26A), Cardiology (23A), Paediatric Intensive Critical Unit (PICU), Other areas by referral only.</p> <p>Auckland Hospital – High Dependency Unit (31), Coronary Care (34), Renal Failure (41), Cardio ByPass /Repair (42), Cardiac Intensive Care Unit (48), Cancer (62&64), High Dependency Unit (81), Neurology (82), High Dependency Unit (83), Birthing (91), Newborn Intensive Critical Unit (92), Tamaki, Motutapu (11), Old People Health (13&14).</p>	

Māori Patient and Whānau Experience Leadership

We have been working closely with the Patient Experience teams at both Auckland and Waitematā DHBs to strengthen the capability in the teams to enable our staff to understand the Māori patient experience and ways to improve this when required. This has resulted in the appointment of a new Māori Patient and Whānau Experience Leadership role at Auckland DHB. Vanessa Duthie has been seconded to this role from the Māori Health Team for 12 months. We are currently in the process of recruiting a similar role at Waitematā DHB.

MALT Update

With the recent secondment of Vanessa Duthie to the Patient and Whānau Experience team at Auckland DHB for 12 months, we have appointed Selah Hart as her interim replacement. Selah is a past employee of Waitematā DHB and is very familiar with the DHB's MALT workforce program.

Waitangi Tribunal Kaupapa Inquiry Stage Two

Preparation for Stage 2 hearings has commenced by the DHBs. Stage 2 of the Inquiry will focus on:

- a. Mental health (including suicide and self-harm);
- b. Māori and disabilities; and
- c. Alcohol and substance abuse (including claims related to tobacco).

A stocktake of innovations in each of the focus areas for Stage 2 is underway. We are also working to identify content experts and spokespeople for each of the key focus areas.

Just Culture

We have been proactively supporting the implementation of Just Culture. Just culture refers to a values-supportive model of shared accountability. It's a culture that holds organisations accountable for the systems they design and for how they respond to staff behaviours fairly and justly. We have identified that critical to the success of Just Culture implementation at Auckland DHB will be ensuring we have robust Māori health, Māori health equity, Tikanga, Pae Ora and Te Tiriti o Waitangi policy in place guiding our daily practice at all levels. This will help us to ensure the DHB is well placed to advance and meet its Māori health aspirations within the Just Culture framework.

He Kamaka Waiora Māori Health Services

A3 owners: Chief Advisor Tikanga, Auckland DHB and General Manager of Māori Health, Auckland DHB

Te Toka Tumai Business Plan 2019/20

Date: May 2019



1

Ngā whāinga : Our priorities	Kei hea tātou ināianei? Where are we now?	Ki hea te tahi o te hiahia? Where do we want to be?
1 – Review, strengthen and implement a new Model of Care for He Kamaka Waiora Services	<ul style="list-style-type: none"> Current service level measures are limited and do not capture key performance areas The team currently has limited capacity that is widely spread as the service has a wide scope and focus Wider understanding of the service and its functions is low. There fore access to the service could be improved upon 	<ul style="list-style-type: none"> A high performing provider, that has a refreshed model of care base d on Te Ao Maori intelligence, relevant evidence , Iwi, whānau, and wider stakeholder aspirations A more robust set of service performance measures A robust, capable and engaged workforce able to effectively implement model of care changes Better , more timely whānau access to high health quality services that positively contribute to their Oranga (Wellbeing)
2 – Develop and facilitate the implementation of the MALT work program and its key objectives	<ul style="list-style-type: none"> MALT work program is currently in draft Consistent workforce reporting within the region remains an issue. It is not timely, standardised or accurate Directorates are still to adequately reflect their commitment to MALT objectives in their Business Plans Our ability to recruit more Māori has been strengthened, however both our retention and attraction of Māori remains a serious issue 	<ul style="list-style-type: none"> Finalised MALT Work program 2019/20 More robust and timely Māori Workforce reports are implemented, particularly across the selection process and in the area of retention Our Maori retention rates have improved by 20% All Directorates have adopted the MALT targets for recruitment, retention and development and these are adequately reflected in their respective Business Plans
3 – Develop and implement a new Māori capability training framework aimed at lifting the capability and commitment of our workforce to care for Whānau	<ul style="list-style-type: none"> The capability and commitment of our workforce to care for Whānau is variable. This is reflected by both the inequitable health outcomes we achieve for Māori as a system and the low representation of Māori in our workforce New graduates from our tertiary institutions do not always arrive fit for purpose, from both a cultural competence and capability perspective There are gaps in our internal training program, which means the status quo will not remedy this matter 	<ul style="list-style-type: none"> A new Māori training framework is developed and implemented across the DHB A new Māori training policy is developed that outlines training expectations for our staff Minimum capability requirements of all staff are agreed and a process to implement across the DHB has commenced
4 – Develop a strategic framework for eliminating 'Racism' against Māori in our organisation	<ul style="list-style-type: none"> Māori staff continue to face racist attitudes and behaviours on a daily basis within our organisation There is currently no safe and effective way for to report racism in our organisation Māori staff tend not to report racism when it occurs. This unfortunately reinforces our racist behaviours and infrastructure 	<ul style="list-style-type: none"> A framework aimed at the elimination of racism in our DHB is developed Our workforce is more aware of, intolerant of and become champions for the elimination of racism in our DHB Staff feel safe and enabled to report racism and the organisation is capable to respond effectively to these reports Our DHB actively promotes Māori health excellence, innovation and best practice

#	Me pēhea tātou e tae ki reira? How are we going to get there?	Te Kaitohutohu : Owner	Due by	#	He pēhea te āhua o te angitu? What does success look like?	Current (end 2018/19)	Target (2019/20)
1	Implement a comprehensive review of He Kamaka Waiora Services	GM Māori Health	Q2	1	Comprehensive review and implementation of He Kamaka Waiora Services	10% Completed	100% Completed
	Implement findings of the comprehensive review	GM Māori Health	Q4				
2	Develop MALT Work program	GM Māori Health	Q1	2	Development of MALT Work program	75% Completed	100% Completed
	Facilitate implementation of work program across the DHB	GM Māori Health	Q2				
3	Develop a robust Maori cultural training framework	GM Māori Health	Q3	3	Development of a robust Maori cultural training framework	50% Completed	100% Completed
	Implement Framework	GM Māori Health	Q4				
4	Develop a framework for eliminating racism against Māori	GM Māori Health	Q3	4	Development of a framework for eliminating racism against Māori	25% Completed	100% Completed
	Implement Framework	GM Māori Health	Q4				

5.7

Mental Health and Addictions Directorate

Speaker: Anna Schofield, Director

Service Overview

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

The Mental Health and Addictions Directorate is led by:

Director:	Anna Schofield
General Manager:	Alison Hudgell
Medical Director:	Allen Fraser
Director of Nursing:	Tracy Silva Garay
Director of Allied Health:	Mike Butcher
Director of Primary Care:	Vacant

Directorate Priorities for 2019/20

Integral to Mental Health's business plan is a patient and family/whānau focus, along with integration and collaboration. To this end, we will work with mental health and physical health services and other agencies and sectors locally, regionally and further afield to improve outcomes for service users.

In 2019/20 our Directorate will contribute to the delivery of the Provider Arm work programmes. In addition to this we will also focus on the following Directorate priorities:

1. Mental Health Inquiry: the Ministerial direction from the Mental Health Inquiry will be addressed at the Directorate level
2. Mental Health Action Plan: commission and provide community-based services that put people first, are culturally competent and work from a strength-building approach
3. Our People: We are committed to enabling our people to do their 'life's best work' in Mental Health and Addictions Services.

Mental Health and Addictions

A3 owner: Anna Schofield, Director

Te Toka Tumai Provider Directorate Plan 2019/20

Date: June 2019



Ngā whāinga : Our priorities	Kei hea tātou ināianei? Where are we now?	Ki hea te tihi o te hiahia? Where do we want to be?
1 – Mental Health Inquiry	The Mental Health (MH) Inquiry catalyst was widespread concern about mental health services, within the mental health sector and the broader community. The Inquiry report captures the voices of all stakeholders about NZ's current approach and what needs to change and recommends specific changes to improve this approach with a particular focus on equity of access, community confidence in the mental health system and better outcomes, particularly for our Māori patients and other groups with disproportionately poorer outcomes. A Ministerial response to the Inquiry Report will be released in March 2019.	The Ministerial direction from the Mental Health Inquiry will be addressed at the Directorate level.
2 – Mental Health Action Plan	This plan has been developed by the Auckland DHB Mental Health directorate and the Mental Health and Addictions Programme Board in response to stakeholder feedback on the need to move toward holistic, empowering and culturally responsive supports, more of which can be accessed early and in community settings.	This action plan will help us commission and provide community-based services that put people first, that are culturally competent and which work from a strength-building approach. Most importantly, we need to attract a wider scope of practitioners into mental health and addiction careers, with more support and development offered so everyone can do their best work.
3 – Our People	Our teams continue to work on being healthy, safe and supportive with opportunities for everyone to improve their practice and increase their skills as one team.	We are committed to enabling our people to do their 'life's best work' in Mental Health and Addictions Services.

#	Me pēhea tātou e tae ki reira? How are we going to get there?	Te Kaitohutohu : Owner	Due by	#	He pēhea te āhua o te angitu? What does success look like?	Current (end 2018/19)	Target (2019/20)
1	We will be accountable and develop an approach to respond to the MH Inquiry ministerial decisions regarding Inquiry Report Recommendations	Director	Q4	1	Inquiry Milestone: We will develop and implement required plans to meet the expected ministerial milestones	Commenced	On-going
2	Everything we do is person and whānau-centred, strength-based and empowering. An empowering approach means people determining their own priorities for support. This can make the greatest difference to wellbeing	Director	Q4	2	Action Plan Milestone: We will actively engage in Building for the Future to ensure facility planning supports people and whānau to get the full range of support they need, at the time they first need it and, wherever possible, in their community	To be commenced	On-going
	People find our services are culturally appropriate and affirming and are actively driving down inequities. By connecting with those communities with high unmet needs, we come to understand their priorities and work with them to respond in the ways that make a real difference	Director	Q4		Action Plan Milestone: We will develop and implement required plans to meet the expected Auckland DHB Programme Board milestones	To be commenced	On-going
	People and whānau get the full range of supports they need, at the time they first need it and, wherever possible, in their community. This community orientation for mental health and addiction requires practitioners working as one system with a shared goal of good mental health, wellbeing and equity	Director	Q4	3	Quality Care Milestones: We will implement the Health Quality and Safety Commission Mental Health 5 year Improvement Programme	In progress	Completed
The workforce gets the support required to do their best work and to enjoy a rewarding career in mental health and addiction services. Everyone working in the field needs to be trained and supported to do their best work. The vision is of many skilled workers working together across disciplines and borders as one team	Nurse Director Allied Health Director Medical Director	Q4	Patient Safety Milestones: 1. Trendcare is fully implemented with 100% actualisation across all our Mental Health inpatient wards/departments in preparation for Care Capacity Demand 2. Management to ensure appropriate response to patient acuity and nursing staffing		To be commenced	On-going	
3	Patient safety, quality care and improved health status will be delivered through the Key Result Areas across the Directorate	Director	Q4	3	Our People Milestones: 1. Engagement Survey - target of 85% engagement for next survey 2. Actions plans are developed, implemented and reviewed 3. Succession Mapping across services will continue to evolve	Commenced	Completed
	We will attract and retain an 'Aim High Angamua' workforce through recruitment, growing our current and future leaders and succession planning. Workforce strategies will support this and we will work together as one team to achieve this	General Manager	Q4		Improved Health Status Milestones: 1. Actions in relation to Equally Well will be implemented to reduce the health disparities for those with low health prevalence health conditions and/or high needs 2. Understand and address inequities for our Māori patients in relation to Compulsory Treatment Orders	To be commenced	Completed

Glossary

Acronym/term	Definition
ACOS	Acute Community Outreach Service
CAMHS	Child and Adolescent Mental Health Services
CBD	Central Business District
FTE	Full-time Equivalent
MoH	Ministry of Health
NGO	Non-Government Organisation

Q1 Actions

1. Mental Health Inquiry

The government response to He Ara Oranga, the Mental Health Inquiry, was to adopt 38 of the 40 recommendations pertaining to 10 themes:

- Expand access and choice
- Transform primary health care
- Strengthen the non-government organisation (NGO) sector
- Enhance wellbeing, promotion and prevention
- Place people at the centre
- Take strong action on alcohol and other drugs
- Prevent suicide
- Reform the Mental Health Act
- Establish a new Mental Health and Wellbeing Commission
- Wider issues and collective commitment

The Wellbeing Budget that followed provides an investment of \$1.9 billion over four years for mental health. Over \$445 million is for primary mental health services, aimed at helping 325,000 people with mild to moderate mental health and addiction needs by 2023-24. This will include having trained mental health workers in doctors' clinics, iwi health providers and other health services. New workforces will be required and \$212m is for health workforce training and development. \$40 million is committed to a new suicide prevention strategy. \$200m for DHB capital investments will be ring-fenced for new and existing mental health and addiction facilities.

We will, at the Directorate level, continue to work toward the Ministerial direction from the Mental Health Inquiry.

Senior leaders in the Mental Health Directorate are being kept informed by the Ministry of Health of progress in relation to these recommendations, including an interim Mental Health and Wellbeing Commission and the establishment of a Suicide Prevention Office. Initial work is underway on the repeal and reform of the Mental Health Act.

At the Directorate level, we are engaged in the following activities that align with He Ara Oranga:

- Māhere Angamua: Mental Health 3 year action plan. See Section 2
- Zero Suicide: development of a framework for implementation in Auckland DHB. See section 1.1
- Workforce: Our People. See section 3

- Alignment Across the Mental Health Continuum: a partnership approach with NGOs to enable the right people delivering the right services in the right place. See section 1.2
- Intersectoral work: focused on the social determinants of mental health and addiction across multiple aspects of wellbeing to address poor social outcomes. See section 1.3.

1.1 Zero Suicide Initiative

As noted above the Government response to He Ara Oranga and the Wellbeing Budget included the establishment of a national suicide prevention office, and increased suicide prevention services delivered by District Health Boards. The Government has not endorsed any particular approach or any targets in relation to suicide prevention.

The Mental Health and Addictions Programme Board elected to implement the Zero Suicide Framework with a view to partnership work with primary care and NGOs. This is a quality improvement framework designed for the purpose of preventing suicide within the population served by a health provider. A project manager has been employed and initial work has focused on the potential scope and scale of implementation of the framework for the Programme Board.

1.2 Alignment across the Mental Health Continuum

He Ara Oranga recognised the increasingly important contribution the NGO sector makes to the delivery of government-funded mental health, addiction and wider health and social services. The Mental Health Directorate is supporting this through a number of initiatives including:

- the housing specialist role employed by an NGO and embedded with specialist mental health services
- the employment, professional support and development of nursing positions providing services to the City Mission
- the reallocation of community support roles from the DHB to NGO employment. This is in keeping with the right services being delivered by the right people in the right place and closer to home. NGOs have the management and workforce development framework for community support work. In the spirit of partnership, the function and form of this realignment is occurring through a co-design process, involving specialist consumers and their whānau and DHB funded mental health specialist services and NGOs. The intention is for this transition to occur in December 2019.

1.3 Intersectoral Work

Housing, and social determinants such as education, employment, family violence and poverty are underlying factors that contribute to overall wellbeing. The impacts of social determinants are complex, interactive and cumulative, and the same social determinants often influence a whole range of social outcomes. In focusing on the social determinants of mental health and addiction, it quickly becomes apparent that the same factors and responses have a role across multiple aspects of wellbeing and poor social outcomes, including such as child abuse and neglect, offending and reoffending, family violence, educational underachievement, unemployment and homelessness.

The interventions needed to prevent poor outcomes and promote wellbeing are often similar across many social problems and sectors and consequently the Mental Health Directorate is involved in a range of intra and intersectoral initiatives. These include:

- Mental Health Programme Board with responsibility for governance of the Auckland DHB Mental Health Action Plan (see 1.1) and a number of workstreams
- Tūhono which is focused on DHB funded providers of NGO and Auckland and Waitematā DHB mental health services with a joint programme of work.

Other mental health related cross sector initiatives include the regional Child and Adolescent Mental Health Services (CAMHS) Oranga Tamariki Network, Taikura Trust Mental Health Governance Group, Ministry of Social Development Work and Income Steering Group and the Central City Collective focused on homelessness and housing in the Central Business District (CBD).

At the DHB level there are programmes of work regarding the interface between Mental Health and other health services including the Community and Long Term Conditions Executive Health of Older People Group. Work across Mental Health and Emergency Department has been re-established at an operational level through regular forums with terms of reference and measures reporting through to a Steering Group of senior leaders.

These initiatives are aimed at improving outcomes for service users who are reliant on a joined up approach / interface between the respective services and agencies involved.

2. Māhere Angamua Mental Health Action Plan 2019 - 23

Māhere Angamua, a forward plan of action for better mental health, wellbeing and equity 2019 - 2023, will guide the actions of Auckland Mental Health and Addictions services over the next three years. It was developed by the Auckland DHB Mental Health Directorate and the Mental Health and Addictions Programme Board working alongside staff, service users, providers, whānau and others. Māhere Angamua is governed by Auckland DHB's Mental Health and Addictions Programme Board.

Māhere Angamua offers a big vision for the longer term along with a small number of prioritised actions that can realistically be advanced within the resources available. These priorities for local action were developed through engaging with staff, service users, providers, whānau and others.

Auckland DHB is now well aligned with the direction for mental health and wellbeing outlined in Te Ara Oranga, the government inquiry into mental health and addiction. We also draw on the recommendations within Whakamanawa, the report which captured the voices of Māori submitters to the Inquiry, and the Mental Health Inquiry Pacific Report.

Māhere Angamua provides a vision for the longer term, along with a small number of prioritised actions that can be realistically advanced within the resources available. The four paths for action, that will be addressed and implemented through a programme of work, led by the programme board, are:

- An empowering response
- Equitable wellbeing outcomes
- Big community response
- Enhanced workforce

The Action Plan is now finalised having had further input from stakeholders to determine priority areas for implementation.

Using Māhere Angamua as our guide, we will commission and provide services that put people first, that are culturally safe and intelligent, build on strengths and enable autonomy. This shifts us towards holistic, empowering and culturally responsive supports, which people can access in community settings and when mental health and addiction issues first arise.

Some of this work is already underway and will be strengthened. We will also develop new programmes that give early access to services in the community.

All the developments proposed rely on a workforce where people are well supported to do their best work. We need an expanded range of practitioners, all of whom have the opportunity to grow their skills and have a rewarding career.

3. Service Improvement Initiatives to Meet Increasing Demand

3.1 Adult Acute Flow

Auckland DHB Mental Health Adult Acute Inpatient Service Te Whetū Tāwera is constantly at capacity. The four adult service groups that refer service users for admission have over a sustained period of time had an increased demand for services and an increase in acuity; and the level of unwellness of service users has contributed to a further increase in demand for beds at Te Whetū Tāwera.

3.1.1 Patient Flow Project

A Patient Flow Project has been implemented, with the support of the Service Improvement team, to address these issues. The outcomes of the project are to:

1. Increase turnover for Te Whetū Tāwera Inpatient Acute Unit and reduce pressure across the 4 adult service groups
2. Developing / refining enablers for integrated care delivery
3. Integrated approach for clinical care planning between adult service groups
4. Improve experience for service users and whānau
5. Service user to enter acute service groups in a timely manner

A further benefit of this project will be improved value add use of our staff time from the reduction in support through more timely access to acute adult services.

The project has focused on identifying root causes and solutions for improvement, as well as reviewing initiatives already underway in Te Whetū Tāwera to leverage off them to support improvement through workshops with key stakeholders.

While this process has been in progress, there have been positive changes in the Length of Stay and earlier admissions. A new care pathway has been defined through this process, along with technological enhancements to further support collaboration and integrated care planning. The next phase is for the Mental Health Directorate to implement these solutions so that they are sustainable, monitored and reviewed regularly.

3.1.2 Lead Clinician

A lead clinician role is currently being trialled in Te Whetū Tāwera. A key component of this role is to provide clinician to clinician consultation and advice pre admission. The role has been in place for around 16 weeks and, during this period, there have been some shifts downward in average weekly

bed usage in Te Whetū Tāwera aside from a spike at the end of May / early June. It is thought the Lead Clinician role has contributed to this trend.

3.1.3 Acute Care Coordinator Role Reconfiguration

The on-going challenges associated with increased demand, along with challenges associated with the way in which the role is currently operating, have contributed to an increasing level of tension between inpatient and community services across the four adult service groups.

The Acute Care Coordinator role is intended to work across the four adult service groups to manage the admission pathway from community to inpatient and the transition back to the community. This includes accessing beds out of the Auckland DHB catchment, having up to date knowledge of all available respite community beds that can be utilised as an alternative to an admission into the acute mental health unit, as well as facilitating an effective discharge process from Te Whetū Tāwera.

Having a cohesive acute care coordinator as part of the acute pathway is a priority to improve the flow and linkages between the adult inpatient and community service groups. Currently the Acute Care Coordinator role has been focused on the movement of service users within the inpatient setting rather than across the continuum of care. Consequently the role has been redesigned to provide:

- improved flow across the adult inpatient and community service groups
- greater overall knowledge of demand for beds on any day
- a single point of access for respite and acute beds in Te Whetū Tāwera and outside Auckland DHB area
- strengthening of the integrated whole of system approach (inpatient and community) for adult resource management
- greater involvement in quality initiatives and improving the flow across the inpatient system of care
- clearer knowledge of all parts of the system and ability to escalate potential issues earlier

A recruitment process is underway for this role.

3.1.4 Housing Specialist Role

Suitable housing is a significant barrier to earlier discharge for some service user, in particular those using the Assertive Community Outreach Service (ACOS) who work with people from across Auckland providing wraparound support to their users, including those needing to be discharged from Te Whetū Tāwera. ACOS has found housing to be a significant bottleneck for their service user group and a proposal for a two year pilot to employ a housing specialist integrated into Te Whetū Tāwera with an initial focus on ACOS, followed by the Taylor Centre (which covers the CBD area), clinical services has recently been approved. The aim of the Housing Specialist is to enable service users early in their admission to Te Whetū Tāwera to have housing as a key part of their recovery plan and to live independently on discharge. The pilot is based on a proven evidence based model, whereby mental health and other services are integrated with non-clinical specialists (in this case housing specialists) working in a mental health team so that housing becomes part of a person's treatment plan.

The next step is for the Request for Proposal to be released to non-government organisations providing relevant mental health services by our Planning and Funding team.

3.2 Services and Models of Care, including current provision and accessibility are understood to inform future responses to demand and need

3.2.1 Regional Youth Forensic Service:

From 1 July 2019 the age criteria for the Youth Court increased to include 17 year olds who were previously dealt with in adult courts and this is likely to see at least a 40% - 50% increase based on Oranga Tamariki modelling of 17 year olds in the youth justice system currently. There is a risk this is a conservative figure and numbers could be higher.

Oranga Tamariki have also determined a need for a further 35 residential beds in the Auckland area across a further 4-5 facilities which could potentially include an additional 20 bed residential unit as well as 3 highly specialized therapeutic smaller care homes.

It is noted this older age group of 17 years will likely present with greater morbidity and severity of offending than 14-16 year olds and the change will significantly impact on the Regional Youth Forensic Service (RYFS).

As the lead provider of the RYFS service, we have engaged with our regional partners to initiate a review of the effectiveness of the current hub and spoke model and to make recommendations to strengthen it to provide an integrated and co-ordinated service to meet the needs of the Youth Justice system in Metro Auckland and Northland District Court areas from July 1st 2019.

In addition, the Well-Being Budget has indicated increased funding for RYFS however we have not, as yet, been informed how this funding might be used to service the increased volumes and address the need for a changed model of care to support this.

Given the timeframe of July 2019, the Mental Health Directorate has undertaken stakeholder engagement in advance, including a Hui Māori and Pacific and an intersectoral workshop, to proactively consider options for alternative and improved service delivery in the future.

A key theme from the stakeholder engagement, given that the majority of young people in the RYFS service are Māori and Pacific, is to invest in kaupapa Māori and Pacific specialist services to deliver all non-clinical work with a strong emphasis on cultural responsiveness and engagement with young people and their whānau. There may be an opportunity for Oranga Tamariki Youth Justice and DHB Mental Health services to commission the same services in the longer term. Such an approach aligns with the Mental Health Inquiry report findings.

4. Our People

With specialist mental health services constantly at capacity and no let up in demand particularly in our acute services, coupled with on-going vacancies that are proving challenging to fill, we are mindful of increasing pressure on our mental health workforce. We are endeavouring to manage this recruitment and a focus on wellbeing.

We are developing a specifically tailored Recruitment Strategy for hard to recruit Mental Health Clinicians and non-clinical/support staff with our recruitment partners that highlights Auckland as a destination.

In terms of Wellbeing, we are working closely with our Human Resources business partner to support our peoples Wellbeing with a focus on:

- Developing high performing teams within the Mental Health and Addiction Directorate and providing outstanding professional and personal development opportunities. This includes accelerating capacity and skill by encouraging their uptake in the Management Development Programme
- Implementing the succession management plan for leadership and key positions in Mental Health that has been developed with leaders across our services
- A Workforce Strategy for Nursing has been developed and senior nursing staff are involved in determining key priority areas
- Work is underway with the Senior Medical Officer group to develop a Medical Workforce Action Plan
- Actively supporting our people to implement action plans developed at team and service level, in response to the employee engagement survey.

Scorecard

Auckland DHB - Mental Health

HAC report for August 2019

Equitable - equity is measured and reported on using stratification of measures in other domains				
Safety				
Metric		Actual	Target	Previous
Medication errors with major harm	PR215	0	Lower	0
Nosocomial pressure injury point prevalence (% of in-patients)	PR097	0%		0%
Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	PR185	0%		0%
Number of falls with major harm	PR199	0	Lower	0
Number of reported adverse events causing harm (SAC 1&2) - excludes suicides	PR201	1	Lower	0
Unviewed/unsigned Histology/Cytology results >=30 days	PR596	0	Lower	0
Reduction in number of AWOLs from inpatient units	PR740	13	Lower	12
Discharges with face-to-face contact within 7 days of discharge	PR230	100%	>=95%	97%
Screening for Family Violence	PR741	78.12%	>=90%	76.74%
Reduction in physical assaults in acute inpatient units	PR742	17	Lower	29
Reduction in verbal threats and abuse in acute inpatient units	PR743	9	Lower	7
Patient-centred				
Metric		Actual	Target	Previous
% hospitalised smokers offered advice and support to quit	PR129	92.86%	>=95%	97.56%
Seclusion episodes: Total	PR213	0	<=7	4
Seclusion episodes: Māori	PR761	0	Lower	1
Seclusion episodes: Pacific	PR762	0	Lower	1
Reduction in episodes of personal restraint	PR214	30	<=86	47
Family/Whānau engagement (Adult CMHS)	PR763	33.08%	>=30%	31.25%
Identifying clients who are parents	PR764	42.81%	>=40%	42.62%
Smoking screening and VBA: Community	* PR765	43%	>=95%	40.88%
Mental Health Act - Family consultation for S76 Reviews	PR779	98.8%	>=30%	93.98%
Timeliness				
Metric		Actual	Target	Previous
3 week Waiting Times: 0-19 years - Total	PR223	65%	>=80%	64.4%
3 week Waiting Times: 0-19 years - Māori	PR785	69.06%	>=80%	68.27%
3 week Waiting Times: 0-19 years - Pacific	PR786	64.94%	>=80%	66.2%
3 week Waiting Times: 0-19 years - Asian	PR787	64%	>=80%	64.84%
3 week Waiting Times: 0-19 years - Other	PR788	63.56%	>=80%	62.55%
3 week Waiting Times: 65+ years - Total	PR227	71.7%	>=80%	71.9%
Section 76 Reviews Completed on Time: Māori	PR744	52.63%	100%	50%
Section 76 Reviews Completed on Time: Non-Māori	PR745	51.10%	100%	51.69%

Effectiveness				
Metric		Actual	Target	Previous
Real time feedback: Percentage of people who would recommend our service	PR780	59.09%	>=90%	65.38%
Percentage of discharges with paired HoNOS assessments - inpatient	PR757	59.8%	>=80%	53.85%
% of people seen face-to-face with HoNOS assessment - community (90 day)	PR746	38.11%	>=80%	43.39%
Provider Arm Access - 0-19Y Total	PR205	2.44%	>=2.05%	2.42%
Provider Arm Access - 0-19Y Māori	PR202	3.92%	>=2.58%	3.94%
Provider Arm Access - 0-19Y - Pacific	PR758	1.67%	>=1.4%	1.7%
Provider Arm Access: 0-19Y - Asian	PR759	1.36%	>=1.12%	1.31%
Provider Arm Access: 0-19Y - Other	PR760	3.06%	>=2.8%	3.02%
28 day Acute Mental Health Re-Admission Rate - Māori	PR789	0%	<=10%	9.09%
28 day Acute Mental Health Re-Admission Rate - Pacific	PR790	0%	<=10%	18.18%
28 day Acute Mental Health Re-Admission Rate - Total	PR791	4.71%	<=10%	8.26%
28 day Acute Mental Health Re-Admission Rate - Deprivation Scale Q5	PR792	0%	<=10%	6.67%

Efficiency				
Metric		Actual	Target	Previous
Discharge transition planning - inpatient	PR781	65.69%	>=95%	53.85%
Discharge transition planning - community	PR782	36.03%	>=95%	34.47%
Te Whetū Tāwera Barriers to discharge: number of people waiting >14 days	PR783	R/U	Lower	8

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

* Quarterly

PR765 (Quarterly)

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

R/U Result Unavailable

Te Whetū Tāwera Barriers to discharge: number of people waiting >14 days

Results Unavailable

Scorecard Commentary

Screening for Family Violence

Although below target, Mental Health Services perform well relative to other services and ongoing efforts to improve screening continue, with regular reporting to, and review by, teams.

% Hospitalised Smokers offered Advice and Support to Quit

Smoking Screening and VBA – Community

A range of initiatives, as reported previously, continue in the smokefree workstream. These include quarterly reporting via dashboards, and other more targeted actions. Inpatient services continue to explore reasons for low compliance when it occurs.

S76 Reviews Completed on Time

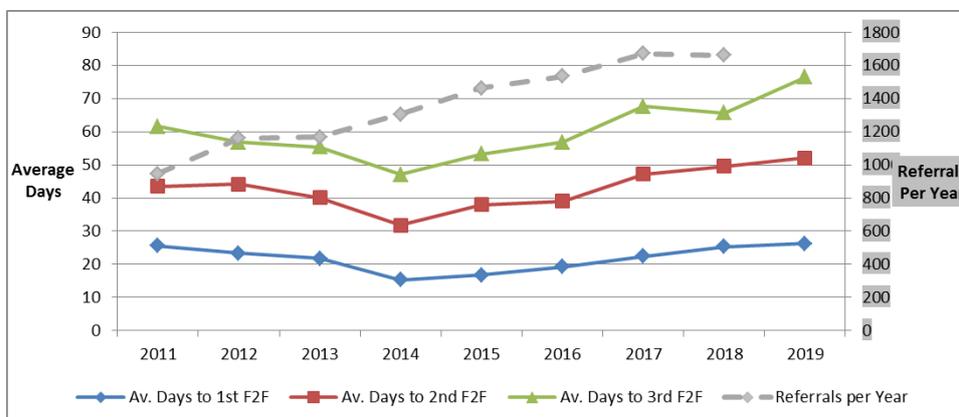
This metric has only recently started to be reported. A system of automated weekly reminders has now been rolled out to both Mental Health Act administrators and Responsible Clinicians. This is aimed at improving awareness of, and planning for, upcoming reviews, as well as their timely completion.

Wait Times

Waiting times reporting is undertaken by Ministry of Health (MoH) using PRIMHD data supplied to them by DHBs. Following a period when Auckland DHB was unable to supply data, we have now resumed full and regular data submissions.

Waiting times remain a challenge for the Older Adult Community Team (Mental Health Service Older People) and for the Child & Adolescent services. Both services have experienced growth in demand and associated activity. In Child & Adolescent services the increase in waiting times for 1st, 2nd and 3rd face-to-face appointments mirrors the growth in referrals (see graph below). The increase in demand and waiting times is occurring for CAMHS services nationally.

Counts of referrals and days waiting for 1st, 2nd, 3rd Face-to-Face appointment at Kari Centre by calendar years



Real Time Feedback

The uptake of Real Time Feedback has been variable. Work is being undertaken to identify a range of approaches to engaging with service users and their families to develop more useful feedback on their experiences.

% Inpatient Discharges with Paired HoNOS assessments

% Community Clients seen Face-to-Face with HoNOS Assessment

Improving the collection and utilisation of HoNOS assessments and data is ongoing. A long-standing issue for clinicians has been the lack of access to data that is collected. A range of reporting has now been made available to improve that data access. It is available on team, clinician and service user levels. The aim, over time, is to not only improve compliance with collection requirements but to use HoNOS data in meaningful ways within teams and with service users. Training on using the new reports is being provided to services and key clinicians.

Discharge Transition Planning (Inpatient & Community)

This is a focus within the HQSC's Connecting Care workstream. Services have previously received feedback on a quarterly basis as part of the MoH PP7 Quarterly report process. Developing monthly reporting to give more regular feedback on progress towards these targets continues to be explored with services.

Key achievements in the month

Māhere Angamua Mental Health Action Plan

The final version of Māhere Angamua, the mental health three year action plan, was presented to the Board for endorsement on 25 September. See section 2 for further details on the Action Plan.

Areas off track and remedial plans

Supra-Regional Eating Disorder Service

There have been discussions with Waikato and Bay of Plenty Mental Health leadership regarding the potential to have a 3 – 5 year contract with Midland DHBs for the adult residential component of the Eating Disorder Programme. The Regional Funder for Mental Health in Midlands has signalled a willingness to confirm their utilisation of the residential unit over the next 3 years and we await correspondence confirming this. This is in keeping with Waikato indicating a desire to ultimately provide services closer to home but enabling all parties to plan for the future whilst other options are explored.

Key issues and initiatives identified in coming months

Facilities

The refit of the alternative facility for the St Lukes Community Mental Health Team to make it fit for purpose is underway. It was hoped the move could happen in September. Unfortunately some landlord related issues (building leaks and plumbing) will need to be fixed before the service can move into the building and the revised date for the move is November 2019.

With the Taylor Centre Community Mental Health Centre facility lease ending in October 2021 and given the challenges with sourcing either a DHB owned or commercial facility in an alternative location, work is ongoing to address safety issues inherent in the style of this building as an extension to the lease is likely to be the preferred option at this stage.

Mental Health is a workstream under the Building for the Future Programme. It is anticipated that Mental Health may be included in Tranche 2 of this programme with the initial focus being

on urgent needs, such as providing more adult acute inpatient space and office accommodation.

Awe Mātau Whānau Education Project Update

Awe Mātau is a whānau education project around psychosis that aligns with recovery and cultural approaches, a strengths focus, and holistic frameworks of health. As Māori and Pacific people experience higher rates of psychosis than the general population, it has been important to ensure the programme is culturally responsive and aligned with Māori and Pacific models of health which generally involve equilibrium of mind, body, spirituality and family. Thus this is a relationship based programme of skills and knowledge, embracing the four cornerstones of Te Whare Tapa Whā.

The development of Awe Mātau has been possible as the result of a generous donation to our Mental Health Directorate in 2018 and through the active involvement of our Family Advisor and a project reference group made up of cultural advisors, lived experience experts and clinicians.

The programme has piloted with two whānau groups and feedback has been very positive. Currently the course material, consisting of facilitators and participants packs is in final design with a view to going to print in the near future. Awe Mātau will be formally launched in Quarter 2.

Financial Results

STATEMENT OF FINANCIAL PERFORMANCE							Reporting Date Aug-19		
<i>Mental Health & Addictions</i>									
(\$000s)	MONTH			YEAR TO DATE (2 months ending Aug-19)					
	Actual	Budget	Variance	Actual	Budget	Variance			
REVENUE									
Government and Crown Agency	77	79	(2) U	165	158	7 F			
Funder to Provider Revenue	10,229	10,215	14 F	20,444	20,430	14 F			
Other Income	140	61	79 F	227	121	106 F			
Total Revenue	10,446	10,355	91 F	20,837	20,709	127 F			
EXPENDITURE									
Personnel									
Personnel Costs	7,084	7,718	634 F	14,204	15,376	1,172 F			
Outsourced Personnel	211	23	(188) U	384	48	(337) U			
Outsourced Clinical Services	73	123	50 F	141	245	104 F			
Clinical Supplies	93	86	(7) U	200	171	(29) U			
Infrastructure & Non-Clinical Supplies	375	399	24 F	804	799	(5) U			
Total Expenditure	7,836	8,349	513 F	15,734	16,639	905 F			
Contribution	2,610	2,006	604 F	5,102	4,070	1,032 F			
Allocations	2,046	2,039	(7) U	4,104	4,080	(24) U			
NET RESULT	564	(33)	597 F	999	(10)	1,008 F			
Paid FTE									
	MONTH (FTE)			YEAR TO DATE (FTE) (2 months ending Aug-19)					
	Actual	Budget	Variance	Actual	Budget	Variance			
Medical	88.8	102.2	13.4 F	89.7	102.2	12.5 F			
Nursing	350.2	357.7	7.5 F	350.0	357.7	7.7 F			
Allied Health	239.6	266.2	26.6 F	238.9	266.2	27.4 F			
Support	7.3	7.4	0.0 F	7.4	7.4	(0.0) U			
Management/Administration	60.8	62.5	1.7 F	60.5	62.5	2.0 F			
Total excluding outsourced FTEs	746.8	796.0	49.2 F	746.4	796.0	49.6 F			
Total :Outsourced Services	12.0	0.0	(12.0) U	11.5	0.0	(11.5) U			
Total including outsourced FTEs	758.9	796.0	37.1 F	757.9	796.0	38.1 F			

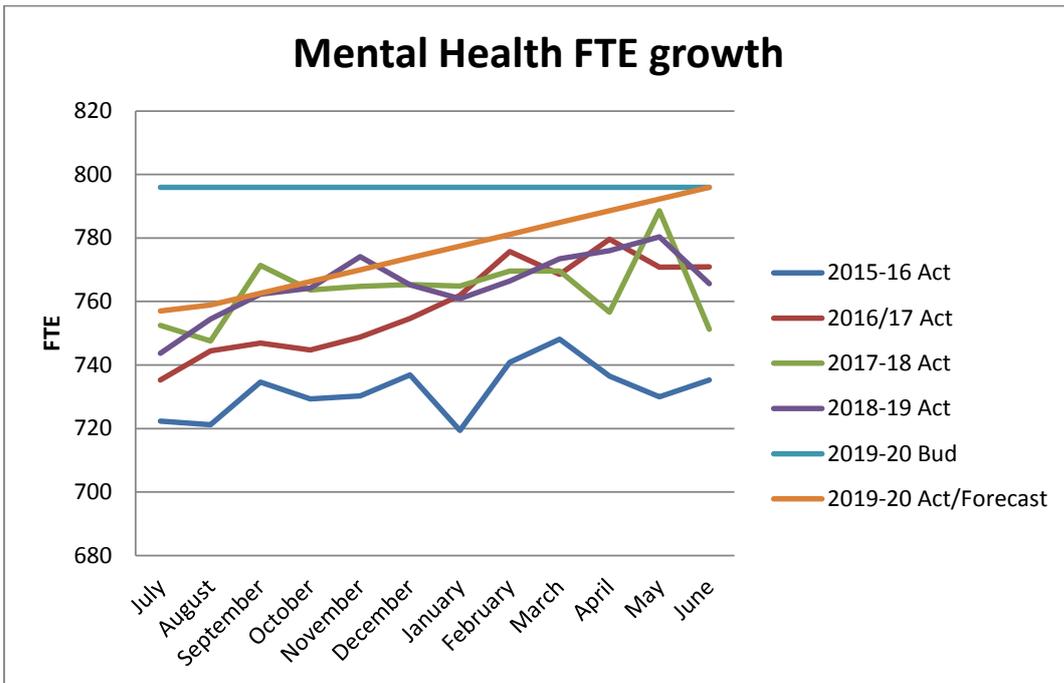
Comments on Major Financial Variances

Mental Health Directorate is favourable to budget for the month of August (\$597k F), and also favourable for the year to Date (\$1,008k F).

The main drivers of the year to date favourable variance are:

- (1) Personnel costs (\$835k F including Outsourced Personnel), with 38 Full-time Equivalent (FTE) less than Budget. There are on-going recruitment difficulties with challenges attracting various staff categories. The Service has been actively recruiting, including developing recruitment videos across 6 different services. With new projects, new graduates, interns and respite services coming on board later this year, we are expecting a steady increase of total FTE number;
- (2) Revenue upside received from higher than budget Youth Court Reporting processed;
- (3) Slower uptake of the Funded GP Visit Discharge pathway programme.

We are forecasting that the favourable variances will reduce over the year as per historic trends, as follows:-



Patient Management Services

Speaker: Alex Pimm, Director

Service Overview

Patient Management Services provide a range of clinical and non-clinical services to support the effective running of Auckland City Hospital, Starship Hospital and Greenlane Clinical Centre as well as other off-site locations.

The services include:

- 24/7 Hospital Functioning Team
- Patient Transport Service
- Orderly Service
- Equipment Pool
- Transition Lounge
- Transit Care Team
- Temporary Staffing Bureau and Resource Nursing Team
- Trendcare and Safe Staffing Team
- Chaplaincy Liaison
- Cleaning Services
- Waste Services
- Staff Residences
- Building for the Future Programme
- Production Planning
- Volunteer Service

Patient Management Services is led by:

Director: Alex Pimm

Nurse Director: Jane Lees

Glossary

Acronym/term	Definition
IOC	Integrated Operations Centre

Patient Management Services

A3 owner: Alex Pimm, Director

Te Toka Tūmahi Provider Directorate Plan 2019/20

Date: June 2019



Ngā whāinga : Our priorities	Kei hea tātou ināianei? Where are we now?	Ki hea te tihi o te hiahia? Where do we want to be?
1 – Quality and safety	<ul style="list-style-type: none"> Largely reactive with a focus on operational issues Limited quality and safety data available to support decision making or prioritisation Tend to focus on post-incident management rather than risk management Large numbers of policies that require reviewing being worked-through Restraint action plan in place, policy revised and processes being reviewed, NZ forum in place 	<ul style="list-style-type: none"> Identified and trained 'Just Culture' champions in the service Improved use of Datix for incident reporting and response action planning Service risks are known and escalated with mitigation plans in place Up-to-date policies and procedures in place Culture of assessment and de-escalation with restraint being an intervention by exception
2 – Patient experience	<ul style="list-style-type: none"> Some patient experience metrics are captured, however these are limited to specific services Limited patient representation in service design or reconfiguration initiatives Some understanding of impact of services on the overall patient experience 	<ul style="list-style-type: none"> Patients and whānau have a positive experience within our services Staff are culturally competent and committed Patients are engaged in key service developments Good quality patient experience data is available for all services
3 – Our people	<ul style="list-style-type: none"> Turnover reduced during the past year and sickness absence higher than desired To Thrive programme embedded Career progression pathways in place but in infancy Staff survey recently completed Variable staff engagement Relatively new leadership in place Positive union engagement 	<ul style="list-style-type: none"> High levels of staff engagement across all services Turnover and sickness absence within agreed limits Developed career progression pathways in place and knowledge of opportunities available are shared with staff Leaders are capable and competent Performance and development plans in place for all leaders and managers Good quality, standardised staff induction and orientation programmes in place for each service Comprehensive response to the staff survey being implemented Effective systems and processes in place to identify, capture and respond to risk and safety issues
4 – Responsive services	<ul style="list-style-type: none"> Services are reactionary and often fail to foresee predictable issues Teams do not always work well together and sometimes have competing priorities There can be delays for service to respond to changes in demand Service models have remained unchanged in some areas, whilst significant change has occurred in other services 	<ul style="list-style-type: none"> Integrated operations centre in place with new ways of working embedded Appropriate tools in place to providing 'real time' information and support decision making, including demand predictions Services are able to flex to meet demand, remaining responsive to patient needs Patients wait no longer than necessary
5 – Technology	<ul style="list-style-type: none"> Limited or out-dated technology in place to support service delivery Reliance on paper and verbal processes Data quality and accuracy issues due to multiple entry of the same information, transcribing information from system-to-system and permissive systems 	<ul style="list-style-type: none"> Technology is used to support service improvement and day-to-day operations Technology is used to support staff engagement People are enabled to do their job to the best of their ability
6 – Financial sustainability	<ul style="list-style-type: none"> Financial challenges in some services, with particular pressure on pay costs Higher than desired spend on overtime, excess annual leave and agency usage Cost pressures in equipment maintenance and clinical supplies Constrained capital available 	<ul style="list-style-type: none"> Sustainable financial position that supports best practice and high quality service provision Minimal usage of overtime and agencies Resourcing decisions supported by evidence and best practice All services reviewed and opportunities for waste minimised

#	Me pēhea tātou e tae ki reira? How are we going to get there?	Te Kaitohutohu : Owner	Due by	#	He pēhea te āhua o te angitu? What does success look like?	Current (end 2018/19)	Target (2019/20)
1	Development of a comprehensive risk register for the service	Director	Q1		Each service has a risk register in place	30% of services	100% of services
	Key service leaders attend 'Just Culture' training	Director	Q2				
2	Staff complete cultural competency training	Director	Q4	1	Service performance metrics established for each service	Metrics in place for most services	Metrics in place for all services
	Develop and implement service-level action plans in response to the staff survey	Director	Q4		Clinical nurse managers fully trained to respond safely to code oranges, applying least restrictive practice	75% of team trained	95% of team trained
	Conclude consultation in hospital operations portfolio, embedding 'one team' approach and revising leadership structure	Operations Manager	Q1				
3	Launch an integrated training and career development programme in conjunction with the Supportive Employment Team	Operations Managers	Q2	2	We understand what's important to our patients from our services	Limited metrics in place	Patient experience data available
	Continue to deliver the To Thrive programme and evolve programme in response to feedback from members of staff	Director	Q3		Staff survey response action plan in place	Key focus areas identified	Action plan in place
	Open new Integrated Operations Centre with revised way of working	Director/ Nurse Director	Q2	3	Level 4 and 5 NZQA qualification courses are in place	Staff enrolled on level 4 course	Staff completed level 4 and enrolled on level 5 courses
4	Continue to support the roll-out of Care Capacity Demand Management (CCDM) across the organisation	Nurse Director	Q4		Identified managers have participated in Management Development Programme	10%	70%
	Embed capacity and demand modelling into day-to-day work and use outputs to plan services	PP Managers/ NUM	Q2	4	Future state model for the Transition Lounge is fully described, considering changes through the Building for the Future strategic programme	Initial ideas documented	Model described
5	Launch Temporary Staff Bureau booking and scheduling app	Operations Manager	Q1	5	Digital technology (orderly and transit system; and bureau app) in place	Scoping work completed	Apps in use
	Implement new orderly and transit digital system	Operations Manager	Q2	6	Year-end budget position is breakeven	Unfavourable	On budget
6	Work with healthAlliance, NZ Health Partnerships Limited and other DHBs regarding procurement opportunities, including waste and temporary staffing contracts	Director	Q4				

Scorecard

Auckland DHB - Patient Management Services

HAC report for August 2019

5.9

Equitable - equity is measured and reported on using stratification of measures in other domains				
Safety				
Metric		Actual	Target	Previous
Medication errors with major harm	PR215	0	Lower	0
Number of falls with major harm	PR199	0	Lower	0
Number of reported adverse events causing harm (SAC 1&2)	PR084	0	<=12	0
Areas audited passed the cleaning audit standard relevant for their area	PR795	95%	>=90%	91.88%
High risk areas achieved 100% cleaning audit compliance	PR796	89%	>=90%	93.59%
Proportion of shift requests filled by the temporary Staffing Bureau	PR797	85.80%	>=85%	84.41%
Patient-centred				
Metric		Actual	Target	Previous
% hospitalised smokers offered advice and support to quit	PR129	100%	>=95%	R/U
Timeliness				
Metric		Actual	Target	Previous
Bed request from adult level 2 to bed allocated within 30 minutes	PR798	52%	>=80%	50%
Orderly service – jobs completed within 30 minutes of request	PR799	43.80%	>=80%	62.25%
Transit nursing – jobs completed within 30 minutes of request	PR800	57.4%	>=80%	74.78%
Effectiveness				
Metric		Actual	Target	Previous
Percentage of target staff attendance through service POP meetings	PR801	92%	>=90%	98.18%
Adult hospital occupancy forecast accuracy	PR802	88.71%	>=90%	88.41%
Efficiency				
Metric		Actual	Target	Previous
Staff residence occupancy	PR803	80%	>=70%	71.2%

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

24/7 hospital functioning and patient flow

- Hospital occupancy has remained significantly higher than previous years. On average, there is an increase of approximately 4.9% in midnight occupancy through winter compared to the same period last year (June 2.1%; July 7.0%; August 4.2%; September 6.5%). This has put substantial

pressure on all clinical and non-clinical services across the hospital and resulted in some days of extremely high occupancy.

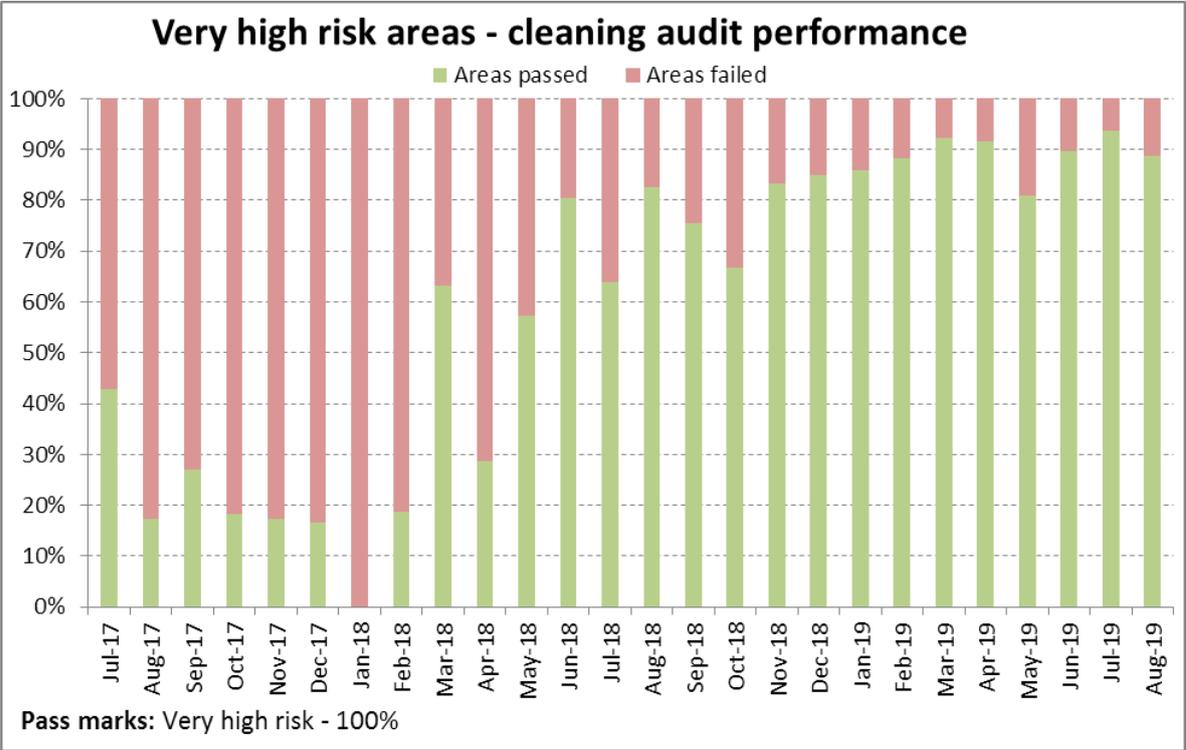
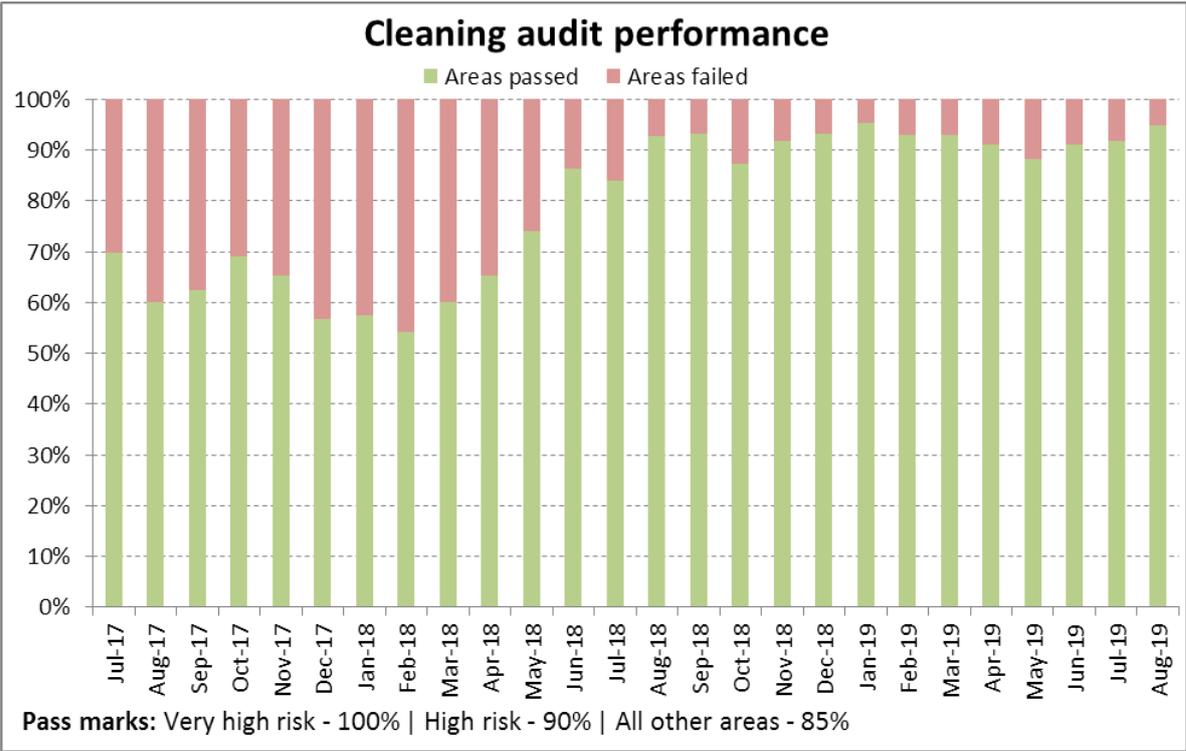
- The time from bed request on adult level 2 (adult emergency department and clinical decisions unit) is influenced by a number of factors, including bed availability, clinical decision making, systems and process, and responsiveness of the patient flow team. In August 2019 just over half of bed requests were allocated an available bed on a ward within 30 minutes. The main reason for delay in allocating a bed was a lack of bed availability.
- The service has put on hold progressing the hospital transit system project due to capital constraints. In the interim the service continues to focus on minimising waiting times for an orderly or transit nurse. This includes adjusting the rosters to ensure that the most people are available when demand is highest.
- Planning for the new Integrated Operations Centre (IOC) is well underway. A steering group has been established to oversee the development of this work, including: development and use of dashboard and live information; processes and ways of working; and the design of the new facility to support integrated working. The new facility is expected to be opened and in use in mid-November 2019.
- The associated IOC dashboards have gone live after extensive user testing. These provide real-time information to clinical nurse managers, patient flow facilitators, charge nurses, senior managers and others to better support decision-making regarding the daily hospital operations. It is planned to release further views to different audiences, including the senior manager on-call and emergency department, and integrate forecasting into future dashboards.

Cleaning Services

- In August 2019, 95% of areas audited passed the cleaning audit standard relevant for their area. This result is above the target of 90% of areas passing and an improvement on previous recent months.
- Performance for very high risk areas is slightly below the 90% target, at 89% for August 2019. This is primarily related to dusting in harder to reach places and floor cleaning under patient beds. With the high hospital occupancy it has not always been possible for cleaners to access patient spaces to clean to the level required to meet the audit standard. This is managed on a case-by-case basis with the relevant charge nurse and cleaning supervisor.
- As hospital occupancy has remained high throughout winter there has been an increased pressure on discharge cleans. The cleaning team have prioritised patient areas in the immediate clinical environment and post-discharge cleans. For example, dusting in corridors and changing rooms has not been completed as frequently.

Waste Services

- The regional waste collection tender process with healthAlliance and metro-Auckland DHBs is progressing and likely to be concluded in late October 2019.
- The service has recently commenced battery collection and recycling and is exploring the recycling of other items and products. The team are also working on compostable collections for food and coffee cups/lids.



Staff Residence

- The overall occupancy rate for August was 80%, significantly above plan. Following further advertising of the facility, there has been an increase in uptake of the rooms.

- Over the past few months the team have focussed on repainting and repairing individual room areas. Focus now moves back to communal spaces including storage rooms, laundry, toilets and shower rooms. There is limited further work that can be done without significant capital investment.
- The staff residence team is working closely with recruitment to advertise the residence to new members of staff, particularly those looking for local, single person, cost-effective accommodation. The service is also working with the Nursing Development Unit to provide accommodation to students on the workforce scholarships programme.

Volunteer Service

- The Volunteer Service transitioned to Patient Management Services in September 2019 following a consultation of the executive leadership team portfolios. This moves the volunteer team within the provider arm.
- The existing service manager, coordinator and admin support staff have been retained and their positions have not been affected by this change.
- The service is reviewing its work plan for the year, including identifying opportunities for development and expansion of the volunteer programmes across the organisation to best support patients.

Progress of quarter one actions

- **Development of a comprehensive risk register for the service**

Risk workshops have been held with the service's senior team and a directorate risk register has been developed. Work continues to ensure that every service has a comprehensive risk register in place. Risks are reviewed regularly, including through service performance and development meetings and significant risks are escalated to the directorate register.

- **Conclude consultation in hospital operations portfolio, embedding 'one team' approach and revising leadership structure**

The consultation document and decision document have been released covering the orderly service, patient transport coordinators, and level 5 reception teams. The proposals aim to embed a 'one team' approach, improve the service's responsiveness and update the service line management structure to provide improved leadership and management. New service leadership roles were established as part of the restructure (supervisor and team leader), which have been fully recruited to. Other changes, including the merger of the dispatch and patient transport coordinator teams is on-going and expected to be concluded in October 2019.

- **Launch Temporary Staff Bureau booking and scheduling app**

A mobile application has been launched for the temporary staff bureau team. This expands the use of Workforce Centre and allows bureau members of staff to provide their availability and book themselves into available shifts through the app, rather than by text message or telephone call. As the app is an extension of the already in place Workforce Centre product, there has been minimal cost to implement and use. There has already been a reduction in duplication of data entry, leading

to reduced payroll errors, reduction in agency usage and positive feedback from bureau members of staff.

Key issues and initiatives identified for the coming months

- Working with the Planning and Funding Team, Commercial Services, healthAlliance and other metro-Auckland DHBs to develop a regional patient land transport strategy, including commencing RFPs for patient transport and non-urgent ambulance providers.
- Progressing the Building for the Future Programme and proposed phase one inpatient capacity expansion (integrated stroke and rehabilitation unit), including new administration office suite. Securing the endorsement and approval of the programme strategic assessment and developing a draft programme business case.
- Continuing to implement the Care Capacity Demand Management work programme and roll-out and embed the use of Trendcare and Variance Indicator Score tool.
- Continuing the integrated operations centre planning and development ready for opening in November.
- Continuing to implement the restraint minimisation action plan.
- Continuing to support the hospital through the expected busy winter period.
- Supporting staff attendance at the Just Culture workshops and training days.
- Developing an integrated training and career development programme in conjunction with the supportive employment team.
- Reviewing the volunteer service and how it can best support the needs of patients and the organisation.
- Developing a hospitals-wide summer plan with directorate teams.
- Focussing on reducing unplanned absence due to sickness and maximising annual leave during the summer period.

Financial results

STATEMENT OF FINANCIAL PERFORMANCE						
<i>Patient Management Services</i>						Reporting Date Aug-19
(\$000s)	MONTH			YEAR TO DATE (2 months ending Aug-19)		
	Actual	Budget	Variance	Actual	Budget	Variance
REVENUE						
Government and Crown Agency	0	5	(5) U	0	10	(10) U
Funder to Provider Revenue	0	0	0 F	0	0	0 F
Other Income	74	81	(7) U	155	163	(8) U
Total Revenue	74	86	(12) U	155	173	(18) U
EXPENDITURE						
Personnel						
Personnel Costs	2,230	2,459	229 F	4,025	4,939	914 F
Outsourced Personnel	201	0	(201) U	635	0	(634) U
Outsourced Clinical Services	0	0	0 F	0	0	0 F
Clinical Supplies	40	27	(13) U	82	54	(28) U
Infrastructure & Non-Clinical Supplies	266	272	7 F	516	545	29 F
Total Expenditure	2,737	2,758	22 F	5,258	5,538	280 F
Contribution	(2,663)	(2,672)	9 F	(5,103)	(5,365)	263 F
Allocations	(57)	(64)	(8) U	(129)	(129)	0 F
NET RESULT	(2,606)	(2,608)	1 F	(4,973)	(5,236)	263 F
Paid FTE						
	MONTH (FTE)			YEAR TO DATE (FTE) (2 months ending Aug-19)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	0.0	0.0	0.0 F	0.0	0.0	0.0 F
Nursing	73.4	78.7	5.3 F	68.7	78.7	9.9 F
Allied Health	0.0	0.0	0.0 F	0.0	0.0	0.0 F
Support	314.5	312.8	(1.7) U	313.2	312.8	(0.4) U
Management/Administration	50.0	49.4	(0.6) U	50.0	49.4	(0.5) U
Total excluding outsourced FTEs	437.9	440.9	3.0 F	431.9	440.9	8.9 F
Total :Outsourced Services	27.0	0.0	(27.0) U	24.9	0.0	(24.9) U
Total including outsourced FTEs	464.9	440.9	(24.0) U	456.8	440.9	(15.9) U

Comments on major financial variances

The year to date (to end of August 2019) result is \$963K favourable. The key drivers of this position are:

- Personnel costs including outsourced are \$280K favourable to budget year to date. The actual cost per FTE is below budget for the first two months of the year. This is the result of phasing of collective employment agreement increases due in the coming year and is not expected to continue.
- The unfavourable FTE variance of 16 FTE is primarily within the cleaning team due to covering unbudgeted positions (e.g. clinical decisions unit) and unexpected absences.

Financial Performance

Consolidated Statement of Financial Performance - August 2019

5.10

Provider \$000s	Month (Aug-19)			YTD (2 months ending Aug-19)		
	Actual	Budget	Variance	Actual	Budget	Variance
<u>Income</u>						
Government and Crown Agency sourced	6,821	8,477	(1,656) U	14,851	16,860	(2,009) U
Non-Government & Crown Agency Sourced	9,179	9,593	(413) U	17,736	18,381	(645) U
Inter-DHB & Internal Revenue	1,407	1,200	207 F	2,536	2,472	64 F
Internal Allocation DHB Provider	123,870	121,756	2,114 F	245,639	243,513	2,126 F
	141,278	141,027	251 F	280,763	281,227	(464) U
<u>Expenditure</u>						
Personnel	92,132	92,839	706 F	181,780	185,407	3,627 F
Outsourced Personnel	2,058	1,063	(995) U	4,323	2,275	(2,048) U
Outsourced Clinical Services	3,248	3,854	606 F	7,848	7,695	(152) U
Outsourced Other	5,604	5,608	5 F	11,197	11,217	19 F
Clinical Supplies	27,099	26,855	(244) U	54,012	53,422	(591) U
Infrastructure & Non-Clinical Supplies	19,046	18,081	(964) U	37,476	36,111	(1,365) U
Internal Allocations	652	652	0 F	1,304	1,304	0 F
Total Expenditure	149,839	148,952	(887) U	297,940	297,431	(509) U
Net Surplus / (Deficit)	(8,561)	(7,926)	(636) U	(17,178)	(16,205)	(973) U

Consolidated Statement of Financial Performance – August 2019

Performance Summary by Directorate

By Directorate \$000s	Month (Aug-19)			YTD (2 months ending Aug-19)		
	Actual	Budget	Variance	Actual	Budget	Variance
Adult Medical Services	960	1,089	(129) U	2,990	2,603	388 F
Adult Community and LTC	1,050	1,192	(143) U	2,297	2,598	(301) U
Surgical Services	10,393	11,306	(914) U	20,307	21,169	(862) U
Women's Health	3,354	3,316	38 F	6,541	6,272	269 F
Child Health	3,818	4,458	(640) U	7,945	8,830	(885) U
Cardiac Services	3,923	3,436	487 F	5,232	5,385	(153) U
Clinical Support Services	482	(1,222)	1,705 F	(1,557)	(2,859)	1,303 F
Patient Management Services	(2,606)	(2,641)	35 F	(4,973)	(5,301)	328 F
Perioperative Services	(11,736)	(11,665)	(71) U	(23,208)	(23,645)	436 F
Cancer & Blood Services	1,493	1,917	(424) U	3,261	3,889	(627) U
Operational - Other	7,639	7,876	(238) U	13,159	15,006	(1,847) U
Mental Health & Addictions	564	(263)	828 F	999	(396)	1,395 F
Ancillary Services	(27,894)	(26,724)	(1,171) U	(50,170)	(49,755)	(416) U
Net Surplus / (Deficit)	(8,561)	(7,926)	(636) U	(17,178)	(16,205)	(973) U

Consolidated Statement of Personnel by Professional Group – August 2019

Employee Group \$000s	Month (Aug-19)			YTD (2 months ending Aug-19)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical Personnel	33,963	34,208	245 F	67,023	68,540	1,518 F
Nursing Personnel	30,864	31,275	411 F	60,570	61,287	717 F
Allied Health Personnel	13,867	14,229	362 F	27,648	28,948	1,301 F
Support Personnel	2,296	2,360	64 F	4,464	4,794	330 F
Management/ Admin Personnel	11,142	10,766	(376) U	22,075	21,837	(238) U
Total (before Outsourced Personnel)	92,132	92,839	706 F	181,780	185,407	3,627 F
Outsourced Medical	1,040	806	(234) U	2,039	1,665	(374) U
Outsourced Nursing	109	15	(94) U	468	30	(439) U
Outsourced Allied Health	67	49	(19) U	147	98	(49) U
Outsourced Support	77	28	(49) U	153	55	(98) U
Outsourced Management/Admin	765	165	(599) U	1,516	428	(1,088) U
Total Outsourced Personnel	2,058	1,063	(995) U	4,323	2,275	(2,048) U
Total Personnel	94,190	93,901	(289) U	186,103	187,682	1,579 F

Consolidated Statement of FTE by Professional Group – August 2019

FTE by Employee Group	Month (Aug-19)			YTD (2 months ending Aug-19)		
	Actual FTE	Budget FTE	Variance	Actual FTE	Budget FTE	Variance
Medical Personnel	1,520	1,499	(21) U	1,508	1,498	(9) U
Nursing Personnel	3,969	3,951	(18) U	3,968	3,951	(17) U
Allied Health Personnel	1,910	1,996	86 F	1,916	1,999	83 F
Support Personnel	453	531	78 F	452	531	80 F
Management/ Admin Personnel	1,516	1,502	(14) U	1,512	1,492	(20) U
Total (before Outsourced Personnel)	9,368	9,479	112 F	9,355	9,472	117 F
Outsourced Medical	33	25	(8) U	32	25	(7) U
Outsourced Nursing	1	1	0 F	1	1	0 F
Outsourced Allied Health	4	0	(4) U	5	0	(5) U
Outsourced Support	21	0	(21) U	21	0	(21) U
Outsourced Management/Admin	119	(3)	(122) U	118	7	(112) U
Total Outsourced Personnel	177	23	(155) U	177	33	(144) U
Total Personnel	9,545	9,502	(43) U	9,532	9,505	(27) U

Consolidated Statement of FTE by Directorate – August 2019

Employee FTE by Directorate Group (including Outsourced FTE)	Month (Aug-19)			YTD (2 months ending Aug-19)		
	Actual FTE	Budget FTE	Variance	Actual FTE	Budget FTE	Variance
Adult Medical Services	1,014	975	(39) U	1,016	975	(41) U
Adult Community and LTC	585	564	(22) U	590	564	(26) U
Surgical Services	946	916	(30) U	942	916	(26) U
Women's Health	388	382	(6) U	387	382	(5) U
Child Health	1,385	1,330	(55) U	1,380	1,330	(51) U
Cardiac Services	567	570	3 F	562	570	7 F
Clinical Support Services	1,344	1,347	3 F	1,345	1,347	2 F
Patient Management Services	465	441	(24) U	457	441	(16) U
Perioperative Services	749	803	54 F	754	803	49 F
Cancer & Blood Services	384	402	18 F	385	405	20 F
Operational - Others	0	14	14 F	0	14	14 F
Mental Health & Addictions	759	796	37 F	758	796	38 F
Ancillary Services	959	962	3 F	955	962	7 F
Total Personnel	9,545	9,502	(43) U	9,532	9,505	(27) U

Month Result

The Provider Arm result for the month is \$0.6M unfavourable. This result is driven by one off unfavourable Infrastructure & Non Clinical Supplies costs.

Overall volumes for the month (for total Auckland DHB and IDF Funders) are reported at 96.5% of the seasonally phased contract - this equates to \$4.2M below the month contract. However, the latest coding update gives total contract performance at 97.6%, equating to \$2.9M below contract.

Total revenue for the month is very close to budget at \$0.3M (0.2%) favourable.

Total expenditure for the month is \$0.9M (0.6%) unfavourable, with the key variances as follows:

- Personnel/Outsourced Personnel costs are very close to budget at \$0.3M (0.3%) unfavourable. Total FTE for the month, were 9,545 which was 43 (0.5%) above budget, however this includes a total of 35 one off FTE relating to backpay/backdated leave for prior periods. Excluding these, total FTE are 9,510 or 8 above budget.
- Outsourced Clinical Services \$0.6M (15.6%) favourable, reflecting cost of outsourcing radiotherapy and elective surgery below month plan.
- Infrastructure & Non Clinical Supplies \$1.0M (5.3%) unfavourable, with the key variance being Facilities costs \$0.8M unfavourable mainly driven by building depreciation (\$0.7M) due to the revaluation of the building asset category.

Year to Date Result

The Provider Arm result for the year to date is \$1.0M unfavourable. The key driver of this result is one off unfavourable building depreciation costs due to the revaluation of the building asset category.

Overall volumes for the year to date (for total Auckland DHB and IDF Funders) are reported at 100.2% of the seasonally phased contract - this equates to \$0.5M above the year to date contract. However, the latest coding update gives total contract performance at 100.9%, equating to \$2.2M above contract.

Total revenue for the year to date is \$0.5M (0.2%) unfavourable, with the key variance being low Non Resident revenue (\$0.9M unfavourable) – this revenue fluctuates from month to month with the full year budget still expected to be achieved.

Total expenditure for the year to date is \$0.5M (0.2%) unfavourable, with the key variances as follows:

- Personnel/Outsourced Personnel costs \$1.6M (0.8 %) favourable. Year to date average FTE are close to budget (27 FTE or 0.3% over budget), but the favourable expenditure variance reflects particularly low medical education costs for the year to date.
- Clinical Supplies \$0.6M (1.1%) unfavourable due to funded pharmaceutical cancer treatment (PCT) costs which are \$540k over budget for the year to date (will be subject to full wash up).
- Infrastructure & Non Clinical Supplies \$1.4M (3.8%) unfavourable, with the key variances being:
 - Facilities costs \$0.8M unfavourable mainly driven by building depreciation (\$0.7M) due to the revaluation of the building asset category. Actual insurance premiums were \$0.2M higher than

the budget offset by favourable budget in variances (\$0.1M) security costs resulting from insourcing of security services.

- o \$0.2M due to delayed capitalisation of information technology and FIRP assets.

FTE

Total FTE (including outsourced) for the month of August were 9,545 which was 43 (0.5%) above budget, however this includes a total of 35 one off FTE relating to backpay/backdated leave for prior periods. Excluding these, total FTE were very close to budget at 9,510 (8 above budget).

2019/20 Provider Financial Sustainability

The full year Provider Financial Sustainability plan is \$31.9M. For August year to date savings of \$4.7M have been achieved against plan of \$4.6M, \$0.1M favourable to plan.

Summary Position

2019/20 Provider Financial Sustainability	YTD	YTD	YTD	Full	Full	Full Year
	Actual	Target	Variance	Year	Year	Full Year
	\$000	\$000	\$000	Forecast	Target	Variance
	\$000	\$000	\$000	\$000	\$000	\$000
Increase revenue	0	542	-542	5,751	5,751	0
Personnel - vacancy management and cost per FTE	4,008	1,871	2,138	11,224	11,224	0
Managing MRI Outsourcing Requirements	201	457	-255	2,740	2,740	0
Blood utilisation	170	333	-163	2,000	2,000	0
Reduce interpreter costs	0	167	-167	1,000	1,000	0
Clinical Supplies savings	74	108	-34	1,648	1,648	0
Procurement savings	291	600	-309	3,600	3,600	0
Delivering more planned care	0	493	-493	2,958	2,958	0
Reducing unnecessary time in hospital	6	6	0	655	655	0
Review of funded transport	0	50	-50	300	300	0
Total	4,750	4,626	124	31,875	31,875	0

Volume Performance

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

Directorate	Service	Aug-2019				YTD (2 months ending Aug-19)			
		\$000s				\$000s			
		Cont	Act	Var	Prog %	Cont	Act	Var	Prog %
Adult Community & LTC	Ambulatory Services	1,511	1,497	(14)	99.1%	3,051	3,103	52	101.7%
	Community Services	2,075	2,126	51	102.5%	4,232	4,385	153	103.6%
	Diabetes	573	588	15	102.7%	1,162	1,164	2	100.1%
	Palliative Care	39	39	0	100.0%	78	78	0	100.0%
	Reablement Services	2,035	2,035	0	100.0%	4,070	4,070	0	100.0%
	Sexual Health	516	570	54	110.5%	1,049	1,182	133	112.7%
Adult Community & LTC Total		6,749	6,855	106	101.6%	13,643	13,983	341	102.5%
Adult Medical Services	AED, APU, DCCM, Air Ambulance	2,572	2,577	5	100.2%	5,100	5,220	120	102.4%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	14,226	13,838	(388)	97.3%	28,815	27,974	(841)	97.1%
Adult Medical Services Total		16,798	16,415	(383)	97.7%	33,915	33,194	(721)	97.9%
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	10,652	10,242	(410)	96.2%	20,394	20,631	237	101.2%
	N Surg, Oral, ORL, Transpl, Uro	11,369	10,482	(887)	92.2%	22,026	21,769	(257)	98.8%
	Orthopaedics Adult	4,776	4,921	145	103.0%	9,309	9,447	138	101.5%
Surgical Services Total		26,797	25,645	(1,152)	95.7%	51,729	51,847	118	100.2%
Cancer & Blood Services	Cancer & Blood Services	10,647	9,699	(948)	91.1%	21,277	20,671	(606)	97.2%
	Genetics	331	210	(121)	63.4%	677	530	(146)	78.4%
Cancer & Blood Services Total		10,978	9,909	(1,070)	90.3%	21,954	21,202	(752)	96.6%
Cardiovascular Services		14,733	13,400	(1,334)	90.9%	27,241	26,642	(599)	97.8%
Children's Health	Child Health Community Services	2,982	3,283	301	110.1%	5,935	7,569	1,634	127.5%
	Child Health Medical	6,604	6,387	(217)	96.7%	12,944	12,373	(571)	95.6%
	Child Health Surgical	10,106	10,644	538	105.3%	20,053	22,025	1,971	109.8%
Children's Health Total		19,693	20,314	621	103.2%	38,932	41,967	3,035	107.8%
Clinical Support Services		3,861	3,838	(23)	99.4%	7,832	7,735	(97)	98.8%
DHB Funds		10,600	10,362	(238)	97.8%	20,972	20,771	(201)	99.0%
Perioperative Services		19	13	(5)	70.6%	38	26	(12)	68.5%
Public Health Services		147	147	0	100.0%	294	294	0	100.0%
Support Services		102	102	0	100.0%	205	205	0	100.0%
Women's Health Total		8,635	7,929	(706)	91.8%	16,809	16,173	(636)	96.2%
Grand Total		119,112	114,929	(4,183)	96.5%	233,563	234,038	475	100.2%

2) Total Discharges for the YTD (2 Months to August 2019)

		Cases Subject to WIES Payment		All Discharges			Same Day discharges		Same Day as % of all discharges	
		Inpatient								
Directorate	Service	2019	2020	Last YTD	This YTD	% Change	Last YTD	This YTD	Last YTD	This YTD
Adult Community & LTC	Ambulatory Services	453	444	583	453	(22.3%)	551	425	94.5%	93.8%
	Reablement Services	0	0	391	396	1.3%	11	21	2.8%	5.3%
Adult Community & LTC Total		453	444	974	849	(12.8%)	562	446	57.7%	52.5%
Adult Medical Services	AED, APU, DCCM, Air Ambulance	2,033	2,568	2,088	2,578	23.5%	1,481	1,820	70.9%	70.6%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	3,746	3,925	3,822	3,958	3.6%	569	618	14.9%	15.6%
Adult Medical Services Total		5,779	6,493	5,910	6,536	10.6%	2,050	2,438	34.7%	37.3%
Cancer & Blood Total		834	939	998	1,084	8.6%	535	588	53.6%	54.2%
Cardiovascular Services Total		1,461	1,502	1,535	1,555	1.3%	431	395	28.1%	25.4%
Children's Health	Child Health									
	Community Services	600	663	602	665	10.5%	33	44	5.5%	6.6%
	Child Health Medical	2,249	2,226	2,518	2,433	(3.4%)	1,813	1,723	72.0%	70.8%
	Child Health Surgical	1,703	2,049	1,823	2,113	15.9%	765	828	42.0%	39.2%
Children's Health Total		4,552	4,938	4,943	5,211	5.4%	2,611	2,595	52.8%	49.8%
DHB Funds Total		281	289	282	289	2.5%	214	216	75.9%	74.7%
Surgical Services	Gen Surg, Trauma, N Surg, Oral, ORL, Transpl, Uro	2,984	3,331	3,484	3,560	2.2%	2,019	1,918	58.0%	53.9%
		1,988	2,186	2,162	2,297	6.2%	885	921	40.9%	40.1%
	Orthopaedics Adult	707	824	747	847	13.4%	142	134	19.0%	15.8%
Surgical Services Total		5,679	6,341	6,393	6,704	4.9%	3,046	2,973	47.6%	44.3%
Women's Health Total		3,371	3,641	3,496	3,766	7.7%	1,241	1,420	35.5%	37.7%
Grand Total		22,410	24,588	24,531	25,994	6.0%	10,690	11,071	43.6%	42.6%

3) Caseweight Activity for the YTD (2 Months to August 2019 (All DHBs))

Directorate	Service	Acute								Elective								Total							
		Case Weighted Volume			\$000s					Case Weighted Volume			\$000s					Case Weighted Volume			\$000s				
		Con	Act	Var	Con	Act	Var	Prog %	Con	Act	Var	Con	Act	Var	Prog %	Con	Act	Var	Con	Act	Var	Prog %			
Adult Community & LTC		220	226	6	1,149	1,181	32	102.8%	21	10	(11)	107	51	(56)	47.6%	241	236	(5)	1,257	1,232	(24)	98.1%			
Adult Medical Services	AED, APU, DCCM, Air Ambulance	646	698	52	3,368	3,642	273	108.1%	0	0	0	0	0	0	0.0%	646	698	52	3,368	3,642	273	108.1%			
	Gen Med, Gastro, Resp, Neuro, ID, Renal	3,740	3,565	(176)	19,511	18,595	(916)	95.3%	2	0	(2)	8	0	(8)	0.0%	3,742	3,565	(177)	19,519	18,595	(925)	95.3%			
Adult Medical Services Total		4,386	4,263	(123)	22,879	22,236	(643)	97.2%	2	0	(2)	8	0	(8)	0.0%	4,388	4,263	(125)	22,888	22,236	(652)	97.2%			
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	1,593	1,761	168	8,310	9,185	875	110.5%	1,282	1,242	(41)	6,689	6,477	(212)	96.8%	2,876	3,003	127	15,000	15,662	662	104.4%			
	N Surg, Oral, ORL, Transpl, Uro Orthopaedics	1,687	1,615	(72)	8,802	8,426	(376)	95.7%	1,335	1,372	37	6,966	7,159	193	102.8%	3,023	2,988	(35)	15,768	15,585	(183)	98.8%			
	Adult	989	1,110	122	5,156	5,793	636	112.3%	611	469	(142)	3,188	2,446	(741)	76.7%	1,600	1,579	(20)	8,344	8,239	(105)	98.7%			
Surgical Services Total		4,269	4,487	218	22,269	23,404	1,135	105.1%	3,229	3,083	(146)	16,843	16,083	(761)	95.5%	7,498	7,570	72	39,112	39,486	374	101.0%			
Cancer & Blood Services		1,104	1,062	(42)	5,759	5,541	(217)	96.2%	0	0	0	0	0	0.0%	1,104	1,062	(42)	5,759	5,541	(217)	96.2%				
Cardiovascular Services		2,709	2,926	217	14,130	15,263	1,133	108.0%	1,904	1,603	(301)	9,932	8,360	(1,572)	84.2%	4,613	4,529	(84)	24,063	23,624	(439)	98.2%			
Children's Health	Child Health Community	674	999	325	3,514	5,211	1,697	148.3%	0	0	0	0	0	0	0.0%	674	999	325	3,514	5,211	1,697	148.3%			
	Child Health Medical	1,553	1,540	(12)	8,099	8,035	(64)	99.2%	3	8	5	17	42	25	252.2%	1,556	1,548	(7)	8,116	8,077	(39)	99.5%			
	Child Health Surgical	1,665	2,205	539	8,687	11,501	2,814	132.4%	1,299	1,107	(192)	6,777	5,774	(1,002)	85.2%	2,965	3,312	347	15,464	17,275	1,811	111.7%			
Children's Health Total		3,892	4,744	852	20,300	24,746	4,446	121.9%	1,302	1,115	(187)	6,793	5,816	(977)	85.6%	5,194	5,859	665	27,093	30,562	3,469	112.8%			
Women's Health Services		1,933	1,791	(143)	10,084	9,340	(745)	92.6%	378	359	(20)	1,974	1,871	(102)	94.8%	2,312	2,149	(162)	12,058	11,211	(847)	93.0%			
DHB Funds		27	0	(27)	136	0	(136)	0.0%	330	325	(5)	1,722	1,695	(26)	98.5%	357	325	(32)	1,858	1,695	(162)	91.1%			
Grand Total		18,540	19,499	959	96,706	101,712	5,005	105.2%	7,166	6,495	(671)	37,380	33,877	(3,503)	90.6%	25,706	25,994	287	134,086	135,588	1,502	101.1%			
<i>Excludes caseweight Provision</i>																									

Acute Services

July and August acute growth continues the trend of increased growth that started in 2019. The WIES reflects this trend, with performance to contract sitting at 106% (the previous table is understated as the clot retrieval discharges was not reported correctly for August year to date - this will be corrected for September, adding a further 140 WIES).

Activity by service type:

- Acute medical discharges were nearly 9% higher than the same two month period last year. Average WIES is 1% lower than the same period, although there was a number of very high WIES discharges coded over July and August (with high WIES cases representing 8% of the total WIES for YTD August compared to 5% for the same period last year). ALOS is 1% lower than the same period last year.
- Acute surgical discharges have increased by 15% over the same two month period last year, however complexity has decreased - average WIES for Aug YTD is 3% lower than the same period last year, while ALOS has also dropped by 4%. This growth in acute surgical discharges is under investigation.
- Obstetric discharges are up 7% YTD August compared to the same period last year. This is driven by a greater number of births. The average WIES has dropped with the introduction of the 19/20 WIES version. While normal delivery WIES has increased by 2%, caesarean section WIES has dropped 7%. Overall the impact is a drop of 8% reflecting the higher value and slightly higher rate of C-sections for the first two months of year compared to last year. ALOS is 12% lower than last year with short LOS for both normal deliveries and C-sections.
- Newborn discharges are up 29%. However, a significant proportion of this represents a shift in the discharge speciality from Obstetrics for babies who require a paediatrician review. Further investigation is required to understand this change. Average WIES is down 2%. However, this is likely to be due to the increased number of low WIES babies being managed by Newborn Services on the Obstetric wards as NICU WIES has increased by 8%. This is reflected in the ALOS which has also dropped by 2%.

Elective Services

Notwithstanding the significant challenges caused by the growth in acute demand, elective performance is 8% higher than the same period last year. Performance to contract is reported at 90% - but with further coding updates this is now estimated to be 96%. There is an increase in average WIES (up 7%, 2% of which is due to the WIES model change), and the ALOS is also up by 8% (noting that this is for two months only and may not be a continuing trend).

4) Non-DRG Activity (ALL DHBs)

Directorate	Service	Aug-2019				YTD (2 months ending Aug-19)			
		\$000s				\$000s			
		Cont	Act	Var	Prog %	Cont	Act	Var	Prog %
Adult Community & LTC	Ambulatory Services	878	889	12	101.3%	1,794	1,871	77	104.3%
	Community Services	2,075	2,126	51	102.5%	4,232	4,385	153	103.6%
	Diabetes	573	588	15	102.7%	1,162	1,164	2	100.1%
	Palliative Care	39	39	0	100.0%	78	78	0	100.0%
	Reablement Services	2,035	2,035	0	100.0%	4,070	4,070	0	100.0%
	Sexual Health	516	570	54	110.5%	1,049	1,182	133	112.7%
Adult Community & LTC Total		6,116	6,248	132	102.2%	12,386	12,751	365	102.9%
Adult Medical Services	AED, APU, DCCM, Air Ambulance	848	771	(77)	91.0%	1,732	1,579	(153)	91.2%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	4,558	4,671	113	102.5%	9,295	9,379	84	100.9%
Adult Medical Services Total		5,405	5,442	37	100.7%	11,027	10,958	(69)	99.4%
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	2,640	2,438	(202)	92.4%	5,394	4,969	(425)	92.1%
	N Surg, Oral, ORL, Transpl, Uro	3,092	3,103	12	100.4%	6,258	6,184	(74)	98.8%
	Orthopaedics Adult	475	601	126	126.6%	965	1,208	243	125.1%
Surgical Services Total		6,206	6,143	(64)	99.0%	12,617	12,360	(256)	98.0%
Cancer & Blood Services	Cancer & Blood Services	7,590	7,312	(278)	96.3%	15,518	15,130	(388)	97.5%
	Genetics	331	210	(121)	63.4%	677	530	(146)	78.4%
Cancer & Blood Services Total		7,922	7,522	(399)	95.0%	16,195	15,660	(534)	96.7%
Cardiovascular Services		1,573	1,434	(139)	91.1%	3,179	3,018	(161)	95.0%
Children's Health	Child Health Community Services	1,204	1,137	(67)	94.4%	2,421	2,359	(63)	97.4%
	Child Health Medical	2,367	2,055	(312)	86.8%	4,828	4,296	(532)	89.0%
	Child Health Surgical	2,274	2,305	32	101.4%	4,590	4,750	160	103.5%
Children's Health Total		5,844	5,497	(347)	94.1%	11,839	11,405	(435)	96.3%
Clinical Support Services		3,861	3,838	(23)	99.4%	7,832	7,735	(97)	98.8%
DHB Funds		9,557	9,538	(19)	99.8%	19,114	19,076	(39)	99.8%
Perioperative Services		19	13	(5)	70.6%	38	26	(12)	68.5%
Public Health Services		147	147	0	100.0%	294	294	0	100.0%
Support Services		102	102	0	100.0%	205	205	0	100.0%
Women's Health Total		2,332	2,252	(80)	96.6%	4,751	4,962	211	104.4%
Grand Total		49,084	48,177	(907)	98.2%	99,477	98,450	(1,027)	99.0%

As is common early on in the year, performance to contract for non DRG activity is slightly below contract. This tends to pick up during the year.

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	N/A	N/A
2. Conflicts of Interest	As per that stated in the open agenda	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3. Confirmation of Confidential Minutes 4 September 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]
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. Chief Executive Officer Verbal Briefing	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]
6.1 Change &	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

Sustainability Benefits Realisation Report	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]
7.1 Auckland Cardiology Electrophysiology Services Oversight Report	Commercial Activities Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] Prejudice to Health or Safety Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time.	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 Clinical Support Oversight Report – MRI Capacity	Commercial Activities Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] Prejudice to Health or Safety Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.3 Ophthalmology Department Oversight Report	Commercial Activities Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] Prejudice to Health or Safety Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.4 Orthopaedic Services Oversight Report	Commercial Activities Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] Prejudice to Health or Safety Information about measures protecting	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

	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.	1982 [NZPH&D Act 2000]
7.5 Perioperative Services – Shortage of Perioperative Workforce Oversight Report	<p>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)]</p> <p>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.</p>	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.6 Radiotherapy Workforce Oversight Report	<p>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)]</p> <p>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.</p>	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.7 Transplant Oversight Report	<p>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.</p> <p>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.</p>	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.8 Women’s Health – Midwifery Recruitment and Retention Oversight Report	<p>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)]</p> <p>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</p>	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

	publication at this time.	
8.1 Clinical Quality and Safety Service Report	<p>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)]</p> <p>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.</p>	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.2 Policies and Procedures (Controlled Document Management)	<p>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)]</p>	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]