Hospital Advisory Committee Meeting

Wednesday, 03 August 2016

2.00 pm

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

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Published 27 July 2016

Agenda
Hospital Advisory Committee
03 August 2016

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

Time: 2.00pm

Committee Members	**Auckland DHB Executive Leadership**	
Judith Bassett (Chair)	Ailsa Claire	Chief Executive Officer
Jo Agnew	Simon Bowen	Director of Health Outcomes – ADHB/WDHB
Peter Aitken	Margaret Dotchin	Chief Nursing Officer
Doug Armstrong	Joanne Gibbs	Director Provider Services
Dr Chris Chambers	Naida Glavish	Chief Advisor Tikanga and General Manager Māori Health – ADHB/WDHB
Assoc Prof Anne Kolbe	Dr Debbie Holdsworth	Director of Funding – ADHB/WDHB
Dr Lester Levy	Fiona Michel	Chief of People and Capability
Dr Lee Mathias	Dr Andrew Old	Chief of Strategy, Participation and Improvement
Robyn Northey	Rosalie Percival	Chief Financial Officer
Morris Pita	Linda Wakeling	Chief of Intelligence and Informatics
Gwen Tepania-Palmer	Sue Waters	Chief Health Professions Officer
Ian Ward	Dr Margaret Wilsher	Chief Medical Officer
	Auckland DHB Senior Staff	
	Dr Vanessa Beavis	Director Perioperative Services
	Dr John Beca	Director Surgical, Child Health
	Anna Schofield	Acting Director Mental Health Services
	Judith Catherwood	Director Long Term Conditions
	Ian Costello	Acting Director Clinical Support Services
	Dr Mark Edwards	Director Cardiac Services
	Dr Sue Fleming	Director Women's Health
	Mr Wayne Jones	Director Surgical Services
	Auxilia Nyangoni	Deputy Chief Financial Officer
	Dr Michael Shepherd	Director Medical, Children's Health
	Dr Barry Snow	Director Adult Medical
	Dr Richard Sullivan	Director Cancer and Blood and Deputy Chief Medical Officer
	Jo Brown	Funding and Development Manager Hospitals
	Clare Thompson	General Manager Non Clinical Support Services
	Marlene Skelton	Corporate Business Manager
	Suzanne Stephenson	Acting Director Communications
	(Other staff members who attend for a particular item are named at the start of the respective minute)	

Apologies Members:

Apologies Staff: Fiona Michel, Clare Thompson

Agenda

Please note that agenda times are estimates only

2.00pm	**1.**	**Attendance and Apologies**
	2.	**Register and Conflicts of Interest** Does any member have an interest they have not previously disclosed? Does any member have an interest that may give rise to a conflict of interest with a matter on the agenda?
2.05pm	**3.**	**Confirmation of Minutes 22 June 2016**
2.10pm	**4.**	**Action Points**
2.15pm	**5.**	**Provider Arm Performance Report – Executive Summary**
	5.1	Provider Arm Scorecard and Operational Performance
	5.2	Financial Performance
2.25pm	**6.**	**Directorate Updates**
	6.1	Clinical Support Services
	6.2	Women's Health Directorate
	6.3	Child Health Directorate
	6.4	Perioperative Services Directorate
	6.5	Cancer and Blood Directorate
	6.6	Mental Health Directorate
	6.7	Adult Medical Directorate
	6.8	Community and Long Term Conditions Directorate
	6.9	Surgical Services Directorate
	6.10	Cardiovascular Directorate
	6.11	Non-Clinical Support Services
2.45pm	**7.**	**Patient Experience Report**
	7.1	Outpatient and Inpatient Experience
2.50pm	**8.**	**Discussion Paper**
	8.1	Auckland and Waitemata District Health Board Joint DNA Strategy and 'Roadmap' Actions
3.05pm	**9.**	**Information Papers**
	9.1	Overall Provider Performance including Health Target Updates
3.10pm	**10.**	**Resolution to exclude the public**

Next Meeting:	Wednesday, 07 September 2016 at 2.00pm A+ Trust Room, Clinical Education Centre Level 5, Auckland City Hospital, Grafton

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Attendance at Hospital Advisory Committee Meetings

Members	09 Dec. 15	17 Feb. 16	30 Mar. 16	11 May. 16	22 Jun. 16	03 Aug. 16	07 Sep. 16	26 Oct. 16	07 Dec. 16
Judith Bassett (Chair)	1	1	1	1	X				
Joanne Agnew	1	1	1	1	1				
Peter Aitken	1	1	1	1	1				
Doug Armstrong	1	1	1	1	1				
Chris Chambers	1	1	1	1	1				
Anne Kolbe	1	1	1	1	X				
Lester Levy	1	1	1	1	1				
Lee Mathias	1	X	1	1	1				
Robyn Northey	1	1	1	1	1				
Morris Pita	X	X	1	1	X				
Gwen Tepania-Palmer	1	1	1	1	X				
Ian Ward	1	1	1	1	1				
Key: x = absent, # = leave of absence									

Conflicts of Interest Quick Reference Guide

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

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

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

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

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

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

IMPORTANT

If in doubt – declare.

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

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

Register of Interests – Hospital Advisory Committee

Member	Interest	Latest Disclosure
Judith BASSETT (Chair)	Fisher and Paykel Healthcare Westpac Banking Corporation Husband – Fletcher Building Husband - shareholder of Westpac Banking Group Daughter - shareholder of Westpac Banking Group	13.07.2015
Jo AGNEW	Director/Shareholder 99% of GJ Agnew & Assoc. LTD Trustee - Agnew Family Trust Professional Teaching Fellow – School of Nursing, Auckland University Appointed Trustee – Starship Foundation Casual Staff Nurse – Auckland District Health Board	15.07.2015
Peter AITKEN	Pharmacy Locum - Pharmacist Shareholder/ Director, Consultant - Pharmacy Care Systems Ltd Shareholder/ Director - Pharmacy New Lynn Medical Centre Shareholder/Director – New Lynn 7 Day Pharmacy Shareholder/Director – Belmont Pharmacy 2007 Ltd Shareholder/Director – TAMNZ Limited Shareholder/Director – Bee Beautiful Limited	07.10.2015
Doug ARMSTRONG	Shareholder - Fisher and Paykel Healthcare Shareholder - Ryman Healthcare Trustee – Woolf Fisher Trust Trustee- Sir Woolf Fisher Charitable Trust Daughter is a partner – Russell McVeagh Lawyers Member – Trans-Tasman Occupations Tribunal Shareholder – Orion Healthcare (no beneficial interest held)	14.07.2015
Chris CHAMBERS	Employee - ADHB Wife is an employee - Starship Trauma Service Clinical Senior Lecturer in Anaesthesia - Auckland Clinical School Member – Association of Salaried Medical Specialists Associate - Epsom Anaesthetic Group Shareholder - Ormiston Surgical	26.01.2014
Anne KOLBE	Director - Kolbe Medical Services Ltd Senior Consultant - Communio NZ Senior Consultant - Siggins Miller, Australia Member - Risk and Audit Committee, Whanganui District Health Board Member – Inaugural Board of EXCITE International Member - Australian Institute of Directors Fellow by Examination – Royal Australian College of Surgeons Vocational medical registration – Medical Council NZ Reviewer – Australia and New Zealand Journal of Public Health Reviewer – European Commission, Personalising Health and Care H2020-PHC2015 – two stage Reviewer - Injury International Journal of Technology Assessment in Health Care Observer to the Medicare Benefits Schedule Review Taskforce (Australia) Chair – Advisory Council EXCITE International Board of Directors – EXCITE International Transition of the NHC Business functions into the New Zealand Ministry of Health was completed on 9th May 2016. Husband:	26.05.2016

	Professor of Medicine, University of Auckland Chair - Health Research Council of NZ, Clinical Trials Advisory Committee Member - Australian Medical Council, Medical School Advisory Committee Lead - Medical Specialties Advisory Committee Accreditation Team, Royal Australian College of General Practitioners Member - Executive Committee, International Society for Internal Medicine Chair - RACP Re-validation Working Party Member - RACP Governance Working Party Daughter – Forensic scientist at Institute of Environmental Science and Research (ESR)	
Lester LEVY	Chairman - Waitemata District Health Board (includes Trustee Well Foundation - ex-officio member as Waitemata DHB Chairman) Chairman - Auckland Transport Chairman – Health Research Council Independent Chairman - Tonkin and Taylor Ltd (non-shareholder) Professor (Adjunct) of Leadership - University of Auckland Business School Head of the New Zealand Leadership Institute – University of Auckland Lead Reviewer – State Services Commission, Performance Improvement Framework Director and sole shareholder – Brilliant Solutions Ltd (private company) Director and shareholder – Mentum Ltd (private company, inactive, non-trading, holds no investments. Sole director, family trust as a shareholder) Director and shareholder – LLC Ltd (private company, inactive, non-trading, holds no investments. Sole director, family trust as shareholder) Trustee – Levy Family Trust Trustee – Brilliant Street Trust	09.02.2016
Lee MATHIAS	Chair - Counties Manukau Health Deputy Chair - Auckland District Health Board Chair - Health Promotion Agency Chair - Unitec Acting Chair - Health Innovation Hub Director - Health Alliance Limited Director/shareholder - Pictor Limited Director - Lee Mathias Limited Director - John Seabrook Holdings Limited Trustee - Lee Mathias Family Trust Trustee - Awamoana Family Trust Trustee - Mathias Martin Family Trust Director – New Zealand Health Partnerships	11.05.2016
Robyn NORTHEY	Trustee - A+ Charitable Trust Shareholder of Fisher & Paykel Healthcare Husband – shareholder of Fisher & Paykel Healthcare Husband – shareholder of Fletcher Building Husband – Chair, Problem Gambling Foundation Husband – Chair, Auckland District Council of Social Service	17.02.2016
Morris PITA	Member – Waitemata District Health Board Shareholder – Turuki Pharmacy, South Auckland Shareholder – Whanau Pharmacy Limited Director and Shareholder of Healthcare Applications Ltd Owner and operator with wife - Shea Pita & Associates Ltd Wife is member of Northland District Health Board Wife provides advice to Maori health organisations	17.02.2016
Gwen TEPANIA-PALMER	Board Member - Waitemata District Health Board Board Member - Manaia PHO Chair - Ngati Hine Health Trust	02.04.2013

	Committee Member - Te Taitokerau Whanau Ora Committee Member - Lottery Northland Community Committee Member - Health Quality and Safety Commission	
Ian WARD	Deputy Chair - NZ Blood Service Director and Shareholder – C4 Consulting Ltd Shareholder – Vector Group Son – Oceania Healthcare	22.06.2016

Minutes
Hospital Advisory Committee Meeting
22 June 2016

Minutes of the Hospital Advisory Committee meeting held on Wednesday, 22 June 2016 in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton commencing at 2.00 p.m.

Committee Members Present	**Auckland DHB Executive Leadership Team Present**	
Jo Agnew	Ailsa Claire	Chief Executive Officer
Peter Aitken	Margaret Dotchin	Chief Nursing Officer
Doug Armstrong	Joanne Gibbs	Director Provider Services
Dr Chris Chambers (Chair)	Fiona Michel	Chief of People and Capability
Dr Lester Levy	Dr Andrew Old	Chief of Strategy, Participation and Improvement
Dr Lee Mathias	Rosalie Percival	Chief Financial Officer
Robyn Northey	Sue Waters	Chief Health Professions Officer
Ian Ward		
	Auckland DHB Senior Staff Present	
	Directors	
	Dr John Beca	Director Surgical Child Health
	Dr Clive Bensemann	Director Mental Health
	Ian Costello	Acting Director Clinical Support Services
	Dr Sue Fleming	Director Women's Health
	Dr Wayne Jones	Director Surgical Services
	Dr Michael Shepherd	Director Medical Child Health
	Dr Richard Sullivan	Director Cancer and Blood
	Other Auckland DHB Senior Staff	
	Jo Brown	Funding and Development Manager Hospitals
	Tony O'Conner	Director of Participation and Experience
	Marlene Skelton	Corporate Business Manager
	Clare Thompson	General Manager Non-Clinical Support Services
	Suzanne Stephenson	Acting Director Communications
	(Other staff members who attend for a particular item are named at the start of the respective minute)	

1. APOLOGIES

That the apologies of Judith Bassett, Anne Kolbe (speaking at the Healthcare Congress), Morris Pita and Gwen Tepania-Palmer be received.

That the apologies of Executive Leadership Team members Linda Wakeling - Chief of Intelligence and Informatics and Margaret Wilsher, Chief Medical Officer, be received.

That the apologies of senior staff members Vanessa Beavis, Director Perioperative Services, Judith Catherwood, Director Long Term Conditions, Mark Edwards, Director Cardiac Services and Barry Snow, Director Adult Medical, be received.

The Chair welcomed Daniel Alexander from Deloitte who was attending the meeting in an

observer capacity.

2. REGISTER AND CONFLICTS OF INTEREST (Pages 6 to 9)

The following changes to the Interests Register were noted:

- Ian Ward advised that he had now been appointed as Deputy Chair of the Blood Services Board.

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

3. CONFIRMATION OF MINUTES 11 May 2016 (Pages 10 to 22)

Resolution: Moved Lee Mathias/ Seconded Chris Chambers

That the minutes of the Hospital Advisory Committee meeting held on 11 May 2016 be confirmed as a true and accurate record.

Carried

4. ACTION POINTS (Pages 23)

There were no current action points to consider.

5. PROVIDER ARM PERFORMANCE REPORT – EXECUTIVE SUMMARY (Pages 24 to 26)

Joanne Gibbs - Director Provider Services spoke to the report highlighting the following:

- ED continues to perform exceptionally well in terms of meeting the 6 hour waiting times target.
- Performance is on track to deliver in quarter 4. Activity has taken a stepped increase to usual winter volumes.
- Ambulatory care unit opened a couple of weeks ago. It is too early for qualitative data on how well the unit is doing. Discussion with clinical teams shows the unit is being used extensively.
- Elective discharges projected to reach 100% for the year.
- Last week's power supply incident had a significant impact on elective surgery scheduling. OR staff prioritised acute patients and made sure no operations were undertaken while the power supply was uncertain. This will be reflected in lower numbers of patients being treated in June.

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

- Noting that a correction was required on page 25, "… the Surgical Board ratified the proposal for the allocation change of 27 existing half day sessions and seven new half day sessions to be converted to 34 full day sessions …."; this should read "17 full day sessions".
- An explanation on how cases were managed on full day lists versus a half day list. Half

day lists are generally less productive than full day lists had capacity to deal with four major cases. Staff enjoyed the 'all day' list which made it easier to manage shift patterns and staff did not waste time traveling across town during the day.

Colleagues tend to swap sessions to accommodate schedules and prevent cancellations. This is managed through the 'SCRUM' process. On the whole this is working well.

That the Hospital Advisory Committee receives the Provider Arm Performance report for June 2016.

Carried

5.1 Scorecard (Pages 27 to 29)

There was no discussion.

6. Provider Arm Financial Performance Report (Pages 30)

6.1 Financial Performance (Pages 31 to 41)

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

- The Provider Arm was overspent in FTE for the month due to pressure in relation to medical and nursing personnel. This is an area of focus for the Provider Arm as if it continues to expend at these levels it will impact on cash for capital available in the next financial year.

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

- Lee Mathias asked whether Management was confident every person employed, is gainfully employed. Rosalie Percival advised that all managers had been asked to ensure that all reporting staff are fully employed and if not, to take appropriate action.
- Chris Chambers asked if it was understood how interventional radiology and TAVI's are expanding and affecting service. Jo Gibbs responded that there is a piece of work being undertaken to look at the longer term use of the Hybrid Theatre. Already this theatre is being used in different ways than originally envisaged. The work being done by Jo Brown on the hyper acute stroke pathway and thrombectomy will also provide more information.

That the Hospital Advisory Committee receives the Provider Arm Financial Performance report for June 2016.

Carried

7. PATIENT EXPERIENCE REPORT (Page 42)

7.1 Inpatient Experience (Pages 43 to 46)

Tony O'Connor, Director of Participation and Experience, asked that the report be taken as read highlighting that 88% of patients had given the organisation an 'excellent' or 'very good' rating, which is a positive upward trend. Communication and information were the two main issues for patients.

Andrew Old took the opportunity to advise that this was Tony's last attendance at a Board meeting as he was leaving. He acknowledged Tony's contribution to the organisation in the year that he had been employed.

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

- National Volunteer week was discussed. It was acknowledged that volunteers were very important and it was getting harder for organisations to find volunteers as the pool was reducing as people were getting older, more were working longer or as grandparents they looked after children. Lindy Lely was actively trying to attract new people into the organisation.
  It was advised that one of hospitals volunteers had recently received a Minister's award. Geraldine had trained many blue coats, was very reliable and often went beyond the call of duty. She regularly consulted with patients and families and was outstanding.

Chris Chambers wished Tony O'Conner well in his future endeavours commenting that Tony had brought a skill set to the organisation not often seen in the healthcare environment and it had been extremely valuable to have had use of those skills.

7.2 Outpatient Experience (Pages 47 to 50)

There was no discussion on this report.

7.3 Overall Rating of Patient Experience (Page 51)

There was no discussion on this report.

8. DIRECTORATE UPDATES – For Information Only (Page 52)

[Secretarial Note: Chris Chambers sought the permission of the Committee to take items within section 8 as one, this was granted. Where there was comment this is noted under that particular item.]

8.1 Clinical Support Services (Pages 53 to 59)

Chris Chambers asked for an update on the current state of pathology in general. Jo Gibbs advised that there had been ongoing issues within the forensic service, as highlighted to HAC through the Quality and Standards reports. There is significant growth being seen in anatomical

pathology demands. The impact of increased melanoma incidence and the Bowel screening programme had a significant impact in this area.

8.2 Women's Health Directorate (Pages 60 to 69)

8.3 Child Health Directorate (Pages 70 to 78)

8.4 Perioperative Services Directorate (Pages 80 to 85)

There was some confusion as to why figures could be reported above the 100% threshold. Jo Gibbs advised that in the area of operating theatre productivity there is no national or international benchmarking, therefore a raw figure had been used and operating capacity was looked at in its broadest sense. Greenlane Clinical Centre is the least efficient and if it is to continue to be developed as the elective surgery centre then it needs to improve by at least 15% to be working at the higher end of productivity benchmarks.

8.5 Cancer and Blood Directorate (Pages 86 to 93)

8.6 Mental Health Directorate (Pages 94 to 103)

8.7 Adult Medical Directorate (Pages 104 to 110)

8.8 Community and Long Term Conditions Directorate (Pages 111 to 123)

Robyn Northey commented that it was wonderful to see the improvements made in this area.

8.9 Surgical Services Directorate (Pages 123 to 133)

8.10 Cardiovascular Directorate (Pages 134 to 142)

8.11 Non-Clinical Support Services (Pages 143 to 152)

8.12 Overall Provider Performance Including Health Target Updates (Pages 153 to 162)

That the Directorate update reports for June 2016 be received.

Carried

9. RESOLUTION TO EXCLUDE THE PUBLIC (Pages 163 to 166)

Resolution: Moved Lee Mathias / Seconded Ian Ward

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

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
3. Confirmation of Confidential Minutes 11 May 2016	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence [Official Information Act 1982 s9(2)(ba)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4. Confidential Action Points	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence [Official Information Act 1982 s9(2)(ba)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.1 Provider Services 16/17 Business Plan	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations** To enable the Board to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations) [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.1 Faster Cancer Treatment	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which if made available: i) would disclose a trade secret; or ii) would be likely to unreasonably prejudice the commercial position of any person who supplied, or who is the	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]

	subject of, such information [Official Information Act 1982 s9(2)(b)]	
6.2 Cardiothoracic Surgery	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which if made available: i) would disclose a trade secret; or ii) would be likely to unreasonably prejudice the commercial position of any person who supplied, or who is the subject of, such information [Official Information Act 1982 s9(2)(b)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.3 Acute Flow Performance	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which if made available: i) would disclose a trade secret; or ii) would be likely to unreasonably prejudice the commercial position of any person who supplied, or who is the subject of, such information [Official Information Act 1982 s9(2)(b)]	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 Security for Safety Programme Review	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which if made available: i) would disclose a trade secret; or ii) would be likely to unreasonably prejudice the commercial position of any person who supplied, or who is the subject of, such information [Official Information Act 1982 s9(2)(b)]	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 External Review of DCCM and Subsequent Actions	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the

	s9(2)(i)] **Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which if made available: i) would disclose a trade secret; or ii) would be likely to unreasonably prejudice the commercial position of any person who supplied, or who is the subject of, such information [Official Information Act 1982 s9(2)(b)]	disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.1 Complaints	**Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence [Official Information Act 1982 s9(2)(ba)] **Privacy of Persons** To protect the privacy of natural persons, including that of deceased natural persons [Official Information Act s9(2)(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]
7.2 Compliments	**Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence [Official Information Act 1982 s9(2)(ba)] **Privacy of Persons** To protect the privacy of natural persons, including that of deceased natural persons [Official Information Act s9(2)(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]
7.3 Incident Management	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations** To enable the Board to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations) [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.4 Policies and Procedures	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the

		disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8. Risk Register Reports	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** The disclosure of information would not be in the public interest because of the greater need to prevent the disclosure or use of official information for improper gain or advantage [Official Information Act 1982 s9(2)(k)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.1 Falls and pressure injuries updates	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

Carried

The meeting closed at 3.45pm.

Signed as a true and correct record of the Hospital Advisory Committee meeting held on Wednesday, 22 June 2016

Chair: _____ Date: _____

Chris Chambers (Deputy Chair)

Action Points from Previous Hospital Advisory Committee Meetings

As at Wednesday, 22 June 2016

Meeting and Item	Detail of Action	Designated to	Action by
17 Feb 2016 Item 6.10	**Child Health Directorate** That an update on the patient focussed booking initiative, with specific detail on Maori and Pacific DNA's work, be included in the May 2016 Child Health Directorate report.	M Shepherd, J Beca	7 Sep 16
16 Sep 2015 Item 8.1	**Auckland Integrated Cancer Centre** That the Strategic Assessment for the Auckland Integrated Cancer Centre business case be provided to the HAC December meeting.	R Sullivan	To be advised
11 May 2016 Item 8.2	**Patient Experience Survey Net Promoter Score** That a presentation be made to the Board on the MOS Board system and how it operated. [*This presentation will be tied to a demonstration showing how the automated scorecard works with MOS*.]	L Wakeling	7 Sept 16

Provider Arm Performance Report

Recommendation

That the Hospital Advisory Committee receives the Provider Arm Performance report for June 2016.

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

Executive Summary

The Executive Team highlight the following performance themes for the June 2016 Hospital Advisory Committee:

The Provider Arm has finished the financial year with a strong operational performance; key points of note include:

- Increased activity as compared to 2014/15:
  - 7% higher attendances in adult ED
  - 4.7% higher medical acute discharges
  - 6% higher surgical acute discharges
  - Small increase (115 discharges) on electives
- Decreased average length of stay:
  - Significant decrease in average length of stay in Adult Medicine (5%) and Surgery (1%)
- ED target met for quarters 4.
- Discharge target met at 100%
- Faster Cancer Treatment target performance has improved over the year and is in line with national performance overall, but still remains short of the 2017 target and has been relatively static for 4 months.

Emergency Department patients with an ED stay of less than 6 hours

- Plans for the winter are in place and are being implemented.
- July performance to date remains strong in Children's and Adult Emergency Departments.

Elective discharge cumulative variance from target

- Fully recovered to achieve 100% due to planned recovery measures.
- 2016/17 discharge target numbers have been finalised with a significant increase in discharges required in Ophthalmology and Orthopaedics.

Provider Services Business Plan

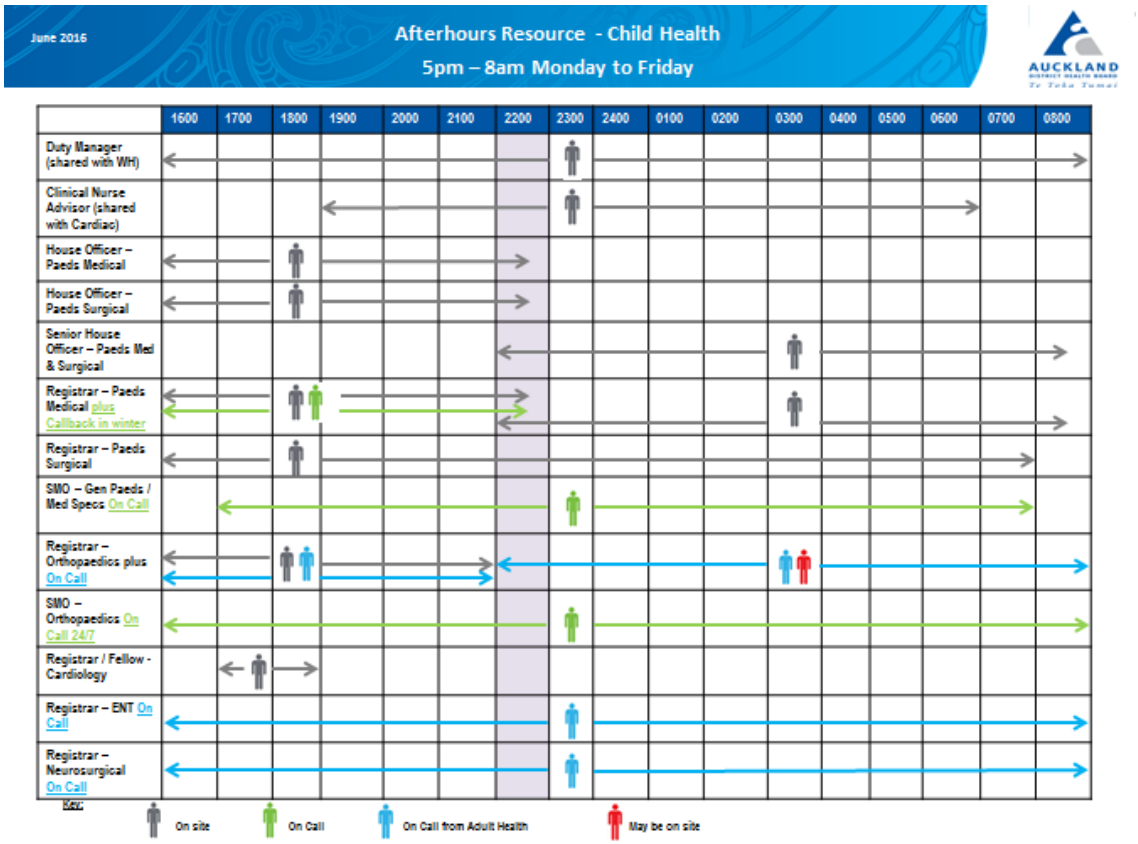
An update regarding each of the six Provider Arm work programmes in the 15/16 Business Plan is included below. As presented at the June Committee meeting, the Provider Arm work programmes

have been revisited as part of the refresh of the Business Plan for 16/17. Four of the current work programmes have been carried forward into the refreshed plan for 16/17, two have been absorbed as business as usual, and two new programmes of work have been shortlisted. Updates will be provided to the Committee regarding the agreed work programmes for 16/17 from the next report.

Please see section 5.1 of the confidential HAC agenda for the revised Provider Services Business Plan for 16/17 following discussion and feedback from the Committee at the June meeting where an early draft was presented.

Afterhours Inpatient Safety

- Considerable effort has gone into building up a comprehensive picture of the current afterhours state for adult services, child health, women's health, mental health and for the hospital as a whole. Each work stream has assessed the strengths, weaknesses, opportunities and risks afterhours for their own areas.
- An accurate summary of afterhours staffing of inpatient areas has been developed. The summary includes both staff roles and numbers in each staff category. Options for sharing these documents with staff to improve visibility of who is available and how to contact them are being explored. A sample of the summary is shown below:



- The SWAN (Safety on Weekends And Nights) tool has been completed by the work groups to further inform the current state. The SWAN tool was designed to assess capabilities for care afterhours and identify opportunities for improving outcomes.
- The work on afterhours inpatient safety intersects with that of two other major work programmes: Deteriorating Patients and Daily Hospital Functioning. As a consequence of a joint workshop and a number of meetings with the programme leads, greater clarity around the work that is the responsibility of each work programme has been achieved.
- Five priorities which impact on all areas of the hospital afterhours have been identified.
    - Information for afterhours staff
    - Staffing afterhours
    - Out of hours theatre access and anaesthetic cover
    - Future oversight of afterhours inpatient safety
    - Structured patient handover
- Each of these priorities will be scoped and developed as a sub-project over the next few weeks. More detail on these sub-projects will be provided in the next update to the Committee.
- The Steering Group are also in the process of refining the measures which can most usefully reflect the impact of the project and provide evidence that we are providing high quality care afterhours.

The Afterhours Inpatient Safety work programme has been carried forward to the 16/17 Provider Services Business Plan.

Delivering the Surgical PVS to Budget

- Terms of Reference for the Capital Planning Committee have been approved by the Surgical Board. Major phases and milestones have been agreed moving forward.
- Weekly monitoring of operating rooms (OR) utilisation continues. This is done on a departmental basis and includes the weekly target, the current "run rate" and progress to date with contingency plans added.
- Enforcement of the 6 week leave policy continues to be monitored by SCDs.

Moving forward, it has been agreed that delivering the PVS to budget will be absorbed as business as usual with the Surgical Board will continue to lead the delivery of this programme of work. This will be the final regular update provided to the Committee regarding the programme of work.

Clinical Services Plan

- The final Clinical Services Plan was presented to the Board in June.
- Key actions in the short term will be to:

- Ensure that the Provider Services Business Plan is aligned to the overall direction outlined in the approved Clinical Services Plan and implementation of the recommendations.
- Undergo wider stakeholder engagement. This includes circulating and sharing key findings, recommendations and actions with key stakeholders.
- Commence the next phase of the process to develop a strategic finalised plan.

The Clinical Services Plan work programme has been agreed to be absorbed as business as usual. This will be the last regular update provided to the Committee regarding the programme of work.

Deteriorating Patients

- This work programme continues to make satisfactory progress against the actions listed in the overarching project plan.
- An audit of current use of the Early Warning Scores (EWS) and Paediatric Early Warning Scores (PEWS) in clinical areas has been completed. The audit has provided information regarding the current completion rate, the percentage of correctly calculated EWS scores and the missed Medical Emergency Team (MET) call rate. It has been proposed that the EWS audit is incorporated into the monthly safety audit, with an initial trial on 2 – 3 wards planned.
- As reported previously, the Steering Group has been exploring options for data collection, storage and reporting on the agreed regular measures. The work groups have developed draft forms for capturing the required information and permission has been granted to use an already established database from New South Wales. Support will be accessed from the Business Intelligence to progress this work. It should be noted that it is our understanding that the HQSC national Deteriorating Patients programme does not encompass the introduction of a national database.
- Both the adult and paediatric work groups have established the preferred structure for the response function and are now awaiting agreement regarding the model of care to sit across the Deteriorating Patients, Afterhours Inpatient Safety and Daily Hospital Functioning work programmes. A joint group, comprised of the leads for each of the three work programmes, has been formed and are making good progress towards developing a draft model of care for wider consultation and feedback.
- A communications plan has been drafted for this work programme which includes an action plan for the provision of regular updates to the key stakeholders identified in the stakeholder mapping exercise. The Steering Group are currently developing a general presentation regarding the work programme – prior to commencing regular updates.
- We continue to liaise with the HQSC to ensure alignment with the national Deteriorating Patients programme. Where necessary, the timing of planned work has been adjusted to ensure that multiple changes are not made to the current system in a short space of time.

The Deteriorating Patients work programme has been carried forward to the 16/17 Provider Services Business Plan.

Daily Hospital Functioning

The table below outlines the key successes that the Daily Hospital Functioning work programme has achieved against the 15/16 plan.

Work Stream	Objectives	Successes
Integrated Operations Centre (IOC)	Improve the coordination of resources across services to deliver improved patient flow, reduced cancelled surgery, improve patient safety (with the right staff in the right place), and enable flexing bed capacity and resource up and down to meet on-the-day patient needs	• Completed refurbishment existing 24 Hour Centre • Mapped processes to allow transfer of Nursing Bureau Coordinator to ACH • Identified preferred location for expanded centre
Variance Response Management	Develop standardised escalation plans and variance response plans with agreed roles and responsibilities to ensure consistent and timely responses to variables affecting patient flow	• Developed and agreed standardised template for escalation plans • Revised escalation plan completed for General Medicine • Escalation plans using the new template in progress for Adult Emergency Department, Adult Hospital, Orthopaedic Surgery, Reablement Services, Cancer and Blood and Cardiovascular Services • Centralised sharepoint repository for escalation plans developed • Nursing redeployment guidelines and variance response management (VRM) indicators drafted as part of Care capacity Demand Management program work
Operational Intelligence & Forecasting	Develop the capability that provides visibility of any current or predicted variation in plan to patient volume, acuity, staffing, facilities, and incidents within minutes; intuitively accessible at a glance or touch anywhere our users are	• Developed and implemented forecast occupancy tool for adults and completed development for Women's and Children's • Completed audit of existing capability and identified opportunities for future development • Developed revised occupancy dashboard

		• Initiated project working group to prioritise additional development priorities
Transition Hub	Enable the transition lounge to handle increased patient volumes and complexity by improving the discharge process and improving the layout of the facility Improve the experience of DOSA patients by using the transition lounge as part of the DOSA admission process and eliminate the need for patients waiting by reception	• Phase 1 facilities changes completed to create a more open and flexible space for patients • Re-organisation and clean-up of utility areas using approach using the well organised ward module from releasing time to care • Initiated project workstreams to review and improve existing DOSA and discharge processes

The Daily Hospital Functioning work programme has been carried forward to the 16/17 Provider Services Business Plan.

Faster Cancer Treatment

- A detailed briefing on progress is included at section 6.1 of the Confidential HAC agenda.

The Faster Cancer Treatment work programme has been carried forward to the 16/17 Provider Services Business Plan (for six months).

Auckland DHB Provider Scorecard

for June 2016

	Measure		Actual	Target	Prev Period	Commentary
Patient Safety	% AED patients seen within triage time - triage category 2 (10 minutes)	PR006	74.6%	>=80%	79.41%	Big drop as space expanded without staff. Department and process redesign remains necessary.
	% CED patients seen within triage time - triage category 2 (10 minutes)	PR008	82.27%	>=80%	87.25%	
	Number of reported adverse events causing harm (SAC 1&2)	PR084	5	<=12	5	
	Central line associated bacteraemia rate per 1,000 central line days	PR087	0	<=1	1.05	
	Healthcare-associated Staphylococcus aureus bacteraemia per 1,000 bed days	PR088	0.16	<=0.25	0.19	
	Healthcare-associated bloodstream infections per 1,000 bed days - Adult	PR089	1.13	<=1.6	1.71	
	Healthcare-associated bloodstream infections per 1,000 bed days - Child	PR090	1.8	<=2.4	1.12	
	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	4.28%	<=6%	4.44%	
	Rate of hospital-onset healthcare-associated Clostridium difficile inpatients >15 years of age per 10,000 bed days (ACH) (Quarterly)	PR143 *	1.68	<=4	2.72	
	Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	PR185	4.02%	<=6%	4.02%	
	% Hand hygiene compliance	PR195	83.31%	>=80%	83.95%	
Better Quality Care	(MOH-01) % AED patients with ED stay < 6 hours	PR013	95.53%	>=95%	94.55%	
	(MOH-01) % CED patients with ED stay < 6 hours	PR016	95.97%	>=95%	96.51%	
	% Inpatients on Older Peoples Health waiting list for 2 calendar days or less	PR023	90.91%	>=80%	93.46%	
	HT2 Elective discharges cumulative variance from target	PR035	1	>=1	1	
	(ESPI-2) Patients waiting longer than 4 months for their FSA	PR038	0.11%	0%	0.02%	
	(ESPI-5) Patients given a commitment to treatment but not treated within 4 months	PR039	0.90%	0%	0.67%	
	Cardiac bypass surgery waiting list	PR042	84	<=104	92	
	% Accepted referrals for elective coronary angiography treated within 3 months	PR043	97.87%	>=90%	99.54%	
	% Urgent diagnostic colonoscopy compliance	PR044	94.03%	>=75%	95%	
	% Non-urgent diagnostic colonoscopy compliance	PR045	73.82%	>=65%	67.46%	
	% Outpatients and community referred MRI completed < 6 weeks	PR046	75.62%	>=85%	63.65%	Improved performance from May. Adult currently sitting at 84.6%. Paediatric MRI under GA continues to be an issue - additional Saturday sessions being implemented from end of July.

	% Outpatients and community referred CT completed < 6 weeks	PR047	95.22%	>=95%	93.19%	
	Elective day of surgery admission (DOSA) rate	PR048	74.5%	>=68%	69.61%	
	% Day Surgery Rate	PR052	57.46%	>=70%	56.71%	Sustained performance which is expected to improve through increased activity at GSU.
	Inhouse Elective WIES through theatre - per day	PR053	111.01	>=99	137.53	
	% DNA rate for outpatient appointments - All Ethnicities	PR056	9.61%	<=9%	11.01%	
	% DNA rate for outpatient appointments - Maori	PR057	18.86%	<=9%	21.58%	While there has been an overall improvement in the DNA data across the specialties, Cardiac and Cancer services has been our focus.
	% DNA rate for outpatient appointments - Pacific	PR058	18.13%	<=9%	21.02%	The call backs continue for Oncology clinics by the Tautai Fakataha team. This has been coordinated with the Advanced Social Worker for Cancer and Blood services.
	% Chemotherapy patients (Med Onc and Haem) attending FSA within 4 weeks of referral	PR059	100%	100%	100%	
	% Radiation oncology patients attending FSA within 4 weeks of referral	PR064	91.04%	100%	77.42%	The service continues to plan to match capacity and demand, factoring in SMO availability across high volume tumour streams.
	% Cancer patients receiving radiation/chemo therapy treatment within 4 weeks of DTT	PR070	100%	100%	100%	
	Average LOS for WIES funded discharges (days)	PR074	2.97	<=3	2.91	
	28 Day Readmission Rate - Total	PR078	R/U	<=6%	9.41%	
	Mental Health - 28 Day Readmission Rate (KPI Discharges) to Te Whetu Tawera	PR119	R/U	<=10%	10.2%	
	Mental Health Average LOS (KPI Discharges) - Te Whetu Tawera	PR120	20.4	<=21	26.3	
	% Very good and excellent ratings for overall inpatient experience	PR154	R/U	>=90%	89.04%	
	Number of CBU Outliers - Adult	PR173	281	0	371	General Medicine patient numbers have risen steadily over June and will be a factor in the Outlier report.
	% Patients cared for in a mixed gender room at midday - Adult	PR175	8.78%	0%	10.29%	No improvement in this area. Continued daily review by Nurse Unit Managers and Charge Nurses.
	31/62 day target – % of non-surgical patients seen within the 62 day target	PR181	R/U	>=85%	70.37%	
	31/62 day target – % of surgical patients seen within the 62 day target	PR182	R/U	>=85%	42.86%	
	62 day target - % of patients treated within the 62 day target	PR184	R/U	>=85%	60.98%	

Improved Health Status	Breastfeeding rate on discharge excluding NICU admissions		PR099	R/U	>=75%	76.2%	
	% Long-term clients with relapse prevention plans in last 12 months (6-Monthly)	*	PR125	89.45%	>=95%	91.41%	Transitioning to new 1 July MoH reporting requirements that will replace relapse with wellness plans.
	% Hospitalised smokers offered advice and support to quit		PR129	96.84%	>=95%	94.6%	

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

R/U = Result unavailable

PR078, PR119
A 35 day period is required to accurately report all acute re-admissions for the previous month's discharges. (35 days = 28 days post discharge as per MoH measures plus 5 working days to allow for coding).

PR099
Result unavailable until after the 20th day of the next month.

PR154
This measure is based on retrospective survey data, i.e. completed responses for patients discharged the previous month.

PR181, PR182, PR184
Results unavailable from NRA until after the 20th day of the next month.

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

PR125 (6-Monthly)
Actual result is for the period ending December 2015. Previous period result is for period ending June 2015.

PR143 (Quarterly)
Actual result is for the period ending March 2016. Previous period result is for period ending December 2015.

Financial Performance

Consolidated Statement of Financial Performance - June 2016

Provider	Month (Jun-16)			Full Year (12 months ending Jun-16)		
$000s	Actual	Budget	Variance	Actual	Budget	Variance
Income						
Government and Crown Agency sourced	8,598	7,869	730 F	93,119	91,810	1,309 F
Non-Government & Crown Agency Sourced	6,224	6,460	(235) U	82,429	78,186	4,243 F
Inter-DHB & Internal Revenue	2,654	1,270	1,384 F	16,143	15,148	996 F
Internal Allocation DHB Provider	101,083	98,589	2,495 F	1,188,832	1,183,067	5,765 F
	118,560	**114,188**	**4,373 F**	**1,380,523**	**1,368,210**	**12,313 F**
Expenditure						
Personnel	76,795	71,695	(5,100) U	862,617	854,503	(8,114) U
Outsourced Personnel	2,977	1,490	(1,487) U	27,836	17,876	(9,960) U
Outsourced Clinical Services	2,761	1,883	(879) U	24,401	22,515	(1,886) U
Outsourced Other	3,596	3,799	203 F	45,481	45,590	109 F
Clinical Supplies	19,295	20,076	781 F	244,642	238,978	(5,664) U
Infrastructure & Non-Clinical Supplies	19,048	15,077	(3,971) U	190,425	182,017	(8,408) U
Internal Allocations	561	562	2 F	5,627	6,695	1,068 F
Total Expenditure	**125,034**	**114,582**	**(10,451) U**	**1,401,029**	**1,368,174**	**(32,855) U**
Net Surplus / (Deficit)	**(6,473)**	**(395)**	**(6,079) U**	**(20,505)**	**37**	**(20,542) U**

Consolidated Statement of Financial Performance – June 2016

Performance Summary by Directorate

By Directorate $000s	Month (Jun-16)			Full Year (12 months ending Jun-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
Adult Medical Services	691	742	(50) U	6,843	9,382	(2,539) U
Adult Community and LTC	1,937	1,679	257 F	20,195	19,086	1,109 F
Surgical Services	7,083	9,056	(1,973) U	94,223	108,505	(14,282) U
Women's Health & Genetics	2,951	2,898	53 F	33,364	34,509	(1,146) U
Child Health	5,585	6,170	(585) U	70,117	74,123	(4,006) U
Cardiac Services	1,857	2,532	(674) U	28,118	30,097	(1,979) U
Clinical Support Services	(2,995)	(2,527)	(468) U	(29,058)	(30,516)	1,457 F
Non-Clinical Support Services	(1,618)	(1,657)	39 F	(19,005)	(19,165)	160 F
Perioperative Services	(11,469)	(10,793)	(676) U	(132,349)	(128,942)	(3,407) U
Cancer & Blood Services	1,797	1,954	(157) U	20,748	23,482	(2,734) U
Operational - Other	4,159	4,831	(673) U	60,475	57,890	2,585 F
Mental Health & Addictions	7	232	(225) U	3,919	3,196	723 F
Ancillary Services	(16,457)	(15,512)	(945) U	(178,094)	(181,611)	3,517 F
Net Surplus / (Deficit)	**(6,473)**	**(395)**	**(6,079) U**	**(20,505)**	**37**	**(20,542) U**

Consolidated Statement of Personnel by Professional Group – June 2016

Employee Group $000s	Month (Jun-16)			Full Year (12 months ending Jun-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical Personnel	28,022	26,825	(1,196) U	323,843	320,510	(3,333) U
Nursing Personnel	28,564	23,375	(5,190) U	291,693	277,363	(14,330) U
Allied Health Personnel	12,081	12,215	134 F	140,832	145,639	4,807 F
Support Personnel	1,551	1,615	64 F	17,681	19,322	1,641 F
Management/ Admin Personnel	6,577	7,665	1,088 F	88,568	91,669	3,101 F
Total (before Outsourced Personnel)	**76,795**	**71,695**	**(5,100) U**	**862,617**	**854,503**	**(8,114) U**
Outsourced Medical	1,234	764	(470) U	10,902	9,157	(1,746) U
Outsourced Nursing	305	254	(51) U	4,257	3,046	(1,212) U
Outsourced Allied Health	110	99	(11) U	1,316	1,185	(130) U
Outsourced Support	172	5	(167) U	2,286	57	(2,229) U
Outsourced Management/Admin	1,156	369	(787) U	9,074	4,431	(4,644) U
Total Outsourced Personnel	**2,977**	**1,490**	**(1,487) U**	**27,836**	**17,876**	**(9,960) U**
Total Personnel	**79,772**	**73,185**	**(6,587) U**	**890,453**	**872,379**	**(18,074) U**

Consolidated Statement of FTE by Professional Group – June 2016

FTE by Employee Group	Month (Jun-16)			Full Year (12 months ending Jun-16)		
	Actual FTE	Budget FTE	Variance	Actual FTE	Budget FTE	Variance
Medical Personnel	1,335	1,335	0 F	1,329	1,334	4 F
Nursing Personnel	3,522	3,488	(34) U	3,511	3,486	(25) U
Allied Health Personnel	1,844	1,893	49 F	1,827	1,895	68 F
Support Personnel	378	422	44 F	374	422	49 F
Management/ Admin Personnel	1,150	1,274	124 F	1,221	1,276	56 F
Total (before Outsourced Personnel)	**8,230**	**8,413**	**183 F**	**8,262**	**8,414**	**152 F**
Outsourced Medical	36	32	(4) U	31	32	0 F
Outsourced Nursing	13	7	(6) U	12	7	(6) U
Outsourced Allied Health	9	3	(6) U	7	3	(5) U
Outsourced Support	50	0	(50) U	53	0	(53) U
Outsourced Management/Admin	132	5	(126) U	100	5	(95) U
Total Outsourced Personnel	**239**	**47**	**(193) U**	**204**	**47**	**(157) U**
Total Personnel	**8,469**	**8,460**	**(10) U**	**8,466**	**8,460**	**(5) U**

Consolidated Statement of FTE by Directorate – June 2016

Employee FTE by Directorate Group (including Outsourced FTE)	Month (Jun-16)			YTD (12 months ending Jun-16)		
	Actual FTE	Budget FTE	Variance	Actual FTE	Budget FTE	Variance
Adult Medical Services	836	826	(10) U	830	826	(4) U
Adult Community and LTC	511	525	14 F	519	525	6 F
Surgical Services	823	790	(33) U	824	790	(34) U
Women's Health & Genetics	390	372	(18) U	380	370	(9) U
Child Health	1,093	1,080	(13) U	1,057	1,086	29 F
Cardiac Services	506	512	6 F	502	512	11 F
Clinical Support Services	1,448	1,454	7 F	1,450	1,454	4 F
Non-Clinical Support Services	264	244	(21) U	253	244	(9) U
Perioperative Services	810	832	22 F	811	832	21 F
Cancer & Blood Services	331	315	(16) U	323	315	(8) U
Operational - Others	0	(3)	(3) U	0	(3)	(3) U
Mental Health & Addictions	735	746	10 F	732	742	10 F
Ancillary Services	722	767	45 F	786	768	(18) U
Total Personnel	**8,469**	**8,460**	**(10) U**	**8,466**	**8,460**	**(5) U**

Month Result

The Provider Arm result for the month is $6.1M unfavourable.

Overall volumes are above contract at 100.9% of base contract for the month, equating to $0.8M above contract.

Total revenue for the month is $4.4M (3.8%) favourable, with the key variances as follows:

- Inter DHB Revenue - IDF washup (non MOH) $1.5M favourable
- Research Income $0.3M favourable, offset by equivalent expenditure
- Non Residents $0.3M favourable – this revenue is variable from month to month, with the full year result $0.6M favourable
- Interest/Financial income $0.4M unfavourable due to the downward trend in interest rates
- Funding Subcontract revenue favourable primarily driven by NRA funding $1.6M, Clinical Genetics $0.4M, additional Capital Charge Funding $0.2M, and funding for National Patient Flow project $0.2M

Total expenditure is $10.5M (9.1%) unfavourable. This includes a number of one off items, with the key variances as follows:

- Personnel/Outsourced Personnel costs $6.6M (9.0%) unfavourable. FTE were close to budget, but the variance reflects cost per FTE targets not met combined with a one off net cost of $1.7M unfavourable for the revaluation of retirement gratuity and long service leave liabilities (the $1.7M is the net of a $4.2M increase in Nursing, offset by decreases totalling $2.5M across all other professional groups).
    - The key unfavourable variance is Nursing which is $5.2M above budget - $4.2M of this relates to the one off revaluation of the retirement gratuity and long service leave liabilities (and is partially offset by the $2.5M reduction across the other professional groups). The remainder of the variance is due to cost per FTE targets not met, combined with Nursing FTE 34 FTE above budget. Additional beds with unbudgeted FTE account for 15 of this variance - the Orthopaedics Elective Unit in Ward 62 (11 FTE - unbudgeted but funded via reduced outsourcing) along with an additional three Bone Marrow Transplant beds to reduce wait times (4 FTE).
      Mitigation strategies include:
        - Nurse Directors have implemented daily staffing oversight forums with a focus on the efficient use of staff resource across the directorates while maintaining a quality, safe service. This includes a refinement of the set of principles for staff replacement with the accountability aligned to the Nurse Unit Manager
        - Focus on reviewing our systems, processes and models of care in regards to vulnerable patients who require a patient attender. An oversight group has been established to provide governance for identified work streams that improves the safety and quality of care to adult vulnerable patients. Workstreams include Enhanced Support Rooms (ESR), Management of AWOL, Post-operative/Post-arrest Delirium and Behaviours of Concern
        - Work continues on recruiting to target skill mixes – this is improving month to month
        - Use of flex beds only as needed, flexing down as soon as possible
    - The other key variance is Medical which is $1.2M unfavourable – although FTE were very close to budget the variance reflects additional costs of expected MECA settlements $0.4M

unfavourable combined with cost per FTE targets not met, and costs of premium rates for additional surgical sessions to meet discharge targets.

- Clinical Supplies $0.8M (3.9%) favourable, primarily due to additional Pharmac rebate, relating to full year, $0.7M favourable.
- Infrastructure and Non Clinical Supplies $4.0M (26.4%) unfavourable – this primarily relates to one off abnormal costs. The key variances are one off facilities maintenance costs, including asbestos removal, $2.6M unfavourable, Bad/Doubtful debts $0.7M and one off project costs $0.7M.

Full Year Result

The Provider Arm full year result is $20.5M unfavourable. This result is driven by unfavourable expenditure – primarily Personnel (including Outsourced) due to cost per FTE targets not met, Clinical Supplies due to very high acute surgical volumes combined with high costs for chemotherapy drugs, and one off additional Infrastructure and Non Clinical Supplies costs.

Overall consolidated volumes are extremely close to contract - reported at 99.9% of base contract for the year, equating to $0.9M below contract.

Total revenue for the year to date is $12.3M (0.9%) favourable, mostly due to revenue streams with offsetting expenditure.

- Key favourable revenue variances:
    - Haemophilia funding $1.9M favourable for abnormally high blood product usage, bottom line neutral as offset by additional expenditure
    - Research Income $4.4M favourable, offset by equivalent expenditure
    - Pharmacy Retail cash sales $0.9M favourable, offset by additional cost of sales expenditure
    - One off revenue for settlement of commercial contracts $0.9M favourable
    - Inter DHB Revenue - IDF washup (non MOH) $3.0M favourable
    - Unbudgeted revenue for Maternal Mental Health Acute Continuum $0.9M favourable
    - Safekids revenue $0.7M favourable – offset by additional promotional expenditure, bottom line neutral
    - Funding Subcontract revenue $7.4M favourable with the key items being additional Capital Charge Funding $2.6M, funding for NRA $1.6M, Pregnancy Smoking Cessation $0.5M, Community Workers in Secondary Schools $0.4M, Clinical Genetics $0.4M and National Patient Flow $0.2M.
- Key unfavourable revenue variances:
    - LabPlus revenue net $0.3M unfavourable - Inter DHB Revenue $1.4M unfavourable for the loss of the LabPlus MidCentral DHB contract, offset by an increase in other external Labplus revenue streams $1.1M favourable
    - Financial income $2.3M unfavourable due to a combination of lower interest rates, lower cash balances and valuation losses for Trust investments
    - ACC Income $1.9M unfavourable – primarily in elective surgery, reflecting the focus on achieving elective MOH discharge targets
    - Donation Income $2.0M unfavourable – revenue fluctuates depending on timing of projects - with no major projects in the current year
    - MOH Public Health $0.7M unfavourable – in line with costs lower than budget

Total expenditure is $32.9M (2.4%) unfavourable, with the key variances as follows:

- Net combined Personnel and Outsourced Personnel Costs $18.0M (2.1%) unfavourable. Full year FTE for total Personnel/Outsourced Personnel are very close to budget at 5 above budget. The unfavourable expenditure variance is primarily due to cost per FTE targets not met, as well as MECA costs above budget ($1.5M unfavourable) and a one off net $1.7M unfavourable variance for revaluation of retirement gratuity liabilities.
    - Personnel Costs are $8.0M unfavourable - payroll FTE are 152 below budget but the favourable variance this creates is offset by cost per FTE targets not met, MECA costs above budget ($1.5M unfavourable) and a one off net $1.7M unfavourable variance for revaluation of retirement gratuity liabilities
    - Outsourced Personnel costs are $10.0M (55.7%) unfavourable (157 FTE above budget), primarily for contract Support (Cleaners) and Administration staff covering vacancies
- Clinical Supplies $5.7M (2.4%) unfavourable with the key variances as follows:
    - The key unfavourable variance is in Cancer & Blood Services - abnormally high haemophilia blood product costs ($1.8M unfavourable) which are fully funded and pharmaceutical costs in Oncology/Haematology ($1.9M unfavourable) due to additional costs for treatment previously funded under a research trial and high cost drugs in Haematology.
    - High volume of TAVI implants in Cardiology (67 for current year versus 41 for last year) - $0.8M unfavourable
    - Radiology $0.9M unfavourable due to higher than budgeted volumes of Interventional Radiology procedures
    - Pharmacy clinical supplies $0.3M unfavourable due to increased clinical trials – offset by additional trial revenue
    - Surgical Services/Perioperative Services are $2.0M unfavourable reflecting volumes for adult surgery at 103.9% of contract ($9.6M above contract) for the year
- Infrastructure and Non Clinical Supplies $8.4M (4.6%) unfavourable, comprising the following key variances – higher food costs during transition phase for new food services contract $1.9M unfavourable, costs of goods sold for retail pharmacy $0.7M unfavourable (offset by additional revenue), Capital Charge $2.0M unfavourable (offset by additional revenue), abnormally high cost of bad/doubtful debts $1.8M and facilities repairs and maintenance costs, including asbestos removal, costs $2.3M unfavourable.

FTE

Total FTE (including outsourced) for the month of June were 8,469, which is 10 FTE above budget.

Total FTE for June was a reduction of 117 FTE from the previous month – 75 of this was in Information Management, reflecting year end capitalisation of IS projects. In addition to this, Nursing FTE reduced by 22 reflecting the various strategies in place to manage the nursing spend, and RMOs reduced by 22 following rotation.

The key unfavourable FTE variance was Nursing at 41 above budget, offset by Allied Health 43 under budget. The Nursing FTE includes 15 unbudgeted positions for additional beds - the Orthopaedics Elective Unit in Ward 62 (11 FTE - unbudgeted but funded via reduced outsourcing) along with an additional three Bone Marrow Transplant beds to reduce wait times (4 FTE). The balance of the variance is 26 FTE above budget - strategies for managing Nursing FTE are summarised in the month expenditure commentary.

2015/16 Savings Programme

The key priorities established since 2013/14 continue into 2015/16 as part of the business transformation framework to deliver services in a cost efficient and productive manner. The savings programme is in line with our strategic plan to live within our means and achieve a break even bottom line.

Key Strategies

In 2015/16 the required savings to be found to close the budget gap was $26.9M mainly within the Provider Arm services. The savings are identified as being one of three key strategies - revenue growth, model of service delivery changes and cost containment.

Table 1: 2015/16 Savings Target ($000s)

Cause of Change	Revenue growth	Model of service delivery changes	Cost Containment	Grand Total
Budget as usual	943	500	13,980	15,423
Business transformation	1,539	1,054	8,869	11,461
Grand Total	**$2,482**	**$1,554**	**$22,849**	**$26,884**

Full Year Result

For the twelve months to June 2016 $21.8M savings have been achieved against the budget of $26.9M, resulting in an unfavourable variance of $5.1M.

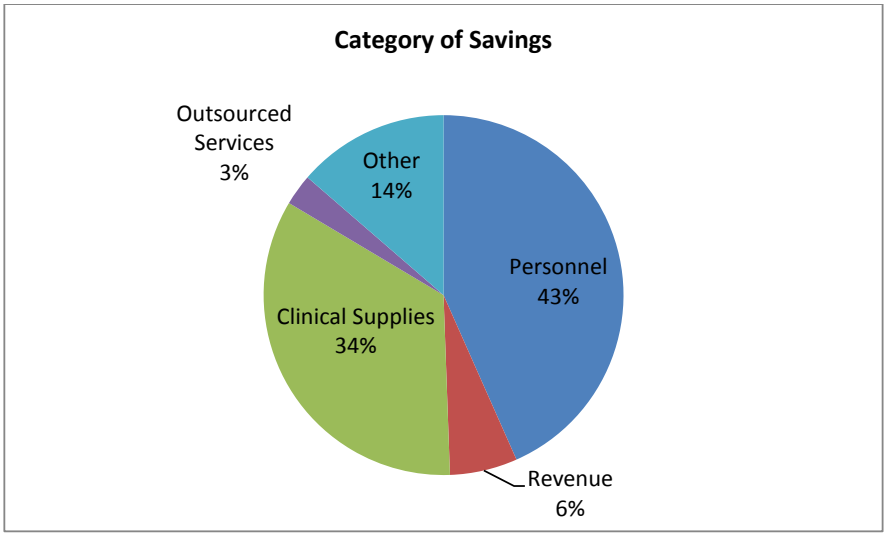
The unfavourable position was impacted by the increased demand in acute volumes above contract in a number of services, hence the flow-on effect on the savings programme - in particular the ACC revenue initiative in Children's Health ($1.2M U), Adult Medical acute demand volumes and Medical Personnel initiatives ($1.3M U), Cancer and Blood Personnel and pharmaceutical initiatives ($782k U), and healthAlliance procurement savings initiative ($3.1M U). Some of this has been offset by favourable savings in staff management within Community and Long Term Conditions ($394k F), and Perioperative theatre efficiencies ($2M F).

Table 2: Savings Programme – Full Year to June 2016 ($000's)

Strategy	Main Category	Savings Budget	Full Year Actual	Variance
Revenue growth	Government & Crown Agency	1,795	998	-797
	Non Government & Crown Agency	363	383	20
	Personnel	24	24	0
	Outsourced Services	200	0	-200
	Internal Allocation	100	225	125
Revenue growth Total		**$2,482**	**$1,630**	**-$852**
Model of service delivery changes	Non Government & Crown Agency	150	296	146
	Personnel	680	522	-158
	Outsourced Services	680	580	-100
	Clinical Supplies	-250	121	371
	Effectiveness improvement	294	1,896	1,602
Model of service delivery changes Total		**$1,554**	**$3,414**	**$1,861**
Cost Containment	Personnel	11,270	8,919	-2,351
	Outsourced Services	181	32	-149
	Clinical Supplies	11,191	7,327	-3,864
	Infrastructure & Non-Clinical	196	508	312
	Internal Allocations	10	0	-10
Cost Containment Total		**$22,849**	**$16,787**	**-$6,062**
Grand Total		**$26,884**	**$21,831**	**-$5,053**

Category of Savings

Personnel initiatives continue to be the major source of savings at $9.5M (43%) and the remaining balance made up of Clinical Supplies $7.4M (34%), Revenue $1.3M (6%), Outsourced Services $612k (3%) and other $3.0M (14%).



Key Points by Service

Adult Medical – Unfavourable variance $1,315k
Acute demand volumes have had a flow on effect on the savings programme and in particular staff management/medical-personnel related initiatives.

Adult Community & LTC – Favourable variance $394k
The full year result reflects the on-going achievement of savings in key areas of the business including; personnel savings particularly around managing staff leave, review of medical allowances and skill mix reviews.

Adult Surgical – Unfavourable variance $104k
The wards continue to manage well below their consumables budget. This is the major contributor to savings. Recruitment phasing also continues to achieve savings. Unfavourable against budget are Radiology/Laboratoriess, DNA rate reductions and implant reductions in Orthopaedics mainly attributed to the increased acute flows above contract. Note, any additional IDF/MOH revenue that would flow to offset the over-delivery will be reflected at organisational level.

Women's – Unfavourable variance $176k
The unfavourable variance is attributed to the non-resident, private patient and multi-disciplinary meeting revenue initiatives.

Children's – Unfavourable variance $1,244k
Initiatives around bed management and FTE management have delivered savings, but the full year unfavourable variance is due to the ACC revenue growth and annual leave management initiative.

Cardiovascular Services – Unfavourable variance $514k
The service exceeded its targets for contributions from research and overseas patients, but this was offset by unfavourable variances for initiatives to increase transplant revenue, annual leave reduction and other cost containment strategies.

Clinical Support – Unfavourable variance $131k
The full year position was close to budget and was driven by additional personnel savings ($596k F) from vacancies and leave management. Additional savings from revenue growth strategies ($135k F) is also being reported.

Non Clinical Support – Unfavourable variance $88k
While the standardised bed making linen initiative and improved co-ordination of milk deliveries to reduce waste were favourable these were partially offset by other contract initiatives not achieved in full.

Perioperative – Favourable variance $2,025k
The Service exceeded its target due to theatre utilisation efficiencies and clinical supplies. These favourable results have been partially offset by the personnel annual leave initiative which has been impacted by the increased acute volumes.

Cancer & Blood – Unfavourable variance $782k
The unfavourable variance is mainly attributed to pharmaceutical drug, blood and employee cost initiatives not full achieved.

Mental Health – Achieved budget savings of $1.5M
The service has achieved its year to date target. This is attributed to additional personnel savings from staff turnover assumptions.

healthAlliance – Unfavourable variance $3.1M
healthAlliance clinical supplies relate to the planned procurement contracted price changes savings. Further data analysis is underway with hA to further verify actual savings achieved to date. The year-end result is estimated at $2.9M versus budget of $5.9M.

Table 3: Savings by Service – Full Year – 12 Months to June 2016 ($000's)

Service	Strategy	2015/16 Savings Budget	2015/16 Savings Actual	Variance Full Year
Adult Medical	Cost Containment	3,069	1,754	-1,315
Adult Medical Total		**3,069**	**1,754**	**-1,315**
Community & LTC	Cost Containment	971	1,365	394
	Revenue growth in defined areas	24	24	0
Community & LTC Total		**995**	**1,389**	**394**
Surgical	Cost Containment	2,211	2,108	-103
	Revenue growth in defined areas	100	99	-1
Surgical Total		**2,311**	**2,207**	**-104**
Womens	Cost Containment	50	44	-6
	Model of service delivery changes	50	-55	-105
	Revenue growth in defined areas	687	622	-65
Womens Total		**787**	**611**	**-176**
Child Health	Cost Containment	2,748	2,033	-715
	Revenue growth in defined areas	804	275	-529
Child Health Total		**3,552**	**2,308**	**-1,244**
Cardiac	Cost Containment	507	281	-226
	Model of service delivery changes	530	617	87
	Revenue growth in defined areas	600	225	-375
Cardiac Total		**1,637**	**1,123**	**-514**
Clinical Support	Cost Containment	2,643	2,470	-173
	Model of service delivery changes	680	587	-93
	Revenue growth in defined areas	200	335	135
Clinical Support Total		**3,523**	**3,392**	**-131**
Non Clinical Support	Cost Containment	559	488	-71
	Revenue growth in defined areas	67	50	-17
Non Clinical Support Total		**626**	**538**	**-88**
Perioperative	Cost Containment	972	1,025	53
	Model of service delivery changes	294	2,266	1,972
Perioperative Total		**1,265**	**3,291**	**2,025**
Cancer & Blood	Cost Containment	1,634	852	-782
Cancer & Blood Total		**1,634**	**852**	**-782**
Mental Health	Cost Containment	1,505	1,505	0
Mental Health Total		**1,505**	**1,505**	**0**
healthAlliance	Cost Containment	5,980	2,863	-3,117
healthAlliance Total		**5,980**	**2,863**	**-3,117**
Grand Total		**$26,884**	**$21,831**	**-$5,053**

Volume Performance

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

		June 2016				YTD (12 months ending Jun-16)			
		$000s				$000s			
Directorate	**Service**	**Cont**	**Act**	**Var**	**Prog %**	**Cont**	**Act**	**Var**	**Prog %**
Adult Community & LTC	A+ Links, HOP, Rehab	4,079	4,290	211	105.2%	47,607	47,435	(173)	99.6%
	Ambulatory Services	1,921	1,926	5	100.3%	22,677	23,714	1,037	104.6%
Adult Community & LTC Total		**6,000**	**6,216**	**216**	**103.6%**	**70,284**	**71,149**	**864**	**101.2%**
Adult Medical Services	AED, APU, DCCM, Air Ambulance	1,972	2,201	228	111.6%	23,698	25,312	1,614	106.8%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	10,091	11,678	1,587	115.7%	120,764	127,872	7,109	105.9%
Adult Medical Services Total		**12,063**	**13,879**	**1,816**	**115.1%**	**144,461**	**153,185**	**8,723**	**106.0%**
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	8,092	8,509	417	105.2%	94,420	101,014	6,594	107.0%
	N Surg, Oral, ORL, Transpl, Uro	8,438	8,615	177	102.1%	102,565	105,180	2,615	102.5%
	Orthopaedics Adult	4,143	4,042	(100)	97.6%	50,210	50,580	370	100.7%
Surgical Services Total		**20,673**	**21,166**	**494**	**102.4%**	**247,195**	**256,775**	**9,579**	**103.9%**
Cancer & Blood Services		**7,793**	**7,227**	**(566)**	**92.7%**	**93,273**	**90,421**	**(2,852)**	**96.9%**
Cardiovascular Services		**10,887**	**10,566**	**(322)**	**97.0%**	**129,745**	**123,998**	**(5,748)**	**95.6%**
Children's Health	Child Health & Disability	891	892	1	100.2%	10,614	10,506	(108)	99.0%
	Medical & Community	6,605	6,214	(391)	94.1%	76,587	74,165	(2,421)	96.8%
	Paediatric Cardiac & ICU	3,673	3,565	(108)	97.1%	44,987	41,127	(3,860)	91.4%
	Surgical & Community	4,640	4,341	(299)	93.6%	56,693	52,668	(4,025)	92.9%
Children's Health Total		**15,808**	**15,012**	**(796)**	**95.0%**	**188,881**	**178,467**	**(10,414)**	**94.5%**
Clinical Support Services		**3,156**	**3,151**	**(5)**	**99.8%**	**36,789**	**37,686**	**897**	**102.4%**
DHB Funds		**6,794**	**6,794**	**0**	**100.0%**	**81,530**	**81,530**	**0**	**100.0%**
Public Health Services		**128**	**128**	**0**	**100.0%**	**1,537**	**1,537**	**0**	**100.0%**
Support Services		**101**	**101**	**0**	**100.0%**	**1,216**	**1,216**	**0**	**100.0%**
Women's Health	Genetics	267	252	(15)	94.4%	3,086	3,304	218	107.1%
	Women's Health	6,804	6,785	(19)	99.7%	81,215	79,043	(2,171)	97.3%
Women's Health Total		**7,071**	**7,037**	**(34)**	**99.5%**	**84,301**	**82,347**	**(1,954)**	**97.7%**
Grand Total		**90,475**	**91,278**	**803**	**100.9%**	**1,079,214**	**1,078,311**	**(903)**	**99.9%**

2) Total Discharges for the Full Year (12 Months to June 2016)

		Cases Subject to WIES Payment		All Discharges			Same Day discharges		Same Day as % of all discharges	
		Inpatient								
Directorate	**Service**	**2015**	**2016**	**Last YTD**	**This YTD**	**% Change**	**Last YTD**	**This YTD**	**Last YTD**	**This YTD**
Adult Community & LTC	A+ Links, HOP, Rehab	0	0	2,192	2,127	(3.0%)	16	9	0.7%	0.4%
	Ambulatory Services	1,561	1,718	1,908	2,059	7.9%	1,729	1,919	90.6%	93.2%
Adult Community & LTC Total		1,561	1,718	4,100	4,186	2.1%	1,745	1,928	42.6%	46.1%
Adult Medical Services	AED, APU, DCCM, Air Ambulance	11,070	12,521	11,084	12,526	13.0%	8,051	9,008	72.6%	71.9%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	18,655	19,324	18,913	19,510	3.2%	3,057	3,247	16.2%	16.6%
Adult Medical Services Total		29,725	31,845	29,997	32,036	6.8%	11,108	12,255	37.0%	38.3%
Cancer & Blood Total		4,796	4,909	5,318	5,320	0.0%	2,476	2,649	46.6%	49.8%
Cardiovascular Services Total		7,884	8,302	8,132	8,594	5.7%	1,965	2,063	24.2%	24.0%
Children's Health	Medical & Community	14,902	14,975	16,404	16,277	(0.8%)	9,444	9,368	57.6%	57.6%
	Paediatric Cardiac &	2,281	2,207	2,518	2,377	(5.6%)	495	493	19.7%	20.7%
	Surgical & Community	9,677	9,134	10,255	9,597	(6.4%)	4,889	4,424	47.7%	46.1%
Children's Health Total		26,860	26,316	29,177	28,251	(3.2%)	14,828	14,285	50.8%	50.6%
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	16,741	18,089	18,803	20,850	10.9%	10,201	11,764	54.3%	56.4%
	N Surg, Oral, ORL, Transpl, Uro	10,742	11,309	11,513	12,012	4.3%	4,639	4,670	40.3%	38.9%
	Orthopaedics Adult	5,003	4,978	5,332	5,247	(1.6%)	915	929	17.2%	17.7%
Surgical Services Total		32,486	34,376	35,648	38,109	6.9%	15,755	17,363	44.2%	45.6%
Women's Health Total		21,562	21,069	22,282	21,847	(2.0%)	8,650	8,189	38.8%	37.5%
Grand Total		**124,874**	**128,534**	**134,654**	**138,343**	**2.7%**	**56,527**	**58,732**	**42.0%**	**42.5%**

3) Caseweight Activity for the Full Year (12 Months to June 2016 (All DHBs))

		Acute							Elective							Total						
		Case Weighted Volume			$000s				Case Weighted Volume			$000s				Case Weighted Volume			$000s			
Directorate	Service	Con	Act	Var	Con	Act	Var	Prog %	Con	Act	Var	Con	Act	Var	Prog %	Con	Act	Var	Con	Act	Var	Prog %
Adult Community & LTC		**843**	**839**	**(4)**	**4,007**	**3,987**	**(20)**	**99.5%**	**107**	**81**	**(27)**	**509**	**383**	**(126)**	**75.2%**	**950**	**920**	**(31)**	**4,516**	**4,370**	**(146)**	**96.8%**
Adult Medical Services	AED, APU, DCCM, Air Ambulance	3,245	3,567	322	15,421	16,950	1,530	109.9%	0	0	0	0	0	0	0.0%	3,245	3,567	322	15,421	16,950	1,530	109.9%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	16,582	17,800	1,218	78,793	84,578	5,785	107.3%	0	0	0	0	0	0	0.0%	16,582	17,800	1,218	78,793	84,578	5,785	107.3%
Adult Medical Services Total		**19,828**	**21,367**	**1,540**	**94,214**	**101,529**	**7,315**	**107.8%**	**0**	**0**	**0**	**0**	**0**	**0**	**0.0%**	**19,828**	**21,367**	**1,540**	**94,214**	**101,529**	**7,315**	**107.8%**
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	8,581	9,554	974	40,771	45,398	4,627	111.3%	7,358	7,290	(68)	34,962	34,641	(322)	99.1%	15,939	16,845	906	75,733	80,039	4,306	105.7%
	N Surg, Oral, ORL, Transpl, Uro	8,021	9,020	999	38,112	42,860	4,748	112.5%	7,275	6,831	(444)	34,567	32,459	(2,108)	93.9%	15,296	15,851	556	72,679	75,319	2,640	103.6%
	Orthopaedics Adult	5,650	5,730	81	26,845	27,228	383	101.4%	3,807	3,774	(33)	18,090	17,934	(156)	99.1%	9,457	9,505	48	44,935	45,162	227	100.5%
Surgical Services Total		**22,251**	**24,305**	**2,054**	**105,728**	**115,486**	**9,759**	**109.2%**	**18,440**	**17,896**	**(544)**	**87,620**	**85,034**	**(2,586)**	**97.0%**	**40,691**	**42,201**	**1,509**	**193,347**	**200,520**	**7,173**	**103.7%**
Cancer & Blood Services		**6,177**	**5,836**	**(340)**	**29,348**	**27,732**	**(1,617)**	**94.5%**	**0**	**0**	**0**	**0**	**0**	**0**	**0.0%**	**6,177**	**5,836**	**(340)**	**29,348**	**27,732**	**(1,617)**	**94.5%**
Cardiovascular Services		**15,358**	**14,274**	**(1,083)**	**72,973**	**67,825**	**(5,148)**	**92.9%**	**9,728**	**9,543**	**(185)**	**46,223**	**45,344**	**(879)**	**98.1%**	**25,085**	**23,817**	**(1,268)**	**119,195**	**113,169**	**(6,027)**	**94.9%**
Children's Health	Medical & Community	10,604	10,434	(170)	50,387	49,577	(810)	98.4%	0	0	0	0	0	0	0.0%	10,604	10,434	(170)	50,387	49,577	(810)	98.4%
	Paediatric Cardiac & ICU	5,772	5,579	(192)	27,425	26,511	(914)	96.7%	2,404	2,503	98	11,425	11,892	467	104.1%	8,176	8,082	(94)	38,850	38,402	(447)	98.8%
	Surgical & Community	5,802	5,284	(519)	27,569	25,106	(2,464)	91.1%	4,713	4,356	(357)	22,393	20,697	(1,696)	92.4%	10,515	9,640	(875)	49,962	45,803	(4,159)	91.7%
Children's Health Total		**22,178**	**21,297**	**(881)**	**105,381**	**101,193**	**(4,188)**	**96.0%**	**7,117**	**6,859**	**(259)**	**33,817**	**32,589**	**(1,229)**	**96.4%**	**29,295**	**28,155**	**(1,140)**	**139,199**	**133,782**	**(5,417)**	**96.1%**
Women's Health Services		**10,384**	**9,862**	**(521)**	**49,339**	**46,862**	**(2,477)**	**95.0%**	**1,879**	**1,987**	**108**	**8,928**	**9,441**	**513**	**105.8%**	**12,263**	**11,849**	**(413)**	**58,267**	**56,303**	**(1,964)**	**96.6%**
Grand Total		**97,018**	**97,781**	**763**	**460,989**	**464,613**	**3,624**	**100.8%**	**37,271**	**36,365**	**(906)**	**177,097**	**172,790**	**(4,307)**	**97.6%**	**134,289**	**134,146**	**(144)**	**638,086**	**637,404**	**(682)**	**99.9%**
Excludes caseweight Provision																						

Acute

Full year acute delivery was 3.6% higher than the last year, with June again being high. There was a very slight decline in average WIES, but when comparing year on year ADHB was slightly better compensated for the acute activity via the change in the WIES model.

- The year ended nearly 4.7% higher for medical discharges. June had an increase in activity but not at the rate of the previous month. There was a slight improvement in the average WIES in June but medical WIES for the year ended up being 2.3% lower than last year. This means ADHB treated 2,500 more people, but overall patients had less complex issues to manage. This is borne out in part by the significant drop in ALOS which was down nearly 5%.
- Acute surgical cases ended up nearly 6% higher than the same period last year. The average WIES also increased by 1.4%, but the ALOS ended up 1% lower than last year. Unlike medical cases, the link between ALOS and average WIES is not strong as the WIES calculation includes surgical costs. The trend in surgical is to do more activity in a short stay setting.
- June was a busy month in Obstetrics compared to last year with 15% more activity, highlighting the unpredictability of this area. This means that the service ended up nearly 2% higher than predicted last month. Newborn services had 8% more discharges in June also. Overall Newborn andOobstetrics services were only 3.4% lower than last year, with the same average WIES and a slightly reduced ALOS.

Elective

115 more WIES funded elective cases were delivered over the previous financial year. This was driven by a drop for ADHB and CMDHB (275 cases) populations mainly offset by increases in delivery for Waitemata and Northland (351 cases). The average WIES dropped slightly in part reflecting the fact that there were increases in areas with low average WIES (e.g. Ophthalmology) and decreases in areas with high average WIES (e.g. Cardiothoracic). There was a reduced ALOS as well.

4) Non-DRG Activity (ALL DHBs)

		June 2016				YTD (12 months ending Jun-16)			
		$000s				$000s			
Directorate	**Service**	**Cont**	**Act**	**Var**	**Prog %**	**Cont**	**Act**	**Var**	**Prog %**
Adult Community & LTC	A+ Links, HOP, Rehab	4,079	4,290	211	105.2%	47,607	47,435	(173)	99.6%
	Ambulatory Services	1,577	1,565	(12)	99.2%	18,161	19,345	1,183	106.5%
Adult Community & LTC Total		**5,656**	**5,855**	**198**	**103.5%**	**65,769**	**66,779**	**1,010**	**101.5%**
Adult Medical Services	AED, APU, DCCM, Air Ambulance	703	687	(16)	97.7%	8,277	8,362	85	101.0%
	Gen Med, Gastro, Resp, Neuro, ID, Renal	3,587	3,647	60	101.7%	41,971	43,294	1,323	103.2%
Adult Medical Services Total		**4,290**	**4,334**	**44**	**101.0%**	**50,248**	**51,656**	**1,408**	**102.8%**
Surgical Services	Gen Surg, Trauma, Ophth, GCC, PAS	1,635	1,736	101	106.1%	18,687	20,975	2,289	112.2%
	N Surg, Oral, ORL, Transpl, Uro	2,545	2,348	(197)	92.3%	29,886	29,861	(25)	99.9%
	Orthopaedics Adult	459	431	(27)	94.0%	5,276	5,418	143	102.7%
Surgical Services Total		**4,639**	**4,515**	**(124)**	**97.3%**	**53,848**	**56,255**	**2,407**	**104.5%**
Cancer & Blood Services		**5,519**	**5,141**	**(378)**	**93.1%**	**63,925**	**62,690**	**(1,235)**	**98.1%**
Cardiovascular Services		**907**	**882**	**(25)**	**97.2%**	**10,550**	**10,829**	**279**	**102.6%**
Children's Health	Child Health & Disability	891	892	1	100.2%	10,614	10,506	(108)	99.0%
	Medical & Community	2,260	2,074	(186)	91.8%	26,200	24,588	(1,611)	93.8%
	Paediatric Cardiac & ICU	526	128	(398)	24.4%	6,138	2,725	(3,413)	44.4%
	Surgical & Community	588	496	(92)	84.3%	6,731	6,865	134	102.0%
Children's Health Total		**4,265**	**3,590**	**(675)**	**84.2%**	**49,682**	**44,684**	**(4,997)**	**89.9%**
Clinical Support Services		**3,156**	**3,151**	**(5)**	**99.8%**	**36,789**	**37,686**	**897**	**102.4%**
DHB Funds		**6,794**	**6,794**	**0**	**100.0%**	**81,530**	**81,530**	**0**	**100.0%**
Public Health Services		**128**	**128**	**0**	**100.0%**	**1,537**	**1,537**	**0**	**100.0%**
Support Services		**101**	**101**	**0**	**100.0%**	**1,216**	**1,216**	**0**	**100.0%**
Women's Health	Genetics	267	252	(15)	94.4%	3,086	3,304	218	107.1%
	Women's Health	1,995	1,833	(162)	91.9%	22,948	22,741	(207)	99.1%
Women's Health Total		**2,262**	**2,085**	**(177)**	**92.2%**	**26,034**	**26,044**	**10**	**100.0%**
Grand Total		**37,718**	**36,576**	**(1,143)**	**97.0%**	**441,128**	**440,907**	**(221)**	**99.9%**

Overall non DRG performance as a whole was almost on budget (a $221k under-delivery against a $440M budget). This was made up of under-delivery in Cancer & Blood Services ($1.2M) offset by over-delivery in Surgical Services (mostly Ophthalmology) and Clinical Support (mostly Laboratory services). It is estimated there is a $1M wash up risk in Cancer & Blood.

Directorate Updates

Recommendation

That the Directorate update reports, which comprise the following sections, be received:

6.1 Clinical Support Services

6.2 Women's Health Directorate

6.3 Child Health Directorate

6.4 Perioperative Services Directorate

6.5 Cancer and Blood Directorate

6.6 Mental Health Directorate

6.7 Adult Medical Directorate

6.8 Community and Long Term Conditions Directorate

6.9 Surgical Services Directorate

6.10 Cardiovascular Directorate

6.11 Non-Clinical Support Services

Endorsed by: Joanne Gibbs (Director Provider Services)

Clinical Support Directorate

Speaker: Ian Costello, Acting Director

Service Overview

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

The Clinical Support Services Directorate is led by:

Acting Director:	Ian Costello
General Manager:	Kelly Teague
Director of Patient Management Services:	Joyce Forsyth
Director of Allied Health:	Moses Benjamin
Director of Primary Care:	Dr Barnet Bond

Directorate Priorities for 15/16

1. Embed the Clinical Leadership model across the Directorate and support and develop our workforce to deliver on expectations.
2. Engage in service planning and integrated delivery with other Directorates/services to strengthen service planning, service delivery, patient pathways and achievement of organisational goals.
3. Integrated Daily Hospital Operations (24/7 – 365) that are patient safety focused.
4. Improve and enhance patient booking, administration and contact processes.
5. Using MOS and other enablers embed a discipline of quality driven activity, financial responsibility and sustainability in each service area

Q3 and Q4 Actions – 90 and 180 day plan

Priority	Action Plan
1	• Laboratory and Radiology strategy documents due for consultation in July 2016
	• MOS system established and functional at Directorate level and at departmental level in the following areas: Daily Operations, Radiology, Pharmacy, Laboratories and Clinical Engineering
	• Leadership appointments, orientation and induction programme to be implemented for Allied Health - July 2016
2	• Operational forecasting and planning - Production planning integrated with Daily Ops function – supports weekly Capacity and Demand forum and seasonal plan development • Phase 1 of Transit Lounge redesign completed – concept plan developed – linked to Integrated Daily Operations to be presented to ELT as a core part of the

	provider arm work programmes. • Medicines pathways under development and led by Pharmacy – additional FTE released from internal management restructure • Introduce regular integrated Clinical Governance and quality meetings at service level – Draft TOR established for Radiology and Laboratory • Services Labs and Radiology engaged in diagnostic pathway development for Faster Cancer Treatment • Radiology MRTs moved from 35 to 40 hour week • The booking process improvement initiative in Radiology has been implemented and is showing favourable results
3	• Director Patient Management Services reviewing the development and implementation of an Integrated Daily Operations function for ACH • Integrated Operations Centre planning under way as per the Daily Hospital Functioning work programme, Steering Group has been established and key leadership roles assigned.
4	• Leadership structure aligned with the Directorate model being further developed • Proposals to enhance appointment letters and text reminders have been written that are aligned with an invite to contact model • A draft policy and protocol framework for the introduction of an 'Access Booking and Choice' model has been completed
5	• Automation of Directorate Scorecard is underway • Radiology and Laboratory scorecards established • Financial objectives set for each Department, monitoring and reporting process centralised at Directorate level • Two Clinical Support Staff members attended the Improvement Practitioner (Green Belt) training • Two Clinical Support Staff members attending the Coaching Programme commencing in March 2016 • Three Clinical Directors attending Leadership Development Programme

Measures

Measure	Actual	Target	Prev Period
Acute flow (hour, day, month)		95%	
Turn around time - Radiology			
% Outpatients & community referred MRI completed < 6 weeks	75.62%	85%	63.65%
% Outpatients & community referred CT completed < 6 weeks	95.22%	95%	93.19%
% Outpatients & community referred US completed < 6 weeks	80.61%	85%	77.9%
Turn around time – Laboratories		85%	
% Histology – Small Biopsies <= 7 days			
Patient Experience (outpatient bookings)		90%	
Turn around time - Pharmacy Dispensary	Measure in development		
Succession plans in place for key roles	Measure in development		

Scorecard

Auckland DHB - Clinical Support

HAC Scorecard for June 2016

	Measure	Actual	Target	Prev Period
Patient Safety	Medication Errors with major harm	0	0	0
	Number of reported adverse events causing harm (SAC 1&2)	0	0	0
Better Quality Care	Number of complaints received	8	No Target	15
	% Outpatients and community referred MRI completed < 6 weeks	75.62%	>=85%	63.65%
	% Outpatients and community referred CT completed < 6 weeks	95.22%	>=95%	93.19%
	% Outpatients and community referred US completed < 6 weeks	80.6%	>=95%	77.9%
Engaged Workforce	Excess annual leave dollars ($M)	$0.59	0	$0.56
	% Staff with excess annual leave > 2 years	8.7%	0%	7.65%
	% Staff with excess annual leave and insufficient plan to clear excess by the end of financial year	100%	0%	100%
	Number of Pre-employment Screenings (PES) cleared before the start date	1	0	5
	Sick leave hours taken as a percentage of total hours worked	4.2%	<=3.4%	3.65%
	% Voluntary turnover (annually)	9.2%	<=10%	9.1%
	% Voluntary turnover <1 year tenure	2.2%	<=6%	2.9%

Scorecard commentary

Radiology

Performance in the past 6 months against the MoH indicators across modalities has continued to improve. The increase in acute referrals continues and the number of admissions requiring imaging diagnostics has been higher than anticipated. In the short term recruitment and staff training combined with outsourcing and process improvement activity within the department will continue to have a positive impact on the waitlist over the coming months.

MRI

Performance against the MRI target of 85% of referrals completed within six weeks has improved in June 2016 (75.62%) compared to May 2016 (63.65%). The waitlist continues to improve and currently stands at 254 in June 2016 compared to 463 in May 2016.

The number of adult patients waiting longer than 42 days has decreased from 10% (22/05) to 6% (26/6). There are now 14 patients waiting longer than 42 days (previously 28).

The number of paediatric patients waiting longer than 42 days has decreased from 51% (22/05) to 46% (26/06). There are now 68 patients waiting longer than 42 days (previously 115). A recovery plan has been devised and additional lists are in place to clear the back- log for the paediatric waiting list with a robust plan in place to sustain the current volumes under 42 days.

Radiology will continue with efforts to accelerate progress toward achieving MoH indicators through a number of planned initiatives including outsourcing, realignment of staffing rosters, the introduction of additional operating hours and service improvement projects. Outsourcing arrangements for adult referrals are assisting in managing demand and a total of 3227 additional procedures have been completed by private providers for the period July 2015 to June 2016. The outsourcing of 'standard' scans has made a significant impact on the waiting list. We are re-

evaluating our outsourcing strategy to ensure we are able to maintain and accelerate progress and meet the increasing requirements for more complex procedures e.g. general anaesthesia and sedation.

In an effort to decrease DNAs and improve the patient experience, our patient administration service is continuing its work on direct patient contact (booking). The department has introduced a dedicated scripted message for all Radiology patient phone calls. The script provided to administrators aims to be as informative as possible about the specific procedure and help reduce patient anxiety. Increase in performance will be seen further when the radiology strategy has been agreed and the new structure has been implemented.

Use of the new dashboard reporting tool is being implemented throughout the department for all SMOs, team leaders and clerical booking staff as a means of monitoring and managing outstanding referrals wait lists and validations.

CT

Performance against the MoH indicator of 95% of out-patients completed within six weeks has improved and is currently 95.22% for June 2016 compared to 93.19% in May 2016. A reliable service model is in place and there is a high degree of confidence that performance against this target will be maintained over the coming months.

Ultrasound

While this is an internal target (95%) we are mindful of the importance of patient access to the service and safe waitlist management. Our performance has shown 80% of outpatients were scanned within 6 weeks in June 2016 compared with 77.9% in May 2016. We continue to work on long term solutions to manage demand, for example, through direct communication with all GP referrers and providing clinical advice and guidance where required.

Increased Patient Safety

There were 8 complaints in June 2016 compared to 15 in May 2016. The themes were around lack of communication, accessibility and clinicians attitude. The Directorate is in the process of introducing a complaints action plan database to ensure that actions are complete and that a 'lessons learnt' approach is adopted which will be shared across all departments.

Health and Safety departmental inspections have taken place in Radiology (ACH & GLCC), Anatomical Pathology Services, Mt Wellington, Forensic Pathology, Allied Health, Patient Service Centre and Contact Centre. There are a number of recommendations which will be actioned within the next month. Further inspections are scheduled throughout July 2016 for the remaining departments within the Directorate.

Better Quality of Care

High suspicion of cancer patient tracker is currently being developed for Radiology. The complexity in amalgamating the data sets required has delayed the planned start date by 1 month.

Radiology has produced a weekly report for all Directorates to support the appropriate allocation of high suspicion of cancer requests from specialties. This will support efficient prioritisation of resources. Radiology is also reviewing the lung pathway to identify further improvements in the availability of CT and MRI.

Engaged Workforce

Each department has compiled a risk register which will feed into the Directorate Risk Register. A gap analysis has been undertaken across the Directorate to determine the training requirements for Health and Safety Representatives.

A monthly HR report has been developed for the Directorate's Senior Leadership team to review and take action with regards to improving excess annual leave, sick leave and voluntary turnover. Work will be undertaken to compile a mandatory training database for the directorate.

Key achievements in the month

- The PC3 laboratory build is complete and was opened on 26 June 2016.
- Scoping exercise complete in relation to text reminders and emailing letters to patients.
- Additional sessions in place to clear the wait list backlog for paediatric MRI patients. An additional session will be implemented to maintain waiting times within 42 days.
- Reduction in radiology waiting lists and increased performance against the MoH targets.

Areas off track and remedial plans

Radiology

The focus remains on meeting MoH indicators for MRI and internal waitlist for Ultrasound. Detailed production plan in place and weekly reporting on status. Bookings will be increased over June 2016 to ensure longest waiting patients have appointments made.

Lab - Anatomical Pathology Service (Mt Wellington)

- Challenges remain in meeting turnaround times for histology. A number of initiatives have been implemented including recruitment to additional two Pathologists and use of locum staff. Engagement with community services has begun to understand significant changes to volumes in certain areas.

- National Screening Unit (Ministry of Health) review of reporting levels in Gynaecology Cytology and progress against IANZ audit requirements. An audit of activity has been completed and provided to MoH. A meeting was held with IANZ leads and outstanding issues are now resolved.

- Significant increases in Zika Virus and Measles samples for analysis have impacted department of Virology.

- SLAs are being developed to clearly define the services being provided vs expectations for both parties going forward.

- Radiology and Laboratory strategies in work up with a view to being out for consultation at the end of July/early August 2016.

Forensic Pathology

Recruitment difficulties will result in the number of Forensic Pathologists reducing from 4 FTE to 2 FTE in July until September. Contingency plans have been developed with the Ministry of Justice and the Chief Coroner which involve transportation of work to the Waikato region as well as restriction upon consultant workload. Essential on-call services for upper North Island will be maintained.

Key issues and initiatives identified in coming months

- Patient Service Centre – Implement a steering and project group for this strategy in line with the agreed project plan

- Implementing an Integrated Daily Operations Centre

- Workforce and capacity plan for laboratory staff

- Radiology FCT tracker

- Improving the process for patients receiving their appointment letters

- Reviewing opportunities for better use of Interpreter resources

Financial Results

STATEMENT OF FINANCIAL PERFORMANCE

Clinical Support Services

Reporting Date Jun-16

($000s)	MONTH			YEAR TO DATE (12 months ending Jun-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
REVENUE						
Government and Crown Agency	1,574	1,486	89 F	17,755	17,843	(88) U
Funder to Provider Revenue	3,125	3,125	0 F	36,905	36,416	488 F
Other Income	1,328	1,335	(7) U	15,725	15,929	(203) U
Total Revenue	**6,028**	**5,946**	**82 F**	**70,385**	**70,188**	**197 F**
EXPENDITURE						
Personnel						
Personnel Costs	10,941	10,818	(124) U	125,230	129,490	4,260 F
Outsourced Personnel	410	249	(162) U	5,518	2,985	(2,533) U
Outsourced Clinical Services	757	560	(198) U	8,385	6,687	(1,698) U
Clinical Supplies	4,083	3,853	(230) U	47,379	45,036	(2,342) U
Infrastructure & Non-Clinical Supplies	684	493	(190) U	6,293	6,039	(254) U
Total Expenditure	**16,876**	**15,973**	**(903) U**	**192,804**	**190,238**	**(2,566) U**
Contribution	**(10,849)**	**(10,027)**	**(821) U**	**(122,419)**	**(120,049)**	**(2,370) U**
Allocations	(7,853)	(7,500)	353 F	(93,361)	(89,533)	3,827 F
NET RESULT	**(2,995)**	**(2,527)**	**(468) U**	**(29,058)**	**(30,516)**	**1,457 F**

Paid FTE

	MONTH (FTE)			YEAR TO DATE (FTE) (12 months ending Jun-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	137.3	141.9	4.7 F	137.4	141.4	4.0 F
Nursing	70.0	73.4	3.4 F	73.5	73.4	(0.1) U
Allied Health	850.0	854.4	4.4 F	842.7	854.4	11.6 F
Support	71.2	68.4	(2.8) U	71.6	68.4	(3.3) U
Management/Administration	296.4	315.0	18.6 F	304.1	315.0	10.9 F
Total excluding outsourced FTEs	**1,424.8**	**1,453.1**	**28.3 F**	**1,429.4**	**1,452.6**	**23.1 F**
Total :Outsourced Services	22.8	1.1	(21.7) U	20.3	1.1	(19.2) U
Total including outsourced FTEs	**1,447.6**	**1,454.2**	**6.5 F**	**1,449.7**	**1,453.7**	**4.0 F**

Comments on major financial variances - Clinical Support Services

The full year result is $1,457k F. The key drivers of this result were:

1. Personnel Costs/Outsourced Personnel $1,727k F due to tight management of cost per FTE combined with number of FTE being below budget.
2. Outsourced Clinical Supplies were U due to additional outsourcing of MRIs to meet Ministry of Health targets.
3. Clinical Supplies were U in Radiology due to additional volumes of Interventional Radiology procedures. Interpreters costs were $669k over budget due to additional volumes.

Women's Health Directorate

Speaker: Dr Sue Fleming, Director

Service Overview

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

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

The Women's Health Directorate is led by:

Director: Dr Sue Fleming

General Manager and Nursing Professional lead: Karin Drummond

Director of Midwifery: Melissa Brown

Director of Allied Health: Linda Haultain

Director of Primary Care: Dr Diana Good

Directorate Priorities for 2015/16

During 15/16 our directorate priorities were focused in five key areas which overlap and support the six Provider Arm Priorities (PAP). Those priorities were:

1. Strengthen our quality and safety governance and culture
2. Support and develop our staff
3. Improve care quality and safety including equity of access and outcomes
4. Improve and enhance service delivery
5. Develop and better utilise our facilities

These priorities provided a framework for prioritising improvement projects within the Directorate. They complement and are aligned to our Maternity Quality and Safety Plan, ADHB Strategic Mandatories and our collaboration work with WDHB.

Q4 Actions – 90 day plan

1. Strengthen our quality and safety governance and culture

We have completed our Maternity Quality and Safety report and integrated this within the Annual Clinical Report, of which will be presented at our Annual Clinical Report day on the 12th of August.

We have made considerable progress on our, 'Strengthening Consumer Voice Project' to increase consumer presence within our clinical governance structure (as part of our Maternity Quality and Safety Programme). We have contracted with our two existing consumer representatives and Women's Health Action to lead a project to develop more innovative ways of capturing the voice of consumers. This includes the establishment of a diverse and multicultural working group of consumers for regular discussions of ideas, events, improvements and feedback on consumer related issues is planned. The project's focus is on *Sustainability (*connected, supported, informed and accountable maternity service consumer representatives), *Effectiveness (*diverse consumer perspectives to inform and shape maternity service design and delivery) and *Added value (*high levels of consumer satisfaction with quality and safety maternity services). This will be achieved through:

- The recruitment and selection of suitable, diverse consumer representatives for all Level 2 and 3 Clinical Governance Groups;
- A formal induction, training and ongoing external support structure for all consumer representatives;
- The establishment of a Consumer Governance Group embedded into the existing clinical governance structure;
- The development of a set of maternity consumer driven outcomes/measures and targets; and
- Working in collaboration with Patient Experience and Performance Improvement teams to engage diverse multicultural groups of maternity consumers via innovative methods.

We are at the stage of short listing applicants and developing a robust induction programme. This project will continue into 2016/17.

2. Support and develop our staff

We have appointed new Service Clinical Directors with the retirement of one of our SCD. We are pleased to announce the appointment of Dr Cindy Farquhar to the position of SCD for Secondary Gynaecology. Dr Jenny McDougall has moved from this portfolio into the Secondary Maternity position. We have also appointed Dr Cindy Ooi as the Clinical Lead for Faster Cancer Gynaecology Services.

Our first Women's Health leader graduated from the ADHB leadership program. The remainder of our Service Clinical Directors and our Nursing Unit Managers are enrolled in the coming programme waves. We are starting to see the benefits within the Directorate, even at this early stage.

We have completed our review of our diabetes midwives team structure and a pay structure aligned to demonstrated competencies. The changes will strengthen Maternal Diabetes clinical skills

development within the service and for stakeholders through development of a midwifery-led clinical competency framework. Midwifery portfolio responsibilities will be more clearly defined as will opportunities for professional advancement.

Access to training and development under the framework will enable Community Midwives to get structured upskilling, and enhance their ability to care for low risk women with gestational diabetes rather than handing over care to the Diabetes Midwifery team.

In response to concerns around workplace stress and its impact on communication between staff, we ran a number of workshops with our medical staff around positive and respectful communication in the context of our values. In recognition of the impact that stress can have on optimal functioning and communication, we developed a support pathway for Senior Medical staff experiencing stress in the workplace.

Over the course of the last year we have paid increasing attention to support of our staff following critical incidents. We have become more proactive in arranging formal debriefs for the staff following a critical incident. In addition, we have collaboration with a senior midwife who is progressing a PhD thesis at AUT on supporting staff after a critical incident. She has developed for us an e-book which enables clinical staff to understand their own needs and emotional responses to a critical incident and enable them to get the support they may need. This will be launched on our Annual Clinical Report day.

We have received our final RANZCOG reaccreditation report. We have been granted provisional registration until March 2018 subject to addressing a number of areas where we only partially met the standards. A working group has been established and action plan formed to address the areas where improvement is required.

3. Improve care quality and safety including equity of access and outcome

This work is aligned with the ADHB priority work streams: Deteriorating Patients and Afterhours Inpatient Safety.

Our workshop with SMO's to explore ways of strengthening afterhours patient care and ensure a sustainable senior doctor staffing model on the 12 August is progressing. A facilitator external to the Directorate will be used (Gil Sewell). We have agreement from the Women's Health leaders from Counties Manukau DHB and Canterbury DHB to participate by teleconference. A pre-workshop survey has been developed to understand the challenges and desire for change from our SMO perspective prior to the workshop.

We are actively working up our business case to enable a safer and more sustainable model for after hour's operating theatres. As well as exploring options to enhance access on level 9, we will be exploring solutions which better serve the needs of the adult hospital as a whole.

4. Improve and enhance service delivery

Our work in this area aligns with the ADHB priority work programmes Daily Hospital Functioning, Delivering the PVS to Budget and Faster Cancer Treatment. We have now appointed a new Clinical Lead for the Faster Cancer Program in Gynaecology.

Our new SMO scheduling program is in use, and undergoing refinements to enable it meets all the service needs and ensuring it is actively managed and updated.

A review of the midwifery workforce commenced in April 2016, with the aim of building midwifery leadership capability through:

- Strong governance and accountability at the clinical interface
- Building workforce capacity
- Promoting workforce diversity
- Developing a succession plan
- Promoting a culture of learning and innovation

Building midwifery workforce capability and capacity will strengthen the delivery of safe, quality maternity care, reduce clinical risk and improve access and flows across the service, using a sustainable and financially responsible approach, in alignment with the Women's Health Directorate key priorities.

A review of the midwifery workforce identified:

- Significant variation in senior midwifery FTE across units
- Variable skill mix across the service
- A high proportion of midwifery staffing filled with Bureau, Registered and Enrolled Nurses and Healthcare Assistants
- Difficulties recruiting to base FTE
- A high turnover of midwives, especially in the first year of practice
- An ageing workforce
- A workforce that doesn't reflect the diversity of women receiving maternity care

A model is being proposed that will increase in midwifery leadership ensuring it is:

- Visible and accessible
- Provide operational support to the Charge Midwives and clinical expert support to less experience staff
- Be instrumental in role modelling and promoting ADHB values and accountability
- Actively manage and improve access and flows across the service, redeploying resources to areas of highest demand, where required

This is at an early stage of socialisation and feedback.

Our Pregnancy and Parenting Programme is well embedded with a number of classes and one to one sessions available. The programme has been designed to meet the needs of the priority populations with specific sessions designed for the different cultural needs. A Marae-based programme has commenced as well as home visits for those women who would not normally engage in antenatal classes. We are working on developing new models to reach Pacific and teenage parents.

5. Develop and better utilise our facilities

Work in this area aligns with ADHB Clinical Services Planning priority.

We continue to progress the model of care work for Epsom Day Unit to develop a more comprehensive Womens Day Procedure unit. We are planning a workshop with Regional DHBs to explore ways in which we can strengthen care and where possible deliver services closer to home.

Building on the success of our "one stop" abnormal uterine bleeding (AUB) pathway, we are planning for a faster cancer rapid access clinic to commence in the next quarter. This will enable women who present with postmenopausal bleeding to be seen promptly and wherever possible receive their diagnostic work up, including hysteroscopy, in an outpatient setting rather than needing an inpatient admission.

In this next quarter we will workshop options with our staff options to reconfigure Auckland City Hospital level 9 and 10 facilities to best meet our changing service needs. Our maternity numbers have declined over 2015 and have fallen below 7,000 births for the first time in almost two decades. Demand on our gynaecological oncology service has substantially increased both in terms of demand for Multidisciplinary Meeting discussions but also inpatient procedures and operating time with average operating minutes per case increasing 38% in 2015/16 compared to the previous 12 months.

Our postnatal inpatient recovery project has fallen a month behind its milestones. A major focus of the project is to better prepare women for their admission and postnatal stay and to facilitate a more streamlined discharge to home or to Birthcare. An important part of the project has been to engage widely with women and their families from all ethnic groups to understand their needs and perspectives. This has taken longer than originally predicted.

15/16 Measures

Measure	Actual	Target	Prev Period
Percentage of L3 CG groups with consumer reps	25%	100%	25%
% of inpatients completing consumer surveys	Est. 10%	>15%	Est. 10%
Satisfaction of WH leaders with leadership training	TBD	75%	TBD
DNA rates for: - Maori - Pacific	 19.39% 17.99%	9%	15%
Afterhours patient experience	TBD	TBD	No baseline
Theatre session usage (Level 9)	97.4%	95%	102%
% of Women who arrive in WAU within 45mins of acceptance	73%	95%	62%

Number of unplanned baby uplift/Yr	Est. 8	0	Est. 8
Genetic waiting list (number waiting >4mths)	100%	95%	100%
Meet FCT targets	66.7%	85%	71.4%
ADHB discharges	93%	100%	91%

Directorate Priorities for 2016/17

In 2016/17 our directorate will have a primary focus on increasing the value of the care that we deliver. Our work will build on that achieved in 2015/16 and contribute to the agreed overall provider arm work programmes. These priorities include:

1. Demonstrably safer care (*Deteriorating Patients, Afterhours Inpatient Safety, Faster Cancer Treatment*);
2. An engaged, empowered and productive workforce *(Leadership development, efficient rostering and scheduling, teaching and training, expanded scope of practice, living our values);*
3. Delivering of services in a manner that is sustainable, closest to home and maximises value *(Daily Hospital Functioning, Using the Hospital Wisely, Outpatient Redesign);*
4. Progress opportunities for regional collaboration *(ADHB – WDHB Maternity Collaboration); and*
5. Ensure business models for services maximise funding and revenue opportunities *(address funding shortfalls, public/private revenue opportunities).*

New Measures for 16/17

	Current (June 2016)	Target (end 16/17)
Average length of stay after elective CS	4.1	3 days
Fully meet RANZCOG training requirements	3 fully, 4 partially	7 fully
Elective surgical targets met	91%	100%
% of category 2 caesarean section patients meeting 60min time target		100%
WH patients accepted from ED meet target	65%	100%
DNA rate for women attending Glen Innes Maternity service		<9%
Nursing and Midwifery FTE variance to Budget		0 FTE
Breakeven revenue and expenditure		breakeven
Faster cancer targets met		85%

Scorecard

Auckland DHB - Women's Health

HAC Scorecard for June 2016

	Measure	Actual	Target	Prev Period
Patient Safety	Medication Errors with major harm	0	0	0
	Number of falls with major harm	0	0	0
	Nosocomial pressure injury point prevalence (% of in-patients)	0%	<=6%	0%
	Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	0.8%	<=6%	0.65%
	Number of reported adverse events causing harm (SAC 1&2)	0	0	0
Better Quality Care	HT2 Elective discharges cumulative variance from target	0.93	>=1	0.92
	(ESPI-1) % Services acknowledging 90% of FSA referrals within 10 working days	R/U	100%	100%
	(ESPI-2) Patients waiting longer than 4 months for their FSA	0.11%	0%	0.11%
	(ESPI-5) Patients given a commitment to treatment but not treated within 4 months	0%	0%	0%
	% DNA rate for outpatient appointments - All Ethnicities	8.46%	<=9%	9.98%
	% DNA rate for outpatient appointments - Maori	19.39%	<=9%	23.5%
	% DNA rate for outpatient appointments - Pacific	17.99%	<=9%	19.82%
	Elective day of surgery admission (DOSA) rate	96.3%	>=68%	97.37%
	% Day Surgery Rate	50.91%	>=50%	55.29%
	Inhouse Elective WIES through theatre - per day	6.69	>=4.5	8.67
	Number of CBU Outliers - Adult	9	0	6
	% Very good and excellent ratings for overall inpatient experience	R/U	>=90%	81%
	% Very good and excellent ratings for overall outpatient experience	R/U	>=90%	88.1%
	Number of complaints received	9	No Target	10
	Number of patient discharges to Birthcare	293	TBC	294
	Average Length of Stay for WIES funded discharges (days) - Acute	2.18	<=2.1	2.09
	Average Length of Stay for WIES funded discharges (days) - Elective	0.61	<=1.5	1.47
	Post Gynaecological Surgery 28 Day Acute Readmission Rate	R/U	No Target	7.11%
Improved Health Status	% Hospitalised smokers offered advice and support to quit	92.45%	>=95%	85.06%
	Breastfeeding rate on discharge excluding NICU admissions	R/U	>=75%	76.2%
Engaged Workforce	Excess annual leave dollars ($M)	$0.31	0	$0.31
	% Staff with excess annual leave > 1 year	33%	0%	30.1%
	% Staff with excess annual leave > 2 years	14.8%	0%	15.42%
	% Staff with excess annual leave and insufficient plan to clear excess by the end of financial year	98.3%	0%	98.4%
	Number of Employees who have taken greater than 80 hours sick leave in the past 12 months	R/U	60	117
	Number of Pre-employment Screenings (PES) cleared before the start date	0	0	0
	% Voluntary turnover (annually)	14.2%	<=10%	13.8%
	% Voluntary turnover <1 year tenure	7.5%	<=6%	8.16%

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

R/U Result unavailable

(ESPI-1) % Services acknowledging 90% of FSA referrals within 10 working days
Result unavailable until after the 12th of the next month.

% Very good and excellent ratings for overall inpatient experience
% Very good and excellent ratings for overall outpatient experience
These measures are based on retrospective survey data, i.e. completed responses for patients discharged or treated the previous month.

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

Breastfeeding rate on discharge excluding NICU admissions
Result unavailable until after the 20th of the next month.

Number of Employees who have taken greater than 80 hours sick leave in the past 12 months
Result unavailable until after the 17th of the next month.

Our quality metrics continue to be green.

Although we managed to close the gap on our ADHB elective targets and exceeded our recovery target we did not manage to fully achieve our contracted target.

Once again we achieved compliance for ESPI 5 but had a breach with one patient on our ESPI 2 target.

Our smoking performance has improved and we hope this is sustained.

Our workforce targets remain out of reach. This is a priority to address in 2016/17.

Key Achievements in the Month

Annual Clinical Report
This year our report has been given an update in form and content. Colour has been used as an aid to interpreting data presented in graphical form. Data tables have been incorporated into the body of the report rather than being included in appendices. Our Maternity Quality and Safety report, monitored by the National Maternity Monitoring Group, is once again integrated into the maternity section of the report. A slightly different approach to the analysis and presentation of our birthing outcome data: where relevant we have presented data according to the professional group providing care.

For the first time in the last decade the number of women birthing in our service has fallen below 7,000. This decline is mostly accounted for by a reduction in birthing numbers for our ADHB population. The reason for this decline is unclear and was not predicted by our forecasting work in 2014. The decline in numbers has been accompanied by a change in the ethnic mix of our birthing population with a consistent increase over time in the proportion of our population identifying as Asian, from 22.7% in 2006 to 32.3% in 2015.

Despite a focus on optimising spontaneous vaginal birth rates over the past year our operative birth rates have increased. Our induction of labour in standard primigravida is well above the national average, and our spontaneous vaginal delivery rate well below the national average. Our Caesarean Section rate, at 35.6% overall, is highest among Private Obstetricians and lowest for the National Women's Community Midwifery group and for self-employed midwives. These trends are reversed for spontaneous vaginal delivery rates. During 2016 we will work towards a better understanding of these differences.

Concerningly, since 2006 we have seen a significant increase in the proportion of babies with low apgar scores at one and five minutes. A low score was significantly more likely to occur when care was delivered by a self-employed LMC or NWH community team than a private obstetrician. An important quality focus in 2016 is to strengthen the competencies of our NWH staff and self-employed midwives in fetal surveillance.

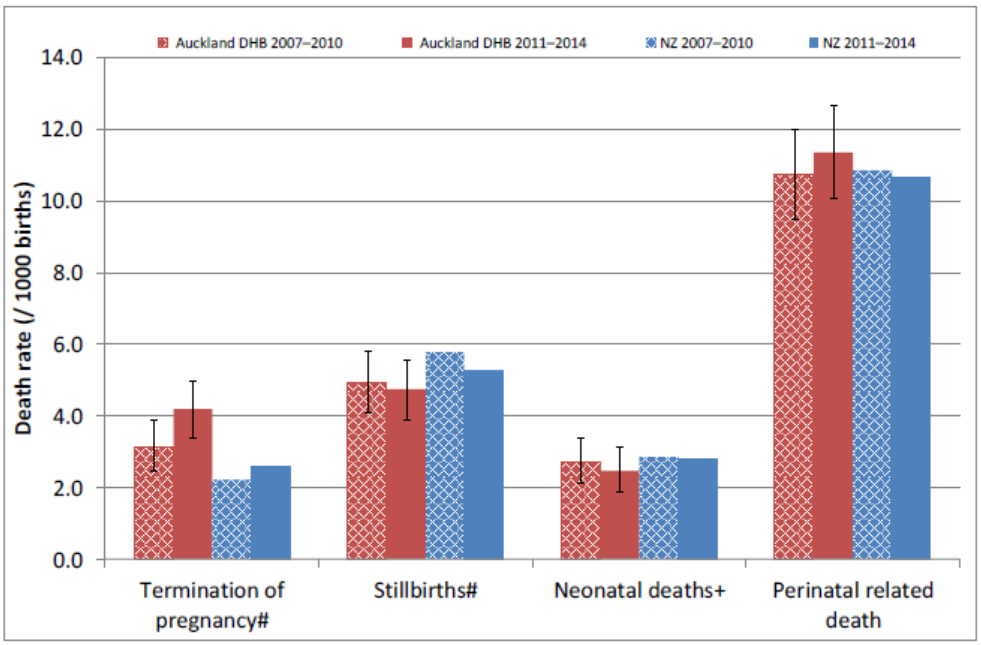
We have seen a notable change in the gestation of our babies at birth. Our rates of preterm birth in 2015 are the lowest they have been in a decade due largely to a reduction in iatrogenic preterm births. This is likely to be due to evidence based changes in practice including more conservative management of pre-term ruptured membranes and hypertensive disorders of pregnancy at lower gestations. Our work on trying to reduce spontaneous pre-term deliveries continues with access to a Preterm Prevention Clinic for those women at highest risk of pre-term birth. Simultaneously we have noted a reduction in births at 40, 41 and 42+ weeks and an increase in births at 38 and 39 weeks due to an increase in inductions and elective caesaean sections at these gestations.

Perinatal related mortality rates amongst women birthing at National Women's was the lowest for 13 years.

Analysis of perinatal related deaths and neonatal encephalopathy where Auckland is the DHB of maternal residence. 2007-2014

This report was released in late June 2016. The outcome data for Auckland benchmarked well with the rest of New Zealand. Termination of pregnancy data reflects our Abortion service and the referrals to our MFM service. The stillbirth rate was significantly lower in the first period 2007-2010 and lower (but not statistically significantly lower) in the second period 2011-2014, than in New Zealand overall. The neonatal death rate was consistent with the national rate in both periods. There has been a significant reduction in the rate of smokers among mothers of perinatal related deaths in the Auckland DHB region and nationally.

Figure 1: Perinatal related mortality rates Auckland DHB (with 95% CIs) compared to New Zealand 2007-2014



Rate per 1000 babies born.
+ Neonatal death rate per 1000 live born babies.

There was a significantly higher rate of perinatal related death associated with congenital abnormality, and a significantly lower rate of hypoxic peripartum death among mothers in the Auckland DHB region.

There was a significantly higher rate of neonatal death due to gastrointestinal conditions and a significantly lower rate of neonatal death due to neurological conditions for the entire period 2007-2014. In the first DHB report 2007-2010 the PMMRC recommended local review of neonatal death due to gastrointestinal conditions. This has occurred and revealed no concerns with care.

The proportion of eligible mothers screened for diabetes in both periods was significantly higher than the proportion in New Zealand overall. There has been an increase in Auckland eligible mothers of perinatal related deaths screened for diabetes from 2007-2010 to 2011-2014. No women in Auckland had unknown diabetes screening status in the second period 2011-2014.

Areas off track and remedial plans

FTE overspend

We have seen an increase in our FTE in the last month which is in part due to the new midwifery graduates requiring a supernumerary period. We expect to bring this to budgeted level in the new financial year.

Northern Genetics hub

The service performed well during 15/16 with respect to reducing waiting lists for both clinical geneticists and genetics counsellors. Recent months have seen a rise in waiting list numbers: for Counsellor from 318 to 402; and for Geneticists from 144 to 165.

The drivers for this have been a rise in referral together with a temporary decrease in counsellor FTE due to vacancies.

Vacancies are being filled: a new GC started on 9 May, a return from parental leave on 4 July and one role is still being recruited to. Clinic templates are being reviewed to ensure appropriate numbers of patients are being booked with clinicians. A Genetics Counsellor planning day is scheduled for 25 August to review referral procedures and non-value added time.

We anticipate bringing the wait list under control quite quickly. The MOH have indicated they are happy with performance and will release the performance dependant funding.

Key issues and initiatives identified in coming months

- Progressing business plan for additional theatre resource both in and out of hours.
- Workshop to explore SMO afterhours work patterns (12 August)
- Annual Clinical Report Day (19 August)
- Active scoping of additional revenue generating initiatives.
- Progress our new Midwifery workforce plan

Financial Results

Womens Health Directorate - Financial Results – Year June 2016

STATEMENT OF FINANCIAL PERFORMANCE

Womens Health Services

Reporting Date Jun-16

($000s)	MONTH			YEAR TO DATE (12 months ending Jun-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
REVENUE						
Government and Crown Agency	367	189	178 F	2,377	2,239	137 F
Funder to Provider Revenue	7,071	7,071	0 F	84,301	84,301	0 F
Other Income	155	175	(21) U	1,965	2,095	(130) U
Total Revenue	**7,593**	**7,436**	**158 F**	**88,642**	**88,635**	**8 F**
EXPENDITURE						
Personnel						
Personnel Costs	3,257	3,222	(35) U	39,276	38,431	(846) U
Outsourced Personnel	94	72	(22) U	729	861	132 F
Outsourced Clinical Services	7	11	4 F	89	130	41 F
Clinical Supplies	380	422	42 F	5,141	5,028	(112) U
Infrastructure & Non-Clinical Supplies	115	101	(14) U	1,248	1,219	(28) U
Total Expenditure	**3,852**	**3,827**	**(25) U**	**46,483**	**45,670**	**(813) U**
Contribution	**3,741**	**3,608**	**133 F**	**42,160**	**42,965**	**(805) U**
Allocations	791	710	(80) U	8,796	8,455	(341) U
NET RESULT	**2,951**	**2,898**	**53 F**	**33,364**	**34,509**	**(1,146) U**

Paid FTE

	MONTH (FTE)			YEAR TO DATE (FTE) (12 months ending Jun-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	70.4	66.5	(3.9) U	67.2	66.5	(0.7) U
Midwives, Nursing	258.2	244.2	(14.0) U	253.3	242.3	(11.1) U
Allied Health	16.8	20.3	3.5 F	17.4	20.3	2.9 F
Support	0.0	0.0	0.0 F	0.0	0.0	0.0 F
Management/Administration	39.2	38.6	(0.6) U	38.5	38.8	0.3 F
Other	0.0	0.0	0.0 F	0.0	0.0	0.0 F
Total excluding outsourced FTEs	**384.5**	**369.6**	**(14.9) U**	**376.5**	**367.9**	**(8.6) U**
Total :Outsourced Services	5.7	2.6	(3.1) U	3.0	2.6	(0.4) U
Total including outsourced FTEs	**390.2**	**372.1**	**(18.1) U**	**379.5**	**370.5**	**(9.0) U**

Comments on major financial variances (June YTD)

The Directorate's result for the annual budget variance finished at $(1,146)k U, mostly from drop in private revenue and personnel variances arising from use of bureau.

Overall CWD volumes finished at 97% of contract and Specialist Neonates at 70% for the year.

The Gynaecology acute WIES finished at 97% of contract and performance of their electives contract at 106% (by value but not discharge target).

The combined DRG and Non-DRG volumes equated to $3,164k U of revenue below contract (not recognised in the Directorate result).

June: Year financial analysis:
Revenue $8k F YTD.

A. **MoH non-Devolved Contracts, excl CTA** (below) $68k F. This is the cumulative variance as a consequence of now having 2 programmes that will either not be rolled over or will have funding reduced - Antenatal HIV Screening and MFM (Maternity Fetal Medicine). On the positive side we have new contracts for Lactation Support and the Pregnancy & Parenting Programme which made the variance favourable.

B. **Non-Resident, Private and Other Income;** this billing slipped and finished at $130k U; these revenues are unpredictable.

C. **Clinical Training** (CTA) $33k F; for School of Health student midwife placement training.

Expenses
Expenditure variance is now $1,154k U YTD; this variance is mostly the net result of:

A. Personnel $846k U mostly from the unfavourable Midwifery/Nursing variance arises from high use of Internal Bureau for shift cover and leave cover. These challenges will be significantly lessened with the increased FTE budget in the new financial year 2016-17.

B. Blood Costs $72k U: during the year we had some patients with very high cost needs.

C. Outsourced personnel $132k F: as a result of a University vacancy during the year.

D. Labs costs variance of $90k U: the Genetics service undertook a large number of genetics tests in June.

E. Nutrition internal service billing $196k U due to one-off implementation costs for the new food service.

Child Health Directorate

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

Service Overview

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

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

Surgical Child Health

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

Medical Child Health

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

The Child Health Directorate is led by

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

Directorate Priorities for 15/16

1. Establishing and embedding our excellence programme
2. Financial sustainability
3. Community services development
4. Aligning services to patient pathways
5. Hospital operations / inpatient safety
6. Meaningful involvement from our workforce in achieving our aims

Q4 Actions – 90 day plan

Priority area	Action plan	Commentary
1	Service-wide excellence programme development	▪ Analysis of the safety culture survey is now complete and priorities for improvement identified. ▪ The Governance Group oversees an established work programme. ▪ Consumer / family engagement in the governance group is particularly good and highly valued.
2	Ongoing effective financial management	▪ Savings activity in progress and emphasis on timing of revenue. ▪ Emphasis on financial strategy across multiple years to ensure enduring change.
2	Tertiary services review	▪ Report and all service summaries in development, stakeholder engagement agreed. Service summaries completed in mid-June.
3	Community services redesign project plan	▪ Design workshops were completed in April. ▪ Model of service concept has been developed in June.
4	Allied Health organisational alignment	▪ Implementation plan in progress. Service Clinical Director recruitment in progress.
4	Rehabilitation and SCI pathway development	▪ Pathway consultation complete. Final pathway due to be published mid-year.
5	Care of physiologically unstable patients model	▪ Child Health workstreams agreed and in progress.
5	Afterhours inpatient safety model	▪ Child Health workstreams agreed and in progress.
5	Surgical production	▪ Recovery plans finalised and being implemented. Capacity constraints in paed surgery addressed through replacement clinician to commence July.
5	Acute flow project	▪ On target performance for Q4.
6	Leadership development programme	▪ Child Health leaders are participating in the phase one programme and the pilot. 360 feedback process is in progress. ▪ Change leadership modules to be delivered for staff working within community services.
6	Improved programme of funding for research and training for all Starship Child Health staff	▪ Programme launched in May and applications are now open for the clinical research, training and innovation projects.

Q1 2016/17 Actions – 90 day plan

Priority area	Action plan
1	Service-wide excellence programme development
2	Ongoing effective financial management
5	Care of physiologically unstable patients model
5	Surgical production
5	Acute flow project
6	Leadership development programme
6	Improved programme of funding for research and training for all Starship Child Health staff

Measures

Measure	Actual	Target	Prev Period
1. Quality and safety metrics established across services	In progress	Defined metrics	In progress
2. Development of quality and safety culture	In progress	Embedded	In progress
3. Continuing to meet budget	Unfavourable	On budget	Unfavourable
4. Community redesign project plan developed	In progress	Complete	In progress
5. Operational structure that follows patient pathways embedded	In progress	Complete	In progress
6. Established rehabilitation pathway including spinal cord impairment	In progress	Complete	In progress
7. Acute flow metric	95.97%	95%	94.52%
8. Surgical production metric	In progress	Defined metrics	Initiated
9. Safety metric – ward arrest, urgent PICU transfer	In development	Defined metrics	In development
10. Vacancies unable to recruit to	Unknown	Measured	Unknown
11. Staff satisfaction	Unknown	Measured	Unknown

Scorecard

Auckland DHB - Children's Health

HAC Scorecard for June 2016

	Measure	Actual	Target	Prev Period
Patient Safety	Central line associated bacteraemia rate per 1,000 central line days	7.63	<=1	0
	Medication Errors with major harm	0	0	0
	Number of falls with major harm	0	0	0
	Nosocomial pressure injury point prevalence (% of in-patients)	2%	<=6%	7.4%
	Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	3.2%	<=6%	3.3%
	Number of reported adverse events causing harm (SAC 1&2)	0	0	0
Better Quality Care	HT2 Elective discharges cumulative variance from target	0.85	>=1	0.87
	(MOH-01) % CED patients with ED stay < 6 hours	95.97%	>=95%	96.51%
	(ESPI-1) % Services acknowledging 90% of FSA referrals within 10 working days	R/U	100%	100%
	(ESPI-2) Patients waiting longer than 4 months for their FSA	0.29%	0%	0.1%
	(ESPI-5) Patients given a commitment to treatment but not treated within 4 months	3.26%	0%	2.31%
	% DNA rate for outpatient appointments - All Ethnicities	11.23%	<=9%	12.34%
	% DNA rate for outpatient appointments - Maori	18.73%	<=9%	19.35%
	% DNA rate for outpatient appointments - Pacific	22.35%	<=9%	24.59%
	Elective day of surgery admission (DOSA) rate	67.31%	TBC	63.91%
	% Day Surgery Rate	58.84%	>=52%	58.82%
	Inhouse Elective WIES through theatre - per day	23.86	TBC	32.36
	% Very good and excellent ratings for overall inpatient experience	R/U	>=90%	91.9%
	% Very good and excellent ratings for overall outpatient experience	R/U	>=90%	81.2%
	Number of complaints received	5	No Target	7
	28 Day Readmission Rate - Total	R/U	<=10%	9.94%
	% Adjusted Theatre Utilisation	74.37%	>=80%	81.72%
	Average Length of Stay for WIES funded discharges (days) - Acute	4.04	<=4.2	4.55
	Average Length of Stay for WIES funded discharges (days) - Elective	0.99	<=1.5	1.57
Improved Health Status	Immunisation at 8 months	93%	>=95%	93%
Engaged Workforce	Excess annual leave dollars ($M)	$0.48	0	$0.45
	% Staff with excess annual leave > 1 year	29.7%	0%	29.01%
	% Staff with excess annual leave > 2 years	9.1%	0%	9.41%
	% Staff with excess annual leave and insufficient plan to clear excess by the end of financial year	99%	0%	98.15%
	Number of Pre-employment Screenings (PES) cleared before the start date	0	0	1
	Sick leave hours taken as a percentage of total hours worked	4.7%	<=3.4%	4.6%
	% Voluntary turnover (annually)	11%	<=10%	10.8%
	% Voluntary turnover <1 year tenure	13.2%	<=6%	12.5%

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

R/U Result unavailable

(ESPI-1) % Services acknowledging 90% of FSA referrals within 10 working days

Result unavailable until after the 12th of the next month.

% Very good and excellent ratings for overall inpatient experience

% Very good and excellent ratings for overall outpatient experience

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

28 Day Readmission Rate - Total

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

Scorecard commentary

Elective discharges

The Child Health Directorate delivered 85% of the target for ADHB discharges at the year ended 30 June 2016. This result largely reflected an insufficient number of ADHB patients, particularly for paediatric ORL and paediatric surgery. Recovery efforts were in place for the majority of the financial year and will continue into the 2016/17 financial year.

Elective performance

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

ESPI -1 (acknowledgement of referral) 100% compliant.

ESPI -2 (time to FSA) 0.28% moderately non-compliant. 6 cases breached in total (1 paed ortho, 5 paed surgery).

ESPI-5 (time to Surgery) 3% non-compliant, 22 cases breached (1 ACHD, 4 Paed Ortho, 1 Paed Cardiac and 16 Paed Surgery) contributing factors include spinal surgery capacity constraints, acute demand and reduced surgical capacity.

DNA rates

Access and DNA (also referred to as Was Not Brought, WNB) rates remain a central focus for the Child Health Directorate. The WNB project is targeting specific services and patient groups with the highest rates. Data analysis of children who were not brought to bronchiectasis clinic in the previous 12 months indicates:

- Maori, Samoan and Tongan populations have the highest rates of WNB
- There were no significant differences in the rates of WNB between DHBs of domicile

A draft policy of how the Child Health Directorate will respond to WNB is being tested in clinical settings. This includes a series of conversations with the parents of those children with a significant history of WNB and consultation with Waitemata and Counties Manukau District Health Boards. Once fully tested and refined this policy will be finalised and embedded.

Excess annual leave usage

Active management of all excess annual leave is continuing. Enhanced reporting is assisting line managers to target areas of concern and is addressed in monthly review meetings with each service.

There is dual emphasis on reducing excess annual leave balances and annual consumption of the leave entitlement for each employee.

Significant progress has been made in the services with the highest leave balances, particularly NICU and SMOs across child health. The full benefits of this work will not be realised until the 2016/17 year as leave planning has taken place over a two year period.

Staff turnover (annual)

Staff turnover within the Child Health Directorate has been maintained at just above the organisational target for some months. Service level analysis of the data has identified specific

services and wards in which turnover is of concern. These are being addressed through a range of engagement initiatives and addressing leadership in several areas.

Key achievements in the month

- The community services redesign work has now produced a concept design which includes the core principles of whanau centred care, equity of access and outcomes with an emphasis on vulnerable populations and knowing and working closely within the community (locality).
- The collaboration with Waitemata DHB around provision of specialised paediatric rehabilitation has delivered a draft model of care across the full rehabilitation continuum. This draft model was distributed across the sector for consultation with all feedback now reviewed and considered.
- The paediatric cardiac recruitment related to the new funding is now complete in most areas. A direct outcome of this has been no cancellations of acute and semi-urgent cases in the last quarter and only 4 PICU related cancellations compared with 23 in the same period as last year.

Areas off track and remedial plans

- Appointment to the Lead Clinician Clinical Excellence role – the first recruitment round did not identify a suitable candidate, further recruitment is in progress.
- Financial performance – unfavourable result YTD, current dual focus on revenue and cost containment.
- The patient lifts in Starship are at the point of failure and frequent faults have risked safe transfer of patients between the wards, PICU, radiology and theatres. Contingency plans are in place to mitigate this and the lift replacement programme is expected to commence in October.

Key issues and initiatives identified in coming months

- Development of service-level clinical excellence groups and finalisation of service-level outcome measures.
- Level 5 refurbishment to commence November 2016.
- Community Services Redesign Project will generate a consultation document following the design and model of service concept testing phases currently underway.
- Completion of the tertiary services review.
- The Child Health Allied Health workforce will be integrated within the Child Health Directorate from 1 July 2016.

Financial Results

STATEMENT OF FINANCIAL PERFORMANCE
Child Health Services

Reporting Date Jun-16

($000s)	MONTH			YEAR TO DATE (12 months ending Jun-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
REVENUE						
Government and Crown Agency	958	832	126 F	10,074	10,012	62 F
Funder to Provider Revenue	17,476	17,623	(147) U	210,009	210,661	(651) U
Other Income	1,066	1,062	4 F	10,331	12,739	(2,408) U
Total Revenue	**19,499**	**19,516**	**(17) U**	**230,415**	**233,412**	**(2,997) U**
EXPENDITURE						
Personnel						
Personnel Costs	10,456	9,900	(556) U	118,801	118,087	(715) U
Outsourced Personnel	158	130	(28) U	1,807	1,562	(245) U
Outsourced Clinical Services	166	217	51 F	2,575	2,608	33 F
Clinical Supplies	1,904	1,926	22 F	22,888	23,028	140 F
Infrastructure & Non-Clinical Supplies	372	268	(103) U	3,521	3,219	(301) U
Total Expenditure	**13,056**	**12,442**	**(614) U**	**149,592**	**148,504**	**(1,088) U**
Contribution	**6,444**	**7,075**	**(631) U**	**80,823**	**84,908**	**(4,085) U**
Allocations	859	905	46 F	10,706	10,785	79 F
NET RESULT	**5,585**	**6,170**	**(585) U**	**70,117**	**74,123**	**(4,006) U**

Paid FTE

	MONTH (FTE)			YEAR TO DATE (FTE) (12 months ending Jun-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	223.6	224.9	1.2 F	222.6	224.9	2.2 F
Nursing	641.3	634.9	(6.4) U	622.1	636.6	14.5 F
Allied Health	130.3	128.6	(1.7) U	122.2	132.1	9.9 F
Support	0.0	0.0	0.0 F	0.0	0.0	0.0 F
Management/Administration	83.0	87.2	4.2 F	81.1	87.5	6.4 F
Total excluding outsourced FTEs	**1,078.2**	**1,075.5**	**(2.6) U**	**1,047.9**	**1,080.9**	**33.0 F**
Total :Outsourced Services	14.6	4.6	(10.0) U	8.8	4.6	(4.2) U
Total including outsourced FTEs	**1,092.8**	**1,080.1**	**(12.6) U**	**1,056.7**	**1,085.5**	**28.9 F**

Comments on major financial variances

The Child Health Directorate was $ 0.585M U for the month and $ 4.006M U year to date. Whilst year to date expenditure was at 100.7% of budget levels ($1.09M U) compared to inpatient activity at 96% of budget volumes, revenue was $3.0M unfavourable and driven by several key factors.

Total inpatient WIES for the month was 99% and year to date is at 96% compared to contract, and at 101% of prior year to date. Elective WIES for the month was 91%.

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

1. Revenue $3.0M U:
    a. ACC revenue is approximately $529k U to budget and is 18% below prior year. Further service focus on process and activity is on-going. Improved (more granular) reporting commenced in April, and over time this level of detail will become helpful in monitoring activity and revenue. ACC revenue has now been at budget level across the past five months, although the first half deficit has not been recovered.

    b. Donation revenue is $2.6M U. Cash-flows fluctuate materially from month to month and our new forecasting tool is giving us the increased level of predictability of short-medium term cash-flows that we expected. We expect this to be particularly helpful in 2016/17, when there are several large projects being supported.

    c. A revenue claw-back of $650k for paediatric cardiac revenue in relation to additional funding in 15 /16, where we have not yet employed up-to the additional funded level of resources.

2. Costs $1.09M U:
    a. Overall YTD expenditure is just above budget levels (100.7%) as a result of June costs being $614k U. This was driven primarily by employee costs ($556k U) and an increase in doubtful debt costs ($114k U) during the month. As FTE numbers have increased to budget levels we have seen employee costs turn unfavourable from February onwards. Overall employee leave balances increased by approximately 3,900 hours (1.6%) in June, and have consistently increased since January. The full year leave increase was 6,600 hours (approx. $320k). Year to date employee costs (and outsourced personnel costs) have now turned marginally unfavourable to budget (100.8%). Other costs are generally well controlled and broadly in line with levels of clinical activity - although surgical services costs are slightly higher than budget and medical are slightly lower when viewed in cost per case weight terms. The only notable exception is bad and doubtful debt provisions which are $393k U. There have been several high cost acute patients through NICU and PICU currently provisioned for as there is considerable doubt about recovery.

3. FTE 28.9 FTE F:

    The year to date position of 28.9 FTE F is driven by vacancies, particularly across Nursing and Allied Health, although in the past three months the vacancy level has reduced significantly. The June result of 12.6 FTE U is driven by nursing leave pay-outs during the month (approx. 12.0 FTE) and Allied Health staff that were unbudgeted, as funding contracts were extended (so there is offsetting revenue). Nursing is now effectively at budget levels and whilst Allied Health reported FTE is also at budget there is offsetting revenue to mitigate that impact. The outsourced services result is a correction over prior months.

Key strategies currently employed to improve the financial position with a view toward 2016 17 include:

1. On-going focus on ACC revenue, now that our position is improved and the data is also improving.

2. Management of donation revenue and phasing in the 16 /17 budget, as it is likely to vary quite significantly from month to month in 2016 /17 with regard to support for major projects.
3. Leave management project to progressively reduce excess leave balances. In reality we have not achieved leave savings through 2015 /16. Our reporting of leave trends and employees with high balances is now quite strong and more structure leave management is in place.
4. Monitoring of clinical activity to ensure bed closures that are consistent with both clinical requirements and budgeted expenditure across the full financial year.
5. Tight management of vacancy and recruitment processes.
6. Mitigating any cost risks that major refurbishment projects in Outpatients and General Paediatric wards may give rise to with regard to decanting processes in 16 /17. A full decant plan for both clinical and non-clinical areas is in development.

Perioperative Directorate

Speaker: Dr Vanessa Beavis, Director

Service Overview

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

The Perioperative Directorate is led by

Director: Dr Vanessa Beavis

General Manager: Tara Argent

Nurse Director: Anna MacGregor

Director of Allied Health: Kristine Nicol

Directorate Priorities for 15/16

In 2015/16 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. Enhance patient care by expanding in the preoperative and postoperative arena.
2. Optimise Operating Room (OR) efficiency.
3. Build strong relationships.
4. Promote Perioperative as a helpful / enabling service providing quality care.

Q4 Actions – 90 day plan

Activity	Progress
Surgical capital planning project	The Terms of Reference have been agreed by the Surgical Board. The first meeting for phase 1 starts this week. The aim is to have an indicative demand and capital model by December 2016.
Stocktake of ADHB pre-assessment clinics compared with the rest of New Zealand.	The data has been collated and the report is in the process of being written up.

Q1 Actions 2016/17 – 90 day plan

Activity	Progress
Maximise resourced sessions in conjunction with Surgical Services.	OR Managers attend weekly capacity meetings which have been implemented across all surgical specialities to ensure that all OR lists are reviewed on PIMs. This is to ensure that sessions are booked effectively and can be managed within the resources available (inc beds, CSSD). Any sessions that will not be used will be identified earlier in the planning cycle and released to SCRUM.
Waiting list management SCRUM process reviewed and improved.	In conjunction with the establishment of the weekly capacity meetings, the SCRUM process will be audited over the next 3 months to ensure that lists are being effectively managed.
Contribute to multidisciplinary team (MDT) meetings for high risk services.	Linking with all specialities to identify the MDMs that take place across ADHB that require anaesthesia input and then plan where attendance is possible.

Measures

Measure	Actual June	Target (End of 15/16)	Progress - update
Single instrument tracking in place	TDoc	Nexus	Completion date for the nexus project has been extended – timeline yet to be confirmed due to IT and significant operational impacts.
Reduction in waiting times for anaesthesia assessment clinic to 2 weeks	RU	85%	This is being reviewed by the project team and developed into a wider patient focused / Transition Hub project led by Performance Improvement. Justin Kennedy Good to lead and identify resource. It links into the activity listed above.
Reduction in the number of preventable session losses across all ORs (including GSU and SSOR	31.3%	30%	The SCRUM process is working effectively as more services are attending the meeting and the surgical bookers are now booking lists further ahead which allows for lists to be recycled and managed more effectively.
Contribute to Multidisciplinary team(MDT) meetings for high risk	By invitation only	Vascular and Liver	Linking with all specialities to identify the MDMs that take place across ADHB that require anaesthesia input and then plan where attendance is possible / accordingly, and the ability to allocate resource. There is reasonable progress in this area, attendance is limited by the clinical workload at present and the need to meet the end of year volume targets.

Scorecard

Auckland DHB - Perioperative Services

HAC Scorecard for June 2016

	Measure	Actual	Target	Prev Period
Patient Safety	% Acute index operation within acuity guidelines	81.7%	>=95%	84.15%
	Wrong site surgery	0	0	0
	% Antibiotics within 60 mins of operation	76.8%	>=80%	79.08%
Better Quality Care	Unplanned overnight admission	5.3%	<=3%	4.74%
	Unplanned ICU / DCCM stay	0.07%	<=1%	0.13%
	30 day mortality rate for surgical events	1.07%	<=2%	1.83%
	CSSD incidents	2.16%	<=2%	3.2%
Improved Health Status	Elective sessions planned vs actual used	95.9%	>=97%	95.8%
	% Adjusted theatre utilisation	85.18%	>=85%	86.54%
	Late starting sessions	7.83%	<=5%	6.28%
Engaged Workforce	Excess annual leave dollars ($M)	$0.34	0	$0.3
	% of Staff with excess annual leave > 1 year < 2 years	28.7%	<=30%	28.85%
	% Staff with excess annual leave > 2 years	10%	0%	9%
	Sick leave hours taken as a percentage of total hours worked	4.5%	<=3.9%	4.06%
	% Voluntary turnover (annually)	9.9%	<=10%	9.6%
	% Voluntary turnover <1 year tenure	2.6%	<=6%	1.3%

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

Scorecard Commentary

There were 2 complaints received for Perioperative services for June, these are being fully investigated by the appropriate team.

No SAC 1 and two SAC 2 incidents reported in the 3 months from 1 April 2016 to 30 June 2016.

All recommendations from previous RCAs have been implemented.

Formal auditing of the surgical safety check list is due to recommence in this quarter.

There were 3 medication incidents reported for June 2016, without harm. Each department holds a monthly quality meeting where all incidents are reviewed and investigated. This is monitored by a Directorate quality meeting where any recurring trends are reviewed and action plans agreed as necessary.

Better Quality Care

Unplanned overnight admissions in June were 5.30% against a target of 3%, which is attributed to the acute load and case mix.

CSSD Incidents in June were reduced to 90 and are predominantly linked to wrap damage. A new wrap has been trialled which has delivered an improvement. Moving forward, new technology with vacuum packing could be introduced to improve the sterility, and reduce patient cancellation and deferred care. This is being investigated at present.

Several projects are currently on hold due to resource availability. The Service Improvement team are undertaking a feasibility study to see how these can be progressed.

Improved Health Status

Elective sessions planned vs actual

June planned vs actual elective session usage was 95%, this is attributed to the improved attendance of the SCRUM meeting and the release and reallocation of sessions across departments. This is set against the on-going increased acute demand. Weekend insourcing lists have been commenced as part of the ADHB recovery plan, but are being managed in conjunction with staff and bed availability. The power outage caused a significant and unexpected loss of production.

Late Starts

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

Engaged Workforce

- Commenced mid-year intake new to OR
- Ongoing training of Occ Health team
- Presentation by the CEO at the OR forum was well received.
- OR hui planned for next month.

Key achievements in the month

- All capex and post implementation reviews for 2015/16 completed.
- Approximately 48, 700 cases were completed / carried out last year (2% increase on the previous year)
- Approximately 17% increase in OR minutes compared with last year
- Completed rollout of OR to PACU nursing staff handover process.
- Handover between all ends of the patient pathway in surgical and perioperative services have been greatly facilitated by the appointed of nurse consultants in the Surgical Directorate to work with the nurse consultant in Perioperative services.

Areas off track and remedial plans

Nexus project is being reviewed, a new project manager has been appointed, and a revised timeline will be discussed at the next steering committee. This has been postponed again, as more background work is being carried out to establish a current status report. Visits have been made to WDHB as well as further contact with CDHB

- An agreed sequence of OR allocation changes have been agreed by the users which has been taken to the Surgical Board for ratification. Business cases have been signed off to enable some of the additional work.

Key issues and initiatives identified in coming months

- Commenced training for the SSCL observational audits that will be going to MOH starting 1 July 2016.
- Financial concerns – the impact of transplants, acutes and off the floor activity is adversely affecting the budget.
- Volumes maintained considering impact of transplant numbers
- Staff movement and skill mix while covering a number of acting role and projects.
- Removal of half day sessions and rationalisation of the OR schedule is underway to improve efficiency.

Financial Results

STATEMENT OF FINANCIAL PERFORMANCE
Perioperative Services

Reporting Date Jun-16

($000s)	MONTH			YEAR TO DATE (12 months ending Jun-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
REVENUE						
Government and Crown Agency	193	189	4 F	2,286	2,274	12 F
Funder to Provider Revenue	0	0	0 F	0	0	0 F
Other Income	19	18	2 F	346	211	135 F
Total Revenue	**212**	**207**	**5 F**	**2,631**	**2,485**	**146 F**
EXPENDITURE						
Personnel						
Personnel Costs	7,565	7,362	(203) U	90,109	87,763	(2,345) U
Outsourced Personnel	77	42	(35) U	765	503	(262) U
Outsourced Clinical Services	0	0	0 F	0	0	0 F
Clinical Supplies	3,848	3,394	(455) U	41,795	40,727	(1,068) U
Infrastructure & Non-Clinical Supplies	163	176	12 F	1,994	2,117	122 F
Total Expenditure	**11,653**	**10,973**	**(680) U**	**134,663**	**131,111**	**(3,553) U**
Contribution	**(11,441)**	**(10,766)**	**(675) U**	**(132,032)**	**(128,626)**	**(3,406) U**
Allocations	28	27	(1) U	317	316	(1) U
NET RESULT	**(11,469)**	**(10,793)**	**(676) U**	**(132,349)**	**(128,942)**	**(3,407) U**

Paid FTE

	MONTH (FTE)			YEAR TO DATE (FTE) (12 months ending Jun-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	161.6	165.5	3.9 F	159.2	165.4	6.2 F
Nursing	410.2	419.0	8.8 F	409.7	418.4	8.7 F
Allied Health	100.7	108.0	7.3 F	103.5	107.9	4.4 F
Support	110.0	113.8	3.8 F	111.9	113.8	1.9 F
Management/Administration	22.9	24.6	1.8 F	23.3	24.6	1.3 F
Total excluding outsourced FTEs	**805.5**	**831.0**	**25.5 F**	**807.7**	**830.2**	**22.5 F**
Total :Outsourced Services	4.0	1.3	(2.7) U	2.9	1.3	(1.6) U
Total including outsourced FTEs	**809.5**	**832.3**	**22.8 F**	**810.5**	**831.5**	**21.0 F**

Comments on major financial variances

Month

The net result for June is an unfavourable variance of $676k due to Personnel expenses ($203k U) and Clinical Supplies ($455k U).

FTE vacancies continue to be filled although are still showing favourable in some theatres, particularly Greenlane where patient patterns are more predictable (18 FTE under budget of 80). While FTE are favourable, costs are not due to additional penal and allowance payments and these are most evident in Adult Surgical ($110k U), Cardiac ($50k U) and Children's theatres ($35k U), all of whom have significantly higher activity this month.

Spending for Clinical Supplies is also primarily patient activity related and reflected in operating minutes 14.6% higher than June last year, and by theatre group are as follows

- Cardiac, 13.1% higher
- Adult Surgical, 22.9% higher and all acute inpatient driven
- Woman/Gynecological 17.8% higher
- Children, 11.6% higher
- Greenlane Surgical, 1.3% lower

There is a one off asset disposal cost of $100k within Clinical Supplies arising out of the replacement of all Anaesthesia monitors across ADHB with homogenous units (including some not fully depreciated, mostly within Greenlane Surgical theatres, hence the disposal cost).

Year

The net result for the full year is $3,407k unfavourable, primarily Personnel ($2,345k U and 2.7% of budget) and Clinical Supplies ($1,068k U and 2.6% of budget). Both of these overspends have been driven by increased patient demand.

This patient demand is reflected in increased full year operating minutes, compared to last year:

- Cardiac 14.5% higher, (759,705 to 636,285).
- Adult Surgical 16.7% higher, (1,664,429 to 1,425,767).
- Woman/Gynecological 11.0% higher, (520,528 to 469,146).
- Children 11.8% higher, (779,551 to 697,552).
- Greenlane Surgical 6.6% higher, (579,876 to 534,034).

While operating minutes were up significantly, actual cases were only up 0.5% (48,690 to 48,467), reflecting increased acuity and resulting in an average minutes per case increase of 13.6% to 88.40 (mins per case), with the Cardiac theatres group having the highest minutes per case average across the five theatre groups of 166.53.

Transplant operations are lengthy and have increased in number from 154 to 178 an increase of 24 or 16%, with 17 of the 24 being renal patients. These cases in particular impact the average minutes per case KPI and also specifically personnel and supply costs.

Business Improvement Savings

Perioperative Business Improvement Savings have exceeded expectation at $3.2M total savings for 2015/16, primarily due to theatre utilisation gains.

Cancer and Blood Directorate

Speaker: Dr Richard Sullivan, Director

Service Overview

Cancer is a major health issue for New Zealanders. One in three New Zealanders will have some experience of cancer, either personally or through a relative or friend. Cancer is the country's leading cause of death (29.8%) and a major cause of hospitalisation.

The Auckland DHB Cancer and Blood Service provide active and supportive cancer care to the 1.5 million population of the greater Auckland region. This is currently achieved by seeing approximately 5,000 new patients a year and 46,000 patients in follow-up or on treatment assessment appointments.

The Cancer and Blood Directorate is led by:

Director: Richard Sullivan

General Manager: Deirdre Maxwell

Director of Nursing: Brenda Clune

Finance Manager: Dheven Covenden

Human Resource Manager: Andrew Arnold

Director of Allied Health: Carolyn Simmons Carlsson

Directorate Priorities for 15/16

In 2015/16 our Directorate will contribute to the delivery of the six Provider Arm priorities. In addition to this we will also focus on the following Directorate priorities:

1. Tumour stream service delivery
2. Reducing time to First Specialist Appointment (FSA)
3. Treating patients within 31 days of referral
4. Bone Marrow Transplant (BMT) capacity and Haematology model of care
5. Supportive care service initiative
6. Northern Region Integrated Cancer Service development
7. Staff engagement in support of achieving these initiatives

Q4 Actions – 90 day plan

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

Our Service Clinical Directors continue to work with our Lead SMO to agree and implement joint ways of working across Medical/Radiation Oncology. There is now significant enthusiasm within our Directorate engaged in this work, consistent with streamlining our services in line with the new regional ways of working in cancer:

- Implementing e-triage, and by tumour stream rather than by clinician.
- Improving the referral process with direct prioritised referrals from tumour stream MDMs.
- Establishing schedulers across Medical and Radiation Oncology tumour streams.
- Increasing co-location for selected Medical and Radiation Oncology tumour stream outpatient clinics.
- Establishing joint pathways and case management meetings.
- Production management of tumour stream clinics.

In addition, we are planning a Directorate-wide revision of how we work, to integrate the three sub-specialty streams of Haematology, Medical Oncology and Radiation Oncology. This is under discussion at present but will likely include integration of acutes first, followed by daystay and clinics. This will be a means to better use our resources/facilities and to streamline patient pathways within our Directorate.

2 Reducing time to First Specialist Appointment across our services.

A range of activities are underway as planned. These include:

- Implementing e-triage consistent with DHB timelines.
- Production planning to flag demand/capacity issues within Medical Oncology. This work now extends to drafting planning routines by tumour stream, which will include data extracts, timings, annual leave, and availability rosters. A special code has been implemented by Information Management to differentiate Medical and Radiation Oncology First Specialist Appointments. This enables us to streamline our planning/scheduling processes.
- Establishing a Radiation Rapid Access Clinic for urgent patient access. Staff engagement and planning continues.

3 Developing processes to ensure all patients receive treatment within 31 days of referral to Cancer and Blood Directorate.

This work is consistent with 1 and 2 above, where we continue to work within Medical Oncology and Radiation Oncology to map 31 day processes from receipt of referral to first treatment. We have identified a range service champions to lead improvement work, and have determined escalation processes whereby Tumour Stream Coordination staff can expedite prospective patient tracking. Prospective patient tracking information is being provided to inform weekly Medical Oncology scheduling prioritisation. Some issues within Radiation Oncology are being worked on, including understanding the number of days the FCT patients have reached at the point at which the referral is received into our service. Our lead tumour stream coordinator has been investigating the FCT

breaches to understand where delays are occurring, specifically at which day the referrals are received from referring DHBs and how they are tracking through our services.

4 Reviewing and improving our model of care for malignant and non-malignant Haematology services.

We continue to ensure robust ways of delivering to the Ministry of Health wait time guidelines concerning Bone Marrow Transplant (BMT) delivery. There are currently no patients waiting longer than the 6 weeks guideline. We continue to work toward outpatient BMT delivery, although as previously signalled, there has been some balancing of this activity with the demands of clinical service provision given the current SMO staffing situation. We have opened the three additional BMT beds having recruited to nursing FTE (as agreed through 2016/17 planning processes).

5 Developing and implementing ADHB and Regional Service for the Supportive Care Initiative.

This new Ministry of Health national initiative sees additional psychosocial support provided for patients experiencing cancer. Referrals have been opened to all services who treat cancer across the DHB and work continues to be done to educate staff and stakeholders about the scope of the initiative. All four Northern Region DHBs are working in collaboration to ensure regional consistency especially for patients who may see multiple DHBs for their treatment of cancer. Whilst we await the official MOH evaluation to commence, we are starting to report referral data to ROOG.

6 Producing a service model for the Northern Region Integrated Cancer Service.

Regional discussions continue regarding the development of this initiative, with Dr Richard Sullivan (Director, Cancer & Blood) having presented a paper to the CEO/CMO forum at a recent meeting. Subsequent discussions at CEO/CMO level have proved very positive.

7 Planned activity based on areas highlighted in staff survey

Work has been undertaken in services within the Directorate to provide improvements for staff as an outcome of both the Burn Out Survey and following the implementation of Living Our Shared Values.

<u>Issues related to the Burn Out Survey:</u>

- Provision of training and systems improvements for communications within the Directorate
- Team building workshops
- Introduction of informal training sessions
- Better annual leave management and cover plans
- A range of break-out and catch up sessions designed to improve communication
- Meeting regularly and exploring reasons for current practice and possible variations in practice
- Recognition of the need for an interdisciplinary collaborative view from the outset and greater recognition of support between professions with an assurance all groups are supporting this
- Assuring the role of the Professional Leader in supporting staff
- The use of union support and implementation of MECA recommendations

Issues related to Living Our Shared Values

- Values discussion as part of team vision and values development
- Introduction of values as part of service induction and orientation
- Overview of values as part of setting the agenda and process for team meetings within services
- Members of staff attendance at an ADHB session on our Values
- Values presented at staff meetings
- ADHB values clearly displayed as A3 posters throughout the Directorate
- Staff meetings dedicated to exploring the behaviours arising from the values and establishing some examples of behaviours that are appropriate and inappropriate to the workplace
- Staff meeting to discuss how each area can disseminate values based care
- Applying ADHB values to competency frameworks within teams

Measures

Measure	Actual	Target (end 15/16)	Previous Period
3 tumour streams implemented within Cancer and Blood (gynaecology, head & neck, lung)	3	3	1
62 day FCT target	74% (ADHB)	85% (Jan 16)	75%
BMT initiative – number of patients achieving recommended 4-6 weeks wait time (no patients waiting longer than 6 weeks)	100%	100%	80%
Supportive Care Services – eligible patients receiving services	tba	75% (July 16)	N/A
Auckland Integrated Cancer Centre Business Case submitted	N/A	Jan submission	N/A
Current and improved employee engagement measures used in the MOS	In progress	Improved measure	N/A

Scorecard

Auckland DHB - Cancer & Blood Services

HAC Scorecard for June 2016

	Measure	Actual	Target	Prev Period
Patient Safety	Medication Errors with major harm	0	0	0
	Number of falls with major harm	0	0	0
	Nosocomial pressure injury point prevalence (% of in-patients)	0%	<=6%	8.3%
	Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	3.1%	<=6%	3.1%
	Number of reported adverse events causing harm (SAC 1&2)	0	0	0
Better Quality Care	(ESPI-1) % Services acknowledging 90% of FSA referrals within 10 working days	R/U	100%	100%
	% DNA rate for outpatient appointments - All Ethnicities	6.03%	<=9%	7.98%
	% DNA rate for outpatient appointments - Maori	9.6%	<=9%	15.1%
	% DNA rate for outpatient appointments - Pacific	9.47%	<=9%	14.93%
	Number of CBU Outliers - Adult	5	0	14
	% Very good and excellent ratings for overall inpatient experience	R/U	>=90%	83.3%
	% Very good and excellent ratings for overall outpatient experience	R/U	>=90%	90.2%
	Number of complaints received	2	No Target	1
	28 Day Readmission Rate - Total	R/U	TBC	21.57%
	Average Length of Stay for WIES funded discharges (days) - Acute	2.66	TBC	4.17
	% Cancer patients receiving radiation/chemo therapy treatment within 4 weeks of DTT	100%	100%	100%
	% Chemotherapy patients (Med Onc and Haem) attending FSA within 4 weeks of referral	100%	100%	100%
	% Radiation oncology patients attending FSA within 4 weeks of referral	91.04%	100%	77.42%
	% Patients from Referral to FSA within 7 days	20.78%	TBC	21.19%
	31/62 day target – % of non-surgical patients seen within the 62 day target	R/U	>=85%	70.37%
	31/62 day target – % of surgical patients seen within the 62 day target	R/U	>=85%	42.86%
	62 day target - % of patients treated within the 62 day target	R/U	>=85%	60.98%
Improved Health Status	% Hospitalised smokers offered advice and support to quit	100%	>=95%	87.5%
	BMT Autologous Waitlist - Patients currently waiting > 6 weeks	0	0	3
Engaged Workforce	Excess annual leave dollars ($M)	$0.13	0	$0.11
	% Staff with excess annual leave > 1 year	26.7%	0%	28.81%
	% Staff with excess annual leave > 2 years	10.6%	0%	8.47%
	% Staff with excess annual leave and insufficient plan to clear excess by the end of financial year	97.30%	0%	96.67%
	% Staff with leave planned for the current 12 months	17.5%	100%	18.73%
	% Leave taken to date for the current 12 months	83.8%	100%	79.34%
	Number of Pre-employment Screenings (PES) cleared before the start date	0	0	0
	Sick leave hours taken as a percentage of total hours worked	4%	<=3.4%	3.25%
	% Voluntary turnover (annually)	11.7%	<=10%	10.4%
	% Voluntary turnover <1 year tenure	5.4%	<=6%	6.1%

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

R/U Result unavailable

(ESPI-1) % Services acknowledging 90% of FSA referrals within 10 working days

Result unavailable until after the 12th of the next month.

% Very good and excellent ratings for overall inpatient experience

% Very good and excellent ratings for overall outpatient experience

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

28 Day Readmission Rate - Total

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

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

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

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

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

Scorecard commentary

Patient Safety Measures: All measures are within satisfactory parameters for this period, as with the previous period.

% DNA rates for outpatient appointments - Maori: We are working with the Strategy department to understand the dynamics and develop an appropriate ongoing response(s) to rectify this, as this level of DNA rate has been fairly constant over the last number of years. We are pleased to see a reduction from the previous period.

Radiation Oncology % patients attending FSA within 4 weeks of referral

The service is responding to difficulties with SMO availability and increased referral numbers. The two service areas under pressure are breast and genito-urinary clinics. We are operating recovery plans for both – these involve close monitoring of clinic attendance, the GU tumour stream SMOs agreeing to see additional FSAs over the next 3 months and a temporary increase in FTE of one SMO. Our SMOs are engaged in this work, and have agreed to see additional patient FSAs where possible. These activities have produced an improvement from the previous period.

Key achievements in the month

Decant planning and the wider opportunities it presents: As previously signalled, we continue to work towards the decant of staff from Building 7 into Building 8, staff representatives are closely involved in decision-making about the best ways to use the space available. This piece of work is encouraging innovative ways to solve long-standing problems of clinic and meeting room space availability, and we are working out how to better incorporate tumour streaming into this work. We are likely to move to fully integrating the ways we work across acutes (all three specialties), daystay (Medical Oncology and Haematology) and clinics (all three specialities). We seek to have completely revised our ways of working ahead of any move into a new building in the years to come.

Areas off track and remedial plans

Clinical Supplies/Herceptin Costs: This continues to show a negative financial impact. As mentioned previously, we have investigated Herceptin use, and have determined that consultant prescribing is consistent with guidelines. The conclusion of a clinical trial is the main driver of this cost pressure.

Haematology SMO staffing concerns

Our Haematology service experienced a reduction in SMO clinician time approximately six months ago due to a staff member leaving, and a cumulative reduction in hours for a range of other reasons. National and international recruitment processes were commenced immediately; however there is a shortage of Haematologist availability nationwide. We have secured a locum SMO from England to commence work in September 2016. Current staff willingness and internal planning work means that the rosters are covered to ensure clinical service delivery continues. Engagement with locum agencies also continues, however this has not resulted in further appointments at this time.

Key issues and initiatives identified in coming months

Faster Cancer Treatment/tumour stream development: Activity continues to ramp up in our service with the support of a FCT lead and an SMO lead (tumour stream development). We continue to flag areas of focus within/between Medical and Radiation Oncology which will improve our timeliness of provision, and have generated Directorate business rules for discussion. We are working with our regional DHB partners to identify and manage FCT timeliness for patients referred to Auckland DHB. The FCT lead is unpicking all breaches to determine where time delays are happening, and working closely with other DHB Directorate staff as a means to highlight where FCT patients journeys can be expedited. In addition, we now see the opportunity to revamp all our Cancer and Blood Service models of care in a more integrated manner.

Pharmac – Nivolumab (Opdivo) availability 1 July 2016, and potential Pembrolizumab (Keytruda) availability 1 September 2016: The 2016 budget indicated the availability of Nivolumab from 1 July, a medication for patients with stage 3 or 4 melanoma. We have commenced provision of this new medication with the service being provided from 1 July. Patient numbers will be tracked, and internal resource applied consistent with the increase in patient volumes. We expect a ramping up of activity over the next months. Very recently, Pharmac has also signalled the potential availability of Keytruda - a further medication for this same patient cohort – from 1 September. This medication has slightly different service impacts and these are being explored.

Financial Results

STATEMENT OF FINANCIAL PERFORMANCE
Cancer & Blood Services

Reporting Date Jun-16

($000s)	MONTH			YEAR TO DATE (12 months ending Jun-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
REVENUE						
Government and Crown Agency	1,146	862	284 F	12,873	10,348	2,526 F
Funder to Provider Revenue	7,793	7,793	0 F	93,273	93,273	0 F
Other Income	55	28	27 F	479	331	148 F
Total Revenue	**8,994**	**8,683**	**311 F**	**106,626**	**103,952**	**2,674 F**
EXPENDITURE						
Personnel						
Personnel Costs	3,118	2,880	(238) U	35,460	34,397	(1,063) U
Outsourced Personnel	69	69	0 F	915	833	(82) U
Outsourced Clinical Services	235	207	(29) U	2,784	2,479	(305) U
Clinical Supplies	3,045	2,865	(180) U	38,121	34,293	(3,829) U
Infrastructure & Non-Clinical Supplies	136	98	(38) U	1,344	1,189	(155) U
Total Expenditure	**6,604**	**6,119**	**(485) U**	**78,624**	**73,190**	**(5,434) U**
Contribution	**2,390**	**2,564**	**(173) U**	**28,002**	**30,762**	**(2,760) U**
Allocations	593	609	16 F	7,254	7,280	26 F
NET RESULT	**1,797**	**1,954**	**(157) U**	**20,748**	**23,482**	**(2,734) U**

Paid FTE

	MONTH (FTE)			YEAR TO DATE (FTE) (12 months ending Jun-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	63.1	62.1	(1.0) U	63.3	62.1	(1.2) U
Nursing	144.8	140.5	(4.2) U	145.7	140.5	(5.2) U
Allied Health	90.5	87.6	(2.9) U	87.8	87.6	(0.2) U
Support	1.0	1.0	0.0 F	1.1	1.0	(0.1) U
Management/Administration	23.2	22.3	(0.9) U	20.4	22.3	1.9 F
Total excluding outsourced FTEs	**322.6**	**313.5**	**(9.1) U**	**318.3**	**313.5**	**(4.8) U**
Total Outsourced Services	8.3	1.3	(7.0) U	4.9	1.3	(3.6) U
Total including outsourced FTEs	**330.9**	**314.8**	**(16.0) U**	**323.2**	**314.8**	**(8.4) U**

Financial Commentary

YTD financial analysis:

The result for the year ended 30 June 2016 is an unfavourable variance of $ 2,734k.
Volumes: Overall volumes are 96.9 % of contract. This equates to $ 2,852k below contract (not recognised in the Cancer and Blood Provider result).

Total Revenue $ 2,674k - favourable mainly due to:

i) Haemophilia blood product reimbursement $ 1,847k F – demand driven offset by higher blood product costs,
ii) Unbudgeted MoH Revenue for supportive care Psychologist and Support Workers $225k F – offset by increased Allied Health staff costs,
iii) Donation Income $ 111k F – mainly Dry July income,
iv) Favourable Non-Residents income $ 57k F.

Total Expenditure- $ 5,408k unfavourable mainly due to:
Personnel Including Outsourced Personnel – $ 1,145k U

Medical $ 444k U mainly unachieved savings target,

Nursing $ 631k U – primarily driven by unachieved savings target and additional unbudgeted BMT nursing staff to cover occupancy, acuity levels and waitlists.

Outsourced Clinical Services $ 305k U – mainly outsourced radiology charges by WDHB and CMDHB offset by internal radiology costs, combined with BMT Donor search fees – volume driven.

Clinical Supplies $ 3,829k U - primarily due to:

- Pharmaceutical costs $ 2,217k U primarily made up of Oncology $2,244k U. This is mainly due to the impact of unbudgeted Herceptin costs of patients coming off research trial and the increase in high cost drug Zolendronate.

- Treatment disposables and blood product $ 2,062k U – mainly Haemophilia Blood product costs (offset by increased revenue) combined with increased Haematology blood products (demand driven).

- Instrument & Equipment $ 465k F – timing of depreciation combined with favourable variances in clinical equipment repairs and maintenance costs.

Mental Health & Addictions Directorate

Speaker: Anna Schofield

Service Overview

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

The Mental Health & Addictions Directorate is led by

Acting Director: Anna Schofield

Director of Nursing: Anna Schofield

Director of Allied Health: Mike Butcher

Director of Primary Care: Kristin Good

Acting General Manager: Alison Hudgell

Directorate Priorities for 15/16

1. Embedding new leadership structures
    - Meeting structures
    - Embedding Management Operating System (MOS)
    - Patient Safety/Clinical Governance framework
2. Integration projects
    - Localities – Tamaki
    - Stepped care (psychosocial interventions)
3. Implementing new Eating Disorders Services Model of Care
4. Clinical Services planning and facilities
    - Te Whetu Tawera (TWT - adult inpatient) co-design
    - Fraser McDonald Unit (FMU - older person inpatient) upgrade
    - Clinical Services Plan development

Q4 Actions – 90 day plan

Yellow – Current Quarter

	Action Plan	Owner	Q1	Q2	Q3	Q4
1(a)	Leadership Structure – implementation of new meeting structure	CB				
1(b)	Patient safety/Clinical Governance – define data sets	AS				
2(a)	Tamaki Localities – develop pathways	CB				
2(b)	Stepped Care implementation in CMHS	MB				
3(a)	EDS communication ongoing with stakeholders	MB				
3(b)	EDS new staffing model decided on Development of facilities business	MB				
3(c)	EDS MOC and service delivery change implemented	MB				
4(a)	Clinical Services Plan enablers – Facilities priority plan	MW				
4(b)	FMU building work commenced and complete	MW				
4(c)	TWT co-design – Steering Committee established	CB				
4(d)	TWT environment upgrade commenced and complete	CB				
4(e)	TWT team building programme	CB				

Q4 Actions Completed – 90 day plan

1 (a) **Leadership Structure – implementation of new meeting structure:** Complete

1 (b) **Patient Safety/Clinical Governance-define data sets:** Complete

2 (a) **Tamaki Localities – develop pathways to support Tāmaki Mental Health & Wellbeing:** The Primary NGO support hours integrating NGO access as a core part of primary care has completed an 'action learning cycle' and a co-design wider implementation plan is underway with the NGO sector, PHOs and the ADHB leadership.

The Primary and Secondary integration work stream continues with pilots of integration initiatives.

2 (b) **Stepped care implementation into CMHS**

The Stepped Care page on the Intranet has been developed, training needs analysis completed, the process for credentialing specialised interventions has been defined and commences in July 16.

3 (a) Implementing new Eating Disorders Model of Care:

The transition phase of the project to establish an ADHB led Eating Disorder Services Hub supporting nine Supra Regional "spoke" services has successfully concluded and is now being managed (from July 1st) as business as usual under the ADHB Mental Health Directorate.

Planning is underway for the co-location of Hub services which currently operate from two key locations in Parnell (the residential service) and Greenlane (outpatient services).

Professional analysis of short and long term options will inform a detailed business case for a preferred colocation option.

There is ongoing negotiation with Midland funders regarding the proposed service funding model which is being led by Northern region lead CEO for Mental Health, Dr Dale Bramley.

ADHB is implementing the new service arrangements in accordance with the agreed service specifications on the understanding that funding agreements will be resolved following further Midland and Northern region CEO discussions.

4 (a) Clinical Services Plan enablers – facilities priority plan:

A Facilities plan covering all mental health services will be developed. Priorities include the St Lukes Community Health team (current lease expires September 2017), the residential eating disorders service (current lease expires March 2017) and the Youth Transition programme service (current leased facility not fit for purpose). The approach for selecting a new facility for the St Lukes Community Health team will reflect the integrated care and localities approach. Work continues to map current CMHC boundaries/populations and utilisation of services against new localities.

4 (b) FMU building work commenced and complete:

Auckland City Council has granted full consent for the project. Detailed specifications are now complete and signed off by the Project Team. Facilities are in the process of submitting a Request for Tenders (RFT). Significant progress has been made with the design features including furniture, fittings, lighting, flooring all of which will be “dementia friendly”. Expectation is that work will commence in September 2016.

4 (c) TWT environment upgrade commenced and complete:

Purchasing of items has commenced, and the environmental improvements are in progress, assisted by a Facilities Project Manager. This work should be complete by the end of the financial year. The majority of the new furniture has arrived, with more scheduled to arrive through July. The painting and upgrade of ICU/HDU is almost complete with only minor further work required. The balance of CAPEX funds will be spent on additional items by the end of July.

4 (d) TWT team building programme:

The number and frequency of verbal assaults on staff are now being recorded by using an application loaded on iPads kept in ward offices. This has been well received by staff. Use of a similar app to enable staff to indicate their level of satisfaction each day is also being investigated. It is expected that both of these initiatives will contribute to team morale.

Measures

Measures	Current	Target (End 2015/16)	2016/17
Tamaki Localities – increase in %GP referrals to CMHC (Manaaki House)	**29%**	**10% increase**	**20% increase**
Tamaki Localities – reduction in length of Community Care episode – GP referrals to Manaaki House	**N/A**	**Baseline identified**	**25% reduction**
Stepped Care - % of staff credentialed – individual therapy and group facilitation (CMHS Pilot sites)	**N/A**	**10% workforce credentialed – off track**	
EDS MOC – staff retention post implementation 1st July 2016 (Residential service (NGO) ahd Regional Eating Disorders Service existing workforces)	**N/A**	**>70% retention – achieved**	
FMU 'real time feedback' – consumer and family satisfaction	**N/A**	**Increase in satisfaction scores . implementation in progress**	
FMU staff satisfaction survey – in development	**N/A**	**To be confirmed – increase in satisfaction scores**	
TWT 'real time feedback' – consumer and family satisfaction	**N/A**	**Increase in satisfaction scores. implementation in progress**	
TWT staff satisfaction survey – in development	**N/A**	**To be confirmed – increase in satifsfaction scores**	

Scorecard

Auckland DHB - Mental Health

HAC Scorecard for June 2016

	Measure	Actual	Target	Prev Period
Patient Safety	Medication Errors with major harm	0	0	0
	Number of falls with major harm	0	0	0
	Nosocomial pressure injury point prevalence (% of in-patients)	0%	<=6%	0%
	Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	0%	<=6%	0%
	Number of reported adverse events causing harm (SAC 1&2) - excludes suicides	0	0	0
	Seclusion. All inpatient services - episodes of seclusion	4	<=7	0
	Restraint. All services - incidents of restraint	82	<=86	91
	Mental Health Provider Arm Services: SAC1&2 (Inpatient & Non-Inpatient Suicides)	0		2
Better Quality Care	7 day Follow Up post discharge	93.3%	>=95%	97.1%
	Mental Health - 28 Day Readmission Rate (KPI Discharges) to Te Whetu Tawera	R/U	<=10%	10.53%
	Mental Health Average LOS (KPI Discharges) - Te Whetu Tawera	20.4	<=21	26.3
	Mental Health Average LOS (All Discharges) - Child & Family Unit	10.2	<=15	12.2
	Mental Health Average LOS (All Discharges) - Fraser McDonald Unit	41.4	<=35	34.8
	Waiting Times. Provider arm only: 0-19Y - 3W Target	74.6%	>=80%	74%
	Waiting Times. Provider arm only: 0-19Y - 8W Target	89.1%	>=95%	88.9%
	Waiting Times. Provider arm only: 20-64Y - 3W Target	84.2%	>=80%	84.5%
	Waiting Times. Provider arm only: 20-64Y - 8W Target	91.2%	>=95%	91.4%
	Waiting Times. Provider arm only: 65Y+ - 3W Target	64.1%	>=80%	64.6%
	Waiting Times. Provider arm only: 65Y+ - 8W Target	84.2%	>=95%	84.6%
Improved Health Status	% Hospitalised smokers offered advice and support to quit	95.56%	>=95%	97.44%
	Mental Health access rate - Maori 0-19Y	5.78%	>=5.5%	5.63%
	Mental Health access rate - Maori 20-64Y	10.15%	>=12%	10.07%
	Mental Health access rate - Maori 65Y+	3.97%	>=4.3%	3.68%
	Mental Health access rate - Total 0-19Y	3.08%	>=3%	3.04%
	Mental Health access rate - Total 20-64Y	3.77%	>=4%	3.76%
	Mental Health access rate - Total 65Y+	3.17%	>=4%	3.15%
Engaged Workforce	Excess annual leave dollars ($M)	$0.12	0	$0.11
	% Staff with excess annual leave > 1 year	26.4%	0%	26.46%
	% Staff with excess annual leave > 2 years	5.4%	0%	5.05%
	% Staff with excess annual leave and insufficient plan to clear excess by the end of financial year	100%	0%	94.74%
	Number of Pre-employment Screenings (PES) cleared before the start date	0	0	0
	Sick leave hours taken as a percentage of total hours worked	4.3%	<=3.4%	4.1%
	% Voluntary turnover (annually)	12.9%	<=10%	12.3%
	% Voluntary turnover <1 year tenure	9.7%	<=6%	13.33%

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

R/U Result unavailable

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

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

Scorecard commentary

Better Quality Care - Average LOS: Te Whetu Tawera

High Average LoS for FMU is heavily influenced by one discharge (>200d stay). The average LoS for the remaining 10 discharges was 24 days.

Better Quality Care - Waiting Times

Three data/reporting factors (from August/September data) affect the ongoing rolling 12 month results and these continue to impact. They are the introduction of a new CAMHS team into MoH reporting, the transfer of existing clients to a new regional Huntington's service, and the management of memory clinic clients within MHSOP. Work is underway to extract the memory clinic data.

Within MHSOP additional analysis of the flow from referral to assessment has been undertaken and some additional practical actions are being implemented- separating triage into East and West teams, visible whiteboards to more quickly identify workload and manage risk.

Recruitment to key vacancies has occurred and more initial assessment slots are available.
MHSOP anticipate gradual improvement in both the three and eight week targets over the next six months but the 'rolling 12 month' data will be slow to demonstrate the improvement

The most recent monthly data shows 8 week target achieved in all age groups and 3 week target achieved for all age groups except 65y+.

Improved Health Status - Access (DHB-wide)

Access rates for the Maori 20-64y group remains a challenge. It has recently been confirmed that this is the highest access target for this group in the country. However it should be noted that, in the adult continuum the DHB provider arm delivers only about 36% of the access for this group, with NGO, CADS and other DHB services delivering the balance. It is challenging to understand the relative performance of different parts of this continuum from this broad access data (which is provided by the MoH).

Engaged Workforce - % of staff with excess Annual Leave

The adult CMHS has set a goal of zero excess AL by the end of December 2016 and is on track to achieve this.

Key achievements in the month

TWT Co-design

A project manager has been appointed to support the TWT leadership in the Co-design work which is progressing well across a range of initiatives. The interviews relating to admission processes are complete and proposed solutions have been generated to be sent back to participants for their input.

The TWT Occupancy Escalation Plan has been reviewed and is in use.

Areas off track and remedial plans

TWT

Work is in progress to establish and/or embed processes and improve performance of the inpatient service in three broad areas: acute flow, patient safety, and staff wellbeing. This focused activity is led by the SCD (who is now on the unit full time for 6 months) and NUM and supported by a project manager with input from the Performance Improvement team as appropriate. This activity is regularly reviewed.

EDS Residential Unit

As described earlier in 3(a) work is underway to identify a suitable location for the EDS residential service which will be co-located with the Regional Eating Disorder Service. If the option is to pursue a facility on an Auckland DHB site it is unlikely that a suitable long term facility will be ready by the time the lease expires on the existing property (31 March 2017). Alternative interim accommodation is being explored currently.

Youth Transition Project

Following a recent health and safety inspection, the existing leased accommodation is deemed to be unfit for purpose. It is not cost effective to undertake the improvements to remedy the facility. The service is looking for a new facility. Options are being explored to co-locate with other related services.

Ligature Risk at Te Whetu Tawera

Ligature risks have been identified and Facilities have indicated several of these risks can be mitigated in the currently allocated funding. However due to the structure of the building, more detailed work has revealed that costs associated with addressing windows and some ensuite fixture (basins and toilets) are significantly greater than budgeted for. In addition Te Whetu Tawera wards would need to be decamped to address these issues. There is a requirement for further seed funding to understand additional costs.

Key issues and initiatives identified in coming months

Localities

Work is on track developing the Directorate integrated care and localities approach which will also inform facilities priority decisions. Key elements of the proposed MH&A Directorate localities approach were presented to the DHB Localities Governance group by the Director and GM on the 4 July.

CFU

An ADHB hosted supra-regional workshop (nine referring DHB) was held in June 15 to seek input and address previous feedback on some aspects of the MOC. The MOC is currently being updated to reflect this cross DHB input.

Financial Results

STATEMENT OF FINANCIAL PERFORMANCE

Mental Health & Addictions

Reporting Date Jun-16

($000s)	MONTH			YEAR TO DATE (12 months ending Jun-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
REVENUE						
Government and Crown Agency	197	66	131 F	1,746	815	932 F
Funder to Provider Revenue	8,613	8,613	0 F	103,360	103,360	0 F
Other Income	63	29	34 F	638	343	295 F
Total Revenue	**8,873**	**8,708**	**166 F**	**105,745**	**104,518**	**1,227 F**
EXPENDITURE						
Personnel						
Personnel Costs	6,295	6,162	(133) U	73,071	73,554	483 F
Outsourced Personnel	268	82	(185) U	2,135	987	(1,147) U
Outsourced Clinical Services	139	129	(9) U	1,028	1,550	522 F
Clinical Supplies	94	65	(29) U	897	781	(115) U
Infrastructure & Non-Clinical Supplies	344	300	(44) U	3,760	3,601	(159) U
Total Expenditure	**7,139**	**6,739**	**(400) U**	**80,889**	**80,473**	**(416) U**
Contribution	**1,735**	**1,969**	**(234) U**	**24,856**	**24,045**	**811 F**
Allocations	1,726	1,737	12 F	20,934	20,849	(85) U
NET RESULT	**9**	**232**	**(223) U**	**3,922**	**3,196**	**726 F**

Paid FTE

	MONTH (FTE)			YEAR TO DATE (FTE) (12 months ending Jun-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	88.6	90.1	1.5 F	92.7	89.3	(3.5) U
Nursing	299.4	304.3	4.9 F	301.2	302.7	1.4 F
Allied Health	265.1	277.8	12.8 F	258.4	276.2	17.8 F
Support	4.9	5.0	0.0 F	4.9	5.0	0.1 F
Management/Administration	57.0	61.6	4.6 F	56.8	61.6	4.8 F
Total excluding outsourced FTEs	**714.9**	**738.7**	**23.8 F**	**714.0**	**734.7**	**20.7 F**
Total :Outsourced Services	20.4	7.1	(13.3) U	18.1	7.1	(11.0) U
Total including outsourced FTEs	**735.3**	**745.8**	**10.5 F**	**732.1**	**741.8**	**9.7 F**

Comments on Major Financial Variances

The result for the month is a surplus of $9k against a budgeted surplus of $232k, leaving an unfavourable variance of $223k. The full year result is $726k F.

The main driver of the favourable result is unbudgeted revenue for the Maternal Mental Health Acute Continuum contract and the Youth Court Report service provided by the Regional Youth Forensic Team, as well as the impact of one-off tertiary training revenue.

Although actual FTE are under budget, we are over budget in Personnel Costs including outsourcing. (Current month $318k U, Full Year $664k U). The key issues are:

- On-going high acuity in Adult Inpatients;
- Difficulty in recruitment for some services, resulting in high overtime, bureau and outsourced personnel at a premium cost and low annual leave;
- Higher cost skill mix, high sick leave, unbudgeted one off allowances and higher CPI increases than budgeted

Actions:

- The service leadership group have commenced work to review the current utilisation of Increased Observations in TWT which will reduce the need for extra staffing for some service user groups. There is also wider focused work commencing on reducing sick leave across the Directorate.
- There is on-going review of relevant expenditure including Authority to Recruits (ATR), overtime and annual leave.
- The strategy to recruit new graduate nurses and the focus on skill mix continues and this will contribute in the long term to a lower skill mix and reduction in the premium paid on backfill.

Savings:

Mental Health achieved the 2015/16 savings programme of $1,505k through on-going active management of recruitment and other personnel costs, which have offset the challenges of the high acuity in Adult Inpatients.

Adult Medical Directorate

Speaker: Dr Barry Snow Director

Service Overview

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

The Adult Medical Directorate is led by:

Director: Dr Barry Snow

General Manager: Dee Hackett

Director of Nursing: Brenda Clune

Director of Allied Health: Carolyn Simmons Carlsson

Director of Primary Care: Position vacant

Supported by:

Dheven Covenden - Finance Manager

Andrew Arnold - HR Manager

Tim Denison - Programme Director Performance Improvement

Directorate Priorities for 16/17

1. Developing the service/speciality leadership team to support the delivery of service transformation, performance management, living the values and financial management
2. Meeting the organisational target across all specialities.
3. Investing and developing our facilities and infrastructure to ensure they are fit for purpose and meet health and safety requirements.
4. Planning and implementation of service developments. Focus on at least one service development per speciality that improves the patient experience.
5. Overall reduction in the number of falls with serious harm, Grade 3 & 4 Pressure Injuries (PIs) and full compliance of 80% for hand hygiene across the Directorate.
6. Identify areas of waste that can be eliminated to save costs and improve quality and efficiency of care. Achieve Directorate financial savings target of $2,267,000 for 2016/17.

Q4 Actions – 90 day plan

	Action Plan	Owner	Q4
1	Continue with weekly and monthly meeting structure to review service improvements	BS	
1 -6	Review progress monthly of priority plans to ensure delivery	BS and OD department	
2	Delivery of capacity and demand plan to gastroenterology to deliver colonoscopy targets	BS, RT, and TD	
2	Review and update the acute flow paper recommendations to support delivery of SSED	BS and TD	
4	Measuring patient experience across a range of measures	BS and GB	
5	Continue to work collaboratively across the Directorate in delivering a safe service	BS and BC	
6	Ensure each initiative within Directorate is reviewing cost effectiveness and value for money. Each service to have developed at least one savings specific project	BS	

- Weekly team and monthly directorate meetings working well. MOS undertaken weekly with the senior leadership team. Each service developing MOS. Have moved timings of Directorate MOS to accommodate SCD's availability.
- Monthly meetings being undertaken and reviewing new priority plans with each service.
- Continuing to develop capacity and demand work for colonoscopy. Working with clinic scheduler ensuring booking patients to appropriate time and avoiding unnecessary breaches
- Steady progress with Renal Indicative Business Case (IBC). Paper presented to SLT to help support business case progression. IBC due for presentation to Board in September/ October 2016.
- Ambulatory area opened in AED, design group for CDU completed concept design and a design challenge took place on the 4 July. Final concept design presented to L2 steering group for sign off.
- Endoscopy work completed. Blessing took place on 25 July 2016 and opening on 29 July 2016.
- Quality forum delivered. New scorecards for all services developed that include quality items. Scorecards reviewed with services on a monthly basis.
- Meeting with NUMs and Operations managers identifying cost effectiveness projects and managing budget efficiently.

Measures

Measures	Current	Target (End 2015/16)	2016/17
ED target, ESPI, FCT, OPD new and Fu's, Colonoscopy	Targets met ED: 95.53% Colonoscopy: Urgent 94% Routine 74% Surveillance 90%	Fully meet ED: 95% Colonoscopy: Urgent 75% Routine 65% Surveillance 65%	Fully meet ED: 95% Colonoscopy: Urgent 75% Routine 65% Surveillance 65%
Business Case (BC) submission	L2 CDU BC submitted to Board	L2 CDU	Renal IBC
L2 CDU build completed	L2 CDU BC submitted to Board		Completion
Reduction in number of falls with serious harm	1	0.23 Falls per 1,000 Bed days in Wd 63, 65, 66,67,68	0.15 Falls per 1,000 Bed days in Wd 63, 65, 66,67,68
PIs grade 3 and 4 hospital acquired	0	0	0
Hand hygiene	81.4%	80%	95%

Measures Commentary

- ED target at 95.53% exceeding the target.
- All Colonoscopy targets for June 2016 were met.
- L2 business case concept design agreed July 2016.
- There was one fall with harm in June 2016 which is also the adverse event causing harm. The fall occurred from a wheelchair as the taxi driver transferred the patient to the waiting taxi following dialysis. The patient sustained a fracture of the right ankle. Full investigation is underway.
- No grade three and four pressure injury.
- 81.4% hand hygiene meeting the target.

Scorecard

Auckland DHB - Adult Medical Services

HAC Scorecard for June 2016

	Measure	Actual	Target	Prev Period
Patient Safety	Central line associated bacteraemia rate per 1,000 central line days	0	<=1	1
	Medication Errors with major harm	0	0	0
	Number of falls with major harm	1	0	0
	Nosocomial pressure injury point prevalence (% of in-patients)	7.1%	<=6%	0%
	Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	5.1%	<=6%	5.1%
	Number of reported adverse events causing harm (SAC 1&2)	1	0	0
Better Quality Care	(MOH-01) % AED patients with ED stay < 6 hours	95.53%	>=95%	94.55%
	(ESPI-1) % Services acknowledging 90% of FSA referrals within 10 working days	R/U	100%	100%
	(ESPI-2) Patients waiting longer than 4 months for their FSA	0%	0%	0%
	% DNA rate for outpatient appointments - All Ethnicities	12.24%	<=9%	12.35%
	% DNA rate for outpatient appointments - Maori	23.78%	<=9%	27.62%
	% DNA rate for outpatient appointments - Pacific	22.22%	<=9%	22.73%
	Number of CBU Outliers - Adult	110	0	110
	% Patients cared for in a mixed gender room at midday - Adult (excluding APU and Ward 62)	8.99%	TBC	5.87%
	% Patients cared for in a mixed gender room at midday - Adult (APU and Ward 62)	17.42%	TBC	19.79%
	% Very good and excellent ratings for overall inpatient experience	R/U	>=90%	77.3%
	Number of complaints received	15	No Target	8
	28 Day Readmission Rate - Total	R/U	<=10%	11.56%
	% Urgent diagnostic colonoscopy compliance	94.03%	>=75%	95%
	% Non-urgent diagnostic colonoscopy compliance	73.82%	>=65%	67.46%
	% Surveillance diagnostic colonoscopy compliance	89.7%	>=65%	67.9%
	Average Length of Stay for WIES funded discharges (days) - Acute	3.85	TBC	3.67
Improved Health Status	% Hospitalised smokers offered advice and support to quit	98.03%	>=95%	94.59%
Engaged Workforce	Excess annual leave dollars ($M)	$0.65	0	$0.63
	% Staff with excess annual leave > 1 year	32.9%	0%	30.54%
	% Staff with excess annual leave > 2 years	12.6%	0%	13.9%
	% Staff with excess annual leave and insufficient plan to clear excess by the end of financial year	97.1%	0%	93.86%
	% Staff with leave planned for the current 12 months	11.74%	100%	12.17%
	% Leave taken to date for the current 12 months	81%	100%	78.5%
	Number of Pre-employment Screenings (PES) cleared before the start date	0	0	1
	Sick leave hours taken as a percentage of total hours worked	4.7%	<=3.4%	4.17%
	% Voluntary turnover (annually)	10.3%	<=10%	9.4%
	% Voluntary turnover <1 year tenure	6%	<=6%	3.9%

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

R/U Result unavailable

(ESPI-1) % Services acknowledging 90% of FSA referrals within 10 working days
Result unavailable until after the 12th of the next month.

% Very good and excellent ratings for overall inpatient experience
This measures is based on retrospective survey data, i.e. completed responses for patients discharged or treated the previous month.

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

Scorecard commentary

- Adult Medical Directorate SSED target – 95.1% meeting target for Quarter 4. We have had a 7% growth in attendance from 14/15 but are still managing.
- We continue to work collaboratively on managing DNA rates for Maori and Pacific to support clinical services in reducing the DNA rates. Trying to understand if the issue is Directorate wide or service specific.
- Routine colonoscopy met target at 73.9%. Continuing capacity and demand exercise to understand weekly deliverables. SMO recruitment is problematic with a worldwide shortage of Gastroenterologists.
- There have been five pressure injuries. Two were noted on admission with the remaining three being Grade 1. Focus continues on assessment and monitoring in all clinical areas.

Key achievements in the month

- Refurbishment and rebuild deliverables for Endoscopy are on track for delivery 22 July 2016.
- Over achieved against ED target despite continued rise in attendance.
- First wave of leadership training complete.
- Extra medical registrars approved. Recruiting in progress.
- Refreshed Directorate priority plan.

Areas off track and remedial plans

- DNA rates for Maori and Pacific. Will continue working to fully understand service specific rationale for DNAs including supporting the Funding and Planning outpatient programme.

Key issues and initiatives identified in coming months

- Development of the full business case for renal redesign and update to Board August 2016.
- Continuing to progress with Acute Flow plan.
- Continuing Endoscopy rebuild working to very tight timeframes.
- Working on development of winter bed plan and exploring readmissions and COPD clinical management pathways.
- Detailed capacity and demand work being undertaken in Neurology and Endoscopy.
- Request to Performance Improvement for capacity and demand training for Operations Managers. Workshops being developed.

Financial Results

STATEMENT OF FINANCIAL PERFORMANCE

Adult Medical Services

Reporting Date Jun-16

($000s)	MONTH			YEAR TO DATE (12 months ending Jun-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
REVENUE						
Government and Crown Agency	329	274	56 F	3,212	3,283	(71) U
Funder to Provider Revenue	12,063	12,063	0 F	144,461	144,461	0 F
Other Income	448	392	55 F	4,657	4,722	(66) U
Total Revenue	**12,840**	**12,729**	**111 F**	**152,331**	**152,467**	**(136) U**
EXPENDITURE						
Personnel						
Personnel Costs	8,296	8,004	(292) U	96,863	95,425	(1,438) U
Outsourced Personnel	90	101	11 F	1,193	1,212	19 F
Outsourced Clinical Services	76	43	(33) U	581	513	(68) U
Clinical Supplies	1,417	1,801	384 F	20,153	21,572	1,419 F
Infrastructure & Non-Clinical Supplies	223	214	(9) U	2,405	2,571	166 F
Total Expenditure	**10,103**	**10,163**	**60 F**	**121,194**	**121,293**	**98 F**
Contribution	**2,738**	**2,567**	**171 F**	**31,136**	**31,174**	**(38) U**
Allocations	2,046	1,825	(221) U	24,294	21,792	(2,502) U
NET RESULT	**691**	**742**	**(50) U**	**6,843**	**9,382**	**(2,539) U**

Paid FTE

	MONTH (FTE)			YEAR TO DATE (FTE) (12 months ending Jun-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	196.3	187.8	(8.5) U	191.0	187.8	(3.2) U
Nursing	529.5	523.0	(6.5) U	528.0	522.9	(5.1) U
Allied Health	47.2	51.5	4.3 F	48.0	51.5	3.4 F
Support	6.5	6.0	(0.5) U	5.9	6.0	0.1 F
Management/Administration	52.2	52.5	0.3 F	52.4	52.5	0.1 F
Total excluding outsourced FTEs	**831.7**	**820.8**	**(10.9) U**	**825.4**	**820.7**	**(4.7) U**
Total :Outsourced Services	4.6	5.2	0.7 F	5.0	5.2	0.2 F
Total including outsourced FTEs	**836.2**	**826.0**	**(10.2) U**	**830.4**	**825.9**	**(4.5) U**

Financial Commentary

YTD financial analysis:

The result for the Year ended 30 June 2016 is an unfavourable variance of $ 2,539k.

Volumes: Overall volumes are 106 % of contract. This equates to $ 8,723k above contract (revenue not recognised in the Adult Medical Provider result).

Total Revenue - $ 136k unfavourable – primarily due to unfavourable Air Ambulance revenue (fewer flights)

Total Expenditure - $ 2,404k unfavourable due to:

Personnel Costs including outsourced personnel - $ 1,419k U – primarily due to unfavourable variances in nursing costs $1,327k U – mainly unachieved savings target driven by increased volumes, acuity and patient security requiring additional staffing hours.

Clinical Supplies - $ 1,419k F – mainly favourable variances in pharmaceuticals (rebate significantly higher than expected combined with savings in Immunosuppression drugs in Neurology and Gastroenterology), blood products (driven by NZBS blood product rebate) and Renal Fluids.

Internal Allocation - $ 2,502k U – primarily due to radiology $ 1,360k U, laboratory costs $ 770k U and nutrition $ 320k U driven by increased volumes - overall volumes are 106 % of contract.

Community and Long Term Conditions Directorate

Speaker: Judith Catherwood, Director

Service Overview

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

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

The Community and Long Term Conditions Directorate is led by

Director: Judith Catherwood

General Manager: Alex Pimm

Director of Nursing: Jane Lees

Director of Allied Health: Anna McRae

Director of Primary Care: Jim Kriechbaum

Interim Medical Director: Barry Snow

Directorate Priorities for 15/16

In 2015/16 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. Leadership and staff development programme
2. Out-patient improvement programme
3. Intermediate care programme
4. Informatics and technology
5. Improvement of healthcare outcomes through new models of care programme

Our goals address the strategic mandatories for Auckland DHB and our priorities create a firm platform on which to continually improve and develop.

Q3 Actions – 90 day plan

1. Leadership and staff development programme

A programme of facilitated team development based on Board mandatories, values and strategic direction has commenced. A Senior Leadership Team event took place between October and December 2015. Service Leadership Team events to mirror this process are in progress across the Directorate.

Two members of our new clinician leadership team have completed their leadership development programme. A further two members of staff will commence in wave two in the near future.

Workforce planning for nursing and allied health role development is in progress. A career pathway for Needs Assessment and Service Coordination workforce has been implemented. New therapy assistant roles are also being planned to support our clinical teams. The new service developments in progress, including rapid response, step home, early supported discharge and stroke services provide opportunities to enhance nursing and allied health roles.

2. Outpatient improvement programme

DNA action plan continues to be implemented with our initial focus on Diabetes Services. After seeing a decline over six months, our Directorate are concerned to see an increase in DNA rates in the last two months which is in part due to inadequate communication about booked appointments with patients. We are working with the PAS team to address these issues. Cancellation rates are also being monitored as late cancellations will have an impact on service delivery and outcomes.

Our new process to reduce rescheduling rates by applying a six week booking rule is in place in a number of outpatient clinics. Our rescheduling rates have reduced and the trajectory is on target to meet our goal. This change mirrors the six week booking rule for leave and ensures we only reschedule a patient's appointment if it is patient initiated or urgent due to specific patient care requirements.

Baseline assessment to ensure accurate measurement of virtual contacts is progressing in all services.

Implementation of business rules into Older People's Health outpatient services and community services has commenced to ensure accurate activity and waiting times reporting on these services from July 2016.

A clinical audit of follow up practice in Rheumatology has been completed to support a sustainable service model for the future. The external clinical review in this service has concluded and the report is being reviewed to identify our plan for the future. This follow up audit and review approach will be extended to other areas in due course. Our Director of Primary Care is involved in this to consider areas of opportunity in our work with primary care.

A plan for the future of the Specialist Diabetes Services was approved by the Board in May 2016 and is in the early stages of implementation.

3. Intermediate Care Programme

The locality model of care implementation process continues involving Community, Gerontology and Diabetes Services in 2016. The new single point of access, triage and assessment is now implemented. Plans to integrate Geriatric Medicine, Diabetes Services and Palliative Care into the locality model are in progress.

Rapid Response services continue to be delivered. The service is now receiving referrals from aged care and St John and roll out to primary care will be completed by July 2016. Referral rates from primary care are currently low but this is anticipated as general practice teams will take time to identify direct access service opportunity in their patient groups. Aged care facilities are beginning to use the service. Further information on current volumes and activity in Rapid Response is provided below for the June 2016 period. We plan to introduce KPIs and further measures of impact into future reports on this service.

The Step Home pilot evaluation report to support planning for the future of intermediate care beds has been completed. We are working with the Health of Older People team to implement new intermediate care beds for a range of patient needs on an ongoing basis.

Implementation of the Better Brain Care Pathway (Dementia) continues across Auckland City Hospital. Further work is progressing with Funding and Planning regarding General Practice, Education and Training and early assessment.

Frailty pathway planning has concluded and implementation is about to begin.

4. Informatics and Technology

Reporting programme to support the Directorate with effective management information from HCC is in progress and will be completed by September 2016.

HCC upgrade for Community and Sexual Health was completed over Easter 2016. The diabetes upgrade is being planned for August 2016. The Directorate would like to thank the Information Services team for their support during this upgrade which was manual and complex work for the staff involved.

The Directorate have identified plans to create a more extensive set of performance measures and clinical metrics to support Adult Palliative Care Services and Older Adult Health Services. We are working with Business Intelligence to progress this work into dashboards to support clinical staff and future service planning.

A Telehealth Directorate Work Programme has commenced. Early work includes a pilot project in District Nursing, trial of hand held devise in community services, telehealth links between the hospice and specialist palliative care teams, and consideration of telehealth remote clinical management in community services. Further developments in Telemedicine are being considered in specific service areas.

5. Improvement of healthcare outcomes through new models of care programme

The integrated all age stroke rehabilitation ward in ACH opened on the 4 July 2016. Early supported discharge services for stroke and other appropriate patients also commenced on this date. Work to implement an all age comprehensive stroke unit are taking shape and a full business case to support the capital planning required will be developed over 2016/17. Community rehabilitation services are now fully integrated and are delivering an all age service.

Dermatology service sizing is completed and will be implemented from July 2016. Recruitment is now progressing. Rheumatology external clinical review has concluded and future plans are being considered within the Directorate. Sexual Health Service change has been implemented and evaluation continues throughout 2016/17.

An Adult Palliative Care Strategy has been approved and is in the process of being implemented. Plans for integrating the specialist service across ADHB are ongoing. The consultation to create an integrated clinical leadership role in both specialist palliative care providers has concluded and a decision document will be released by end of July 2016.

Measures

Measures	Current	Target (End 2015/16)	Previous Period
Reduce DNAs	13.6%	9%	14.7%
Reduce rescheduling rates	55.5%	40%	58.5%
Increase virtual activity (currently supporting accurate recording to create baseline)	TBC	5% (TBC)	TBC
Meet waiting times and patient flow targets	4 mths (max)	3 mths (max)	4 mths (max)
Reduce 28 day readmissions of elderly patients	11.1%	10%	11.2%
Increase proportion of older people living in their own home (accurate measure in development)	TBC	95%	TBC
Recruit to the structure and develop leadership capacity	Implementation phase	Completion phase	Fully developed phase

Scorecard

Auckland DHB - Adult Community and Long Term Conditions

HAC Scorecard for June 2016

	Measure	Actual	Target	Prev Period
Patient Safety	Medication Errors with major harm	0	0	0
	Number of falls with major harm	0	0	0
	Nosocomial pressure injury point prevalence (% of in-patients)	4%	<=6%	8%
	Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	5.5%	<=6%	5.6%
	Number of reported adverse events causing harm (SAC 1&2)	0	0	1
Better Quality Care	(ESPI-1) % Services acknowledging 90% of FSA referrals within 10 working days	R/U	100%	100%
	(ESPI-2) Patients waiting longer than 4 months for their FSA	0%	0%	0%
	% DNA rate for outpatient appointments - All Ethnicities	13.64%	<=9%	14.69%
	% DNA rate for outpatient appointments - Maori	22.95%	<=9%	31.01%
	% DNA rate for outpatient appointments - Pacific	26.55%	<=9%	30.98%
	% Patients cared for in a mixed gender room at midday - Adult	0.34%	<=2%	3.57%
	% Very good and excellent ratings for overall inpatient experience	R/U	>=90%	100%
	% Very good and excellent ratings for overall outpatient experience	R/U	>=90%	91.2%
	Number of complaints received	1	No Target	5
	% Inpatients on Older Peoples Health waiting list for 2 calendar days or less	90.91%	>=80%	93.46%
	% Inpatients on Rehab Plus waiting list for 2 business days or less	82.35%	>=80%	73.68%
	% Discharges with Length of Stay less than 21 days (midnights) for OPH and Rehab Plus combined	65.12%	>=80%	65.9%
Improved Health Status	% Hospitalised smokers offered advice and support to quit	100%	>=95%	94.12%
Engaged Workforce	Excess annual leave dollars ($M)	$0.03	0	$0.02
	% Staff with excess annual leave > 1 year	36.7%	0%	36.43%
	% Staff with excess annual leave > 2 years	3.2%	0%	2.79%
	% Staff with excess annual leave and insufficient plan to clear excess by the end of financial year	76.5%	0%	93.3%
	Number of Pre-employment Screenings (PES) cleared before the start date	0	0	0
	Sick leave hours taken as a percentage of total hours worked	3.6%	<=3.4%	3.34%
	% Voluntary turnover (annually)	14.2%	<=10%	13.2%
	% Voluntary turnover <1 year tenure	6.4%	<=6%	6.8%

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

R/U Result unavailable

(ESPI-1) % Services acknowledging 90% of FSA referrals within 10 working days
Result unavailable until after the 12th of the next month.

% Very good and excellent ratings for overall inpatient experience
% Very good and excellent ratings for overall outpatient experience
These measures are based on retrospective survey data, i.e. completed responses for patients discharged or treated the previous month.

Scorecard Commentary

There were no SAC 1 or 2 events recorded in June 2016.

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

We are currently compliant with ESPI 1 and ESPI 2 targets. Our area of greatest risk is Dermatology and we forecast to be moderately non-compliant in July 2016. All urgent patient care is continuing to be prioritised. Recruitment to the new service size is ongoing and we are progressing both permanent and temporary appointments to address the capacity gap.

We continue to work with services to support improvement in waiting times and remain confident we can achieve a three month maximum waiting time within the Directorate. We are working with services on demand and capacity planning, virtual capacity and follow up practice, which all influence the ESPI 2 waiting time. We are also working to ensure all services, even if not covered by ESPI 2, have appropriate waiting times and effective monitoring systems in place.

Our DNA rates continue to improve. There has been a similar improvement in the Maori and Pacific DNA rates. Changes to the definition did have some impact as have changes to patient focussed booking in certain areas. We remain committed to reducing these rates.

The Directorate remains committed to minimising the number of patients in mixed gender rooms and were within target in June 2016. Plans are in progress to change the current way we support patients with behaviours of concern so that acute observation units become single sex.

Patient flow targets have been met throughout Reablement Services in June 2016. Improved flow remains one of our goals and this has been sustained despite reduced bed capacity and is a reflection of improvements in practice and community service offerings.

Complaints are being actively managed within our Directorate and action plans to address any learning points have been created and are being monitored. There was one complaint received in the month of June and was responded to within the agreed target time.

The Directorate has achieved a significant reduction in excess leave in the last year. We have plans to reduce this further. Sick leave is monitored monthly and currently just above target and is being actively managed applying the Auckland DHB Wellness Guide. We have established the Directorate Wellness Group to support staff health. Turnover has increased and is being actively monitored including regrettable turnover levels by service. As a Directorate with a significant change agenda, some turnover is to be expected.

Key achievements in the month

- A plan to progress integration of service in Specialist Palliative Care across Hospice and Hospital services continue to progress. A consultation on a new clinical leadership structure has concluded. There are six priority areas being focussed on to implement the palliative care strategy. They include co-design work with patients, education, psychosocial and allied health support in the community and integrated clinical records and data.
- The Locality Model of Care in Community Services is continuing to be implemented. The engagement with primary care and aged residential care is progressing. The new single point of access, daily triage system and integrated single assessment process has been implemented successfully.
- Rapid response services have opened access to primary care, aged care and St John. The early supported discharge service has commenced. This service will support intensive rehabilitation in the home for appropriate patients. Both these services will improve flow and support care closer to home.
- Patient flow has improved to meet the new local stretch targets. We aim to keep to these throughout winter, which will support ED and the acute services and ensure quality care in the right place at the right time.
- A new programme of work has commenced with ACC to resign the care pathways within non-acute rehabilitation services for older adults and implement a new case mix funding model. This has the potential to further improve the LOS and clinical outcomes and integration of care for the frail older adult.
- The new all age stroke rehabilitation ward and single stroke pathway was introduced on 4th of July.
- The Directorate has recruited to the role of Medical Director. We are delighted to have a full leadership team within the Directorate and will be in a position to support further change and service development as a result in the future.

Rapid Response Services Update

The Directorate launched a Rapid Response Service in August 2015. The service has been very successful and feedback from staff, other service stakeholders and patients is extremely positive. The model of care has developed and will see further integration, embedding this service into the locality model of care over 2016. There is strong liaison between Rapid Response staff and NASC, and Gerontology Services. Access to St John, Aged Care and Primary Care has commenced in a staged roll out across June and July. All will have access by mid July 2016. We have had no serious adverse events or quality concerns. The Directorate would like to commend staff in Community and Gerontology Services for their commitment and support in establishing this new service. HAC will see an increase in volumes in this service reflecting the change from July 2016 onwards.

- Over the last four months, there is an average of 54 first assessments and 600 follow up assessments per month delivered by the Rapid Response Service.
- Follow up activity has been steadily increasing since the service was introduced in August 2015 with a peak in April of 625 contacts.
- 42% of contact activity for the service is delivered in the patient's home. 16% of activity is delivered in the ED department or in hospital. As overall contact numbers have increased over time a growing proportion of follow up contacts are delivered via telephone conversations with the patient. Telephone consultations now comprise 43% of the patient contacts.

Areas off track and remedial plans

- DNA action plan for the Directorate has been developed and is being implemented across all services. A direct booking approach and reminder service has commenced in Diabetes Services. Other options including drop in clinics and shared care clinics are also being progressed as part of the plan to improve accessibility for patients. The direct booking approach is also being used in Rheumatology Services and will be used in other areas in due course.
- A number of our services use HCC to record activity. There have been no clear business rules in place to ensure the services record activity and volumes accurately which has an impact on revenue, funding, projection planning and understanding patient flow. The plan developed with Business Intelligence to address this issue is progressing well. The new business rules have been implemented in Sexual Health and are being implemented in Community Services currently. Improved reporting on activity will be in place by July 2016.
- Dermatology Services continue to experience high demand for services which is impacting on waiting times in this service. A service sizing exercise to address this has been finalised. Additional FTE has been agreed and we are in the process of recruiting. The new service model will be operational as soon as recruitment can be achieved. The change will include the establishment of a 'see and treat' clinic to ensure all patients with suspected melanoma will meet the required FCT targets.
- The Directorate has experienced challenges in the discharge planning of patients who require disability funding support in the community. This has a particular impact on Rehab Plus given the case mix. We are working with Taikura Trust to reduce these delays as quality of care outcome is now being hindered when patients are ready to be cared for in home but cannot receive the required care due to delays in edibility and assessment processes.
- The Community Nursing Service has had a number of serious clinical incidents relating to the lack of follow up and treatment of rheumatic fever patients. There have also been two serious complaints in the service around wound care and clinical practice. The Directorate has taken these concerns seriously and a significant change programme has commenced to ensure the service and workforce develops to meet the demands of the future. New systems and processes to prevent the lack of follow up treatment for the rheumatic fever patients have been developed and are being implemented.

Key issues and initiatives identified in coming months

- Complete recruitment to the Directorate Leadership team. Recruitment to three key leadership posts in the Directorate is in progress currently.
- Implementation, orientation and development of the revised Directorate structure, which introduces the Clinician Leadership model. A key priority for our directorate is the development of Clinician Leadership skills and capability. Senior staff have commenced the new Clinician Leadership Programme.
- Embed management operating system and improved clinical governance and decision making systems across the Directorate at service level.
- Implementation and further development of the locality model within home health services, integrating Diabetes Services, Palliative Care and Geriatric Medical Services into the model during 2016. This will reduce duplication of effort and enhance community responsiveness.
- Implement the new Clinician Leadership model in the Adult Palliative Care Services across the district and integrate specialist palliative care.
- Implement the outpatient improvement programme in all relevant areas of our directorate.
- Implement the Specialist Diabetes Plan across ADHB and continue to support the DSLA in their work to redesign the care pathway for people with diabetes in WDHB/ADHB.
- Continue the development of work streams to improve the quality and outcome of the patient's journey including intermediate care, dementia care, frailty pathway and the stroke pathway. A plan to progress the implementation of the integrated stroke services during 2016/17 has commenced with the opening of the all age stroke rehabilitation unit in July 2016.
- Development of a capital planning programme for the Directorate and the facilities our services utilise. A number of our buildings are in need of refurbishment. Plans for refurbishment are in development for OPH, Rehab Plus and Ambulatory and Community services based at Greenlane. Our future requirements need to be informed by our clinical Services plans and support a whole of Auckland DHB approach.
- Develop improved performance within our Ambulatory Services through a combination of enhanced production, demand and capacity planning, benchmarking and quality improvement to create sustainable, accessible services within available resources.

Financial Results

STATEMENT OF FINANCIAL PERFORMANCE

Adult Community and LTC

Reporting Date Jun-16

($000s)	MONTH			YEAR TO DATE (12 months ending Jun-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
REVENUE						
Government and Crown Agency	1,179	1,065	114 F	13,259	12,942	317 F
Funder to Provider Revenue	6,000	6,000	0 F	70,284	70,284	0 F
Other Income	10	16	(6) U	272	188	85 F
Total Revenue	**7,189**	**7,080**	**108 F**	**83,815**	**83,414**	**402 F**
EXPENDITURE						
Personnel						
Personnel Costs	4,085	3,999	(86) U	46,948	47,646	698 F
Outsourced Personnel	109	67	(43) U	1,182	874	(307) U
Outsourced Clinical Services	111	143	33 F	1,573	1,722	149 F
Clinical Supplies	260	670	409 F	7,428	7,848	419 F
Infrastructure & Non-Clinical Supplies	341	170	(170) U	2,091	2,034	(57) U
Total Expenditure	**4,906**	**5,049**	**142 F**	**59,222**	**60,124**	**902 F**
Contribution	**2,282**	**2,032**	**251 F**	**24,593**	**23,290**	**1,303 F**
Allocations	346	352	7 F	4,399	4,205	(194) U
NET RESULT	**1,937**	**1,679**	**257 F**	**20,195**	**19,086**	**1,109 F**

Paid FTE

	MONTH (FTE)			YEAR TO DATE (FTE) (12 months ending Jun-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	67.7	71.1	3.4 F	68.4	71.1	2.7 F
Nursing	274.8	280.4	5.7 F	278.5	280.4	1.9 F
Allied Health	123.1	129.3	6.2 F	124.2	129.3	5.2 F
Support	0.0	0.0	0.0 F	0.0	0.0	0.0 F
Management/Administration	39.6	41.7	2.2 F	38.9	41.7	2.8 F
Total excluding outsourced FTEs	**505.2**	**522.6**	**17.4 F**	**509.9**	**522.6**	**12.6 F**
Total :Outsourced Services	5.6	2.3	(3.3) U	9.0	2.8	(6.2) U
Total including outsourced FTEs	**510.7**	**524.8**	**14.1 F**	**519.0**	**525.3**	**6.4 F**

Comments on Major Financial Variances

The month result for June is $257k F, which brings the full year result to $1,109k F.

Current month

The significant drivers in the directorate's result are mostly one-offs:

- A further Pharmac rebate received ($199k F);
- Full year costs of high-cost drug (Berinert) funded ($112k F);
- ACC revenue received was 8.7% higher than budget ($70k F);
- One off HCC project costs ($212k U);

Full year result

Price Volume Schedule (PVS) volumes ended the year above base contract at 101.2%. This equates to $864k over contract. Interdistrict flows (IDF) are over-delivered by $691k, while for the ADHB population, the result was an over-delivery of $174k. The net over delivery of volumes is not recognised in the Directorate result.

Total net result for the year is $1,109k F. Significant drivers of this are:

- ACC revenue $234k F, with Sexual Assault ongoing high volumes not budgeted;
- Personnel and outsourced costs combined $539k F, due to delayed recruitment, one-off corrections from 2014/15, and nursing staff mix improvements, which kept the average cost per FTE slightly lower than in the previous year;
- Clinical supplies $419k F overall after Pharmac rebates ($517k F) and agreement on funding Berinert ($112k F), offset by increased demand for patient appliances (ostomy products) in Community Services ($121k U).

Savings

The directorate ended the year exceeding its savings targets by $394k.

Surgical Directorate

Speaker: Wayne Jones, Director

Service Overview

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

The services in the Directorate are now structured into the following 4 portfolios:

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

The Surgical Directorate is led by:

Director: Wayne Jones

General Manager: Tara Argent

Nurse Director: Anna MacGregor

Director of Allied Health: Kristine Nicol

Director of Primary Care: Kathy McDonald

Supported by Les Lohrentz (HR), Justin Kennedy-Good (Service Improvement) and Jack Wolken (Finance).

Directorate Priorities for 15/16

In 2015/16 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. Teamwork within our departments, Directorate and across the organisation, keeping staff engaged to streamline processes and procedures
2. Meet all health, financial and efficiency targets
3. Deliver equitable access to care for emergency, acute and elective patients
4. Align all the elements of local operating systems along the patient pathway
5. Improve the quality of all services, learning from our success, best practice and monitoring of our clinical outcomes
6. Put the patient at the centre of everything we do to provide a positive healthcare experience

Q4 Actions

1. Teamwork within our Departments, Directorate and across the organisation, keeping staff engaged to streamline processes and procedures

Activity	Progress
Induction of new directorate management team	Second part of orientation workshop scheduled for 8 August
Training and appraisals for all staff groups	Ongoing programme
Celebrate our successes	Continue to provide nominations for Hospital Heroes

2. Meet all health, financial and efficiency targets

Activity	Progress
Manage discretionary spend	Directorate level review on-going with additional controls put in place.
Improve inventory management	Consignment / implant workgroup - end to end process established and first meeting held. Becoming part of organisational top 10 long term projects.

3. Deliver equitable access to care for emergency, acute and elective patients

Activity	Progress
Managing capacity and demand	FCT – Priority code is now visible on the WT05 report / waiting list. PAS team leaders now need to ensure that all bookers are trained to enter the field to show the FCT status of the patient. This will improve our reporting and scheduling of patients from a surgical perspective.
Waitlist management and SCRUM	Implementation of an OPD SCRUM is being progressed and is expected to be rolled out on 1 June 2016.

4. Align all the elements of local operating systems along the patient pathway

Activity	Progress
Performance ”pizza” to go live	Awaiting business objects upgrade. Roll out date is dependent on BI time frames.
SMO timetable alignment	PVS 16/17 draft to determine demand. Job and Service size planning for all specialities. FTE reconciliation exercise complete.

5. Improve the quality of all services, learning from our success, best practice and monitoring of our clinical outcomes

Increase ERAS with orthopaedic unit	Delivered
Implement nurse led discharge pilot	Elective ERAS orthopaedic ward to pilot nurse led discharges Pilot underway to enable nurse led discharge.
Nurse led follow ups	Currently being trialled in ASU, patients that are discharged from ASU have nurse led telephone follow ups. This ensures timely advice and guidance is given and prevents emergency readmissions through ED as patients are brought back to the appropriate setting.
Establish Quality and Patient Safety meetings within each department	Nurse Consultant appointed and commenced April 2016. Areas of focus for the first 90 days are: • A stocktake of current service quality meetings • Process for the escalation of risks for consideration at the Directorate Quality Meeting. • Corrective actions from certification
Analyse patient satisfaction information	Standing agenda item on the weekly Directorate Quality and Patient Safety meeting.
Monitor clinical outcomes	Directorate input into CRAB implementation , Directorate representatives have been identified.

6. Put the patient at the centre of everything we do to provide a positive healthcare experience

Conduct a patient safety culture survey	Developed and implementation planned.

Measures

Measure		June	Target	May
ESPI compliance	ESPI 2	0.14%	Fully compliant =0%	0.0%
	ESPI 5	0.81%	Fully compliant =0%	0.48%
DNA rates for all ethnicities (%)		9.15%	9%	10.54%
Elective day of surgery admission rate (DOSA) %		83.13%	≥68%	82.3%
Day surgery rate (%)		61.34%	≥70%	81.26%
Number of complaints received		26	≤10/month	16
Theatre list usage (%) (Utilisation adult services)		95.8%	≥94%	96%
Reduction in the number of preventable session losses		33.3%	>50%	50%
Orthopaedic productivity (elective only)		97% (-2)	100%	98% (-2)
Ophthalmology productivity		117%(+27)	100%	102% (+4)

Scorecard

Auckland DHB - Surgical Services

HAC Scorecard for June 2016

	Measure	Actual	Target	Prev Period
Patient Safety	Medication Errors with major harm	0	0	0
	Number of falls with major harm	1	0	0
	Nosocomial pressure injury point prevalence (% of in-patients)	5.2%	<=6%	4.1%
	Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	4.7%	<=6%	4.5%
	Number of reported adverse events causing harm (SAC 1&2)	1	0	1
Better Quality Care	HT2 Elective discharges cumulative variance from target	0.97	>=1	0.96
	(ESPI-1) % Services acknowledging 90% of FSA referrals within 10 working days	R/U	100%	71.4%
	(ESPI-2) Patients waiting longer than 4 months for their FSA	0.14%	0%	0%
	(ESPI-5) Patients given a commitment to treatment but not treated within 4 months	0.81%	0%	0.48%
	% DNA rate for outpatient appointments - All Ethnicities	9.15%	<=9%	10.54%
	% DNA rate for outpatient appointments - Maori	20.83%	<=9%	22.04%
	% DNA rate for outpatient appointments - Pacific	16%	<=9%	17.36%
	Elective day of surgery admission (DOSA) rate	83.13%	>=68%	81.26%
	% Day Surgery Rate	61.34%	>=70%	60.74%
	Inhouse Elective WIES through theatre - per day	61.77	TBC	70.38
	Number of CBU Outliers - Adult	103	0	197
	% Patients cared for in a mixed gender room at midday - Adult	7.56%	TBC	11.7%
	% Very good and excellent ratings for overall inpatient experience	R/U	>=90%	86.5%
	% Very good and excellent ratings for overall outpatient experience	R/U	>=90%	84.2%
	Number of complaints received	26	No Target	16
	28 Day Readmission Rate - Total	R/U	<=10%	8.52%
	Average Length of Stay for WIES funded discharges (days) - Acute	3.1	TBC	3.48
	Average Length of Stay for WIES funded discharges (days) - Elective	1.55	TBC	1.04
	31/62 day target – % of non-surgical patients seen within the 62 day target	R/U	>=85%	70.37%
	31/62 day target – % of surgical patients seen within the 62 day target	R/U	>=85%	42.86%
	62 day target - % of patients treated within the 62 day target	R/U	>=85%	60.98%
Improved Health Status	% Hospitalised smokers offered advice and support to quit	96.58%	>=95%	96.21%
Engaged Workforce	Excess annual leave dollars ($M)	$1.2	0	$1.15
	% Staff with excess annual leave > 1 year	30%	0%	29.91%
	% Staff with excess annual leave > 2 years	18.2%	0%	16.86%
	% Staff with excess annual leave and insufficient plan to clear excess by the end of financial year	100%	0%	100%
	Number of Pre-employment Screenings (PES) cleared before the start date	0	0	0
	Sick leave hours taken as a percentage of total hours worked	3.4%	<=3.4%	3.4%
	% Voluntary turnover (annually)	10.3%	<=10%	9.8%
	% Voluntary turnover <1 year tenure	3.9%	<=6%	5.4%

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

R/U Result unavailable

(ESPI-1) % Services acknowledging 90% of FSA referrals within 10 working days
Result unavailable until after the 12th of the next month.

% Very good and excellent ratings for overall inpatient experience
% Very good and excellent ratings for overall outpatient experience
These measures are based on retrospective survey data, i.e. completed responses for patients discharged or treated the previous month.

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

31/62 day target – % of non-surgical patients seen within the 62 day target
31/62 day target – % of surgical patients seen within the 62 day target
62 day target - % of patients treated within the 62 day target
Results unavailable from NRA until after the 20th day of the next month.

Scorecard Commentary

Health Targets

Elective Discharges

In June, the in month achievement was 116% discharges however cumulative achievement across the Provider Arm was 100% of target. Adult Services achieved 96% of the Auckland DHB Adult discharge target (-12 patients). The recovery plans agreed with each service have been delivered despite the high on-going acute demand.

The June Adult IDF discharge cumulative position was 109% of the target (+356 patients). The main areas of deviation were Orthopaedics and Ophthalmology. At the end of June the ESPI 2 position was compliant for ADHB at 0%.

The organisational position for ESPI 5 is reported as moderately non-compliant for patients not receiving a date for surgery within 4 months at 0.61% (the target is <1.0%).

Increased Patient Safety

There was one SAC 2 event reported in the month of June. An RCA team has been formulated to review the event.

There were 23 medication errors reported for the month of June, without harm. The Directorate continues to work towards undertaking audits on medication administration compliance.

There were 23 falls reported for the month of June (none with major harm). These will be thoroughly reviewed at the Directorate Falls meeting and the weekly Quality meeting.

There were 24 pressure injuries reported for June, categories for which are as follows:

12 x Category 1 (Non-blanchable erythema)
11 x Category 2 (Partial thickness skin loss)
1 x Category 3 (Full thickness skin loss) – This was noted on admission.
0 x Category 4 (Full thickness tissue loss)

Better Quality Care

The DNA rate for appointments for all ethnicities in June is on target at 9.15%.

Patients cared for in a mixed gender room at midday in June has increased slightly to 7.56%; this continues to be due to the pressures on bed capacity as a result of the high acute load.

The number of outliers has reduced again in June to 103, this reflects the effectiveness of the elective orthopaedic beds opened on ward 62. Where possible teams have been working to align the capacity, co-horting and repatriating patients to reduce the outliers across the surgical bed base, to support the rest of the hospital and the patient flow.

Day surgery rates have increased again during the month to 61.34% against a target of 70%. The elective DOSA rate increased in June to 83.13% and is above the 68% target.

Improved Health Status

Smoking Cessation

Performance has improved in June to 96.58%. This is as a result of the work undertaken by the Charge Nurses to ensure that the information is being captured correctly.

Engaged Workforce

- The first part of the Surgical Services Orientation was held on 16 May with focusing on priorities for the directorate, leadership, values and teamwork. The group identified expectations surrounding the new roles and this identified areas that will require further training programmes. The second part of the workshop is scheduled for the 8 August.

Picture from the Surgical Services Orientation during one of the group work sessions.

- Two of the Surgical Services Directorate staff completed the first wave of the Leadership Development Programme.

Key achievements in the month

- Delivery of additional Ophthalmology capacity for WDHB (outsourcing 200 patients)
- Reduced the impact of the power outage on the discharge target.
- Achieved the overall discharge target.

Key issues and initiatives identified in coming months

- DNA rates- An audit is being undertaken in Orthopaedics to understand the reasons behind a recent surge in DNAs across the clinics.
- 16/17 key priorities for Surgical Services identified in the Business Plan.
- Urology transfer activity from ACH to Greenlane.
- OR allocation – The Surgical Board has approved the proposed changes which will affect General Surgery and Urology lists predominantly. The business case for the associated FTE has been approved so the sessions will be resourced accordingly.

Financial results for June 2016

STATEMENT OF FINANCIAL PERFORMANCE
Surgical Services

Reporting Date Jun-16

($000s)	MONTH			YEAR TO DATE (12 months ending Jun-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
REVENUE						
Government and Crown Agency	771	862	(91) U	8,484	10,343	(1,859) U
Funder to Provider Revenue	20,464	20,597	(133) U	245,851	246,288	(437) U
Other Income	502	419	83 F	4,603	5,029	(426) U
Total Revenue	**21,738**	**21,878**	**(140) U**	**258,938**	**261,661**	**(2,722) U**
EXPENDITURE						
Personnel						
Personnel Costs	8,201	7,258	(942) U	94,182	86,579	(7,604) U
Outsourced Personnel	559	239	(320) U	4,032	2,869	(1,162) U
Outsourced Clinical Services	702	327	(375) U	2,845	3,920	1,075 F
Clinical Supplies	2,512	2,445	(68) U	30,169	29,243	(926) U
Infrastructure & Non-Clinical Supplies	242	185	(57) U	3,229	2,226	(1,003) U
Total Expenditure	**12,217**	**10,454**	**(1,763) U**	**134,457**	**124,837**	**(9,620) U**
Contribution	**9,521**	**11,424**	**(1,903) U**	**124,481**	**136,824**	**(12,343) U**
Allocations	2,438	2,368	(70) U	30,258	28,319	(1,939) U
NET RESULT	**7,083**	**9,056**	**(1,973) U**	**94,223**	**108,505**	**(14,282) U**

Paid FTE

	MONTH (FTE)			YEAR TO DATE (FTE) (12 months ending Jun-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	201.3	200.1	(1.2) U	200.3	200.1	(0.2) U
Nursing	493.2	470.3	(22.9) U	499.4	470.3	(29.1) U
Allied Health	39.2	37.4	(1.9) U	37.4	37.4	(0.0) U
Support	0.0	0.0	0.0 F	0.0	0.0	0.0 F
Management/Administration	70.8	67.9	(2.9) U	68.7	67.9	(0.8) U
Total excluding outsourced FTEs	**804.4**	**775.7**	**(28.7) U**	**805.8**	**775.7**	**(30.1) U**
Total :Outsourced Services	18.6	14.0	(4.6) U	18.3	14.0	(4.3) U
Total including outsourced FTEs	**823.0**	**789.7**	**(33.3) U**	**824.2**	**789.7**	**(34.5) U**

Comments on major financial variances

Month result
The month result is $2.0M unfavourable, reflecting higher expenditure driven by ongoing high base contract volumes, 2.4% over contract for the month ($0.5M), with the additional revenue not recognised in the directorate result.

Revenue
ACC Revenue is $179k unfavourable and this continues to be impacted by high acute volumes reducing the capacity to carry out elective ACC work. Funder to Provider revenue is $133k unfavourable due to the Orthopaedics Interim Care Scheme (ICS) now being directly managed by the ADHB Funder - offset by reduced expenditure of $133k F in Orthopaedics Outsourcing.

Expenditure

The high patient workload continues to impact personnel costs ($942k unfavourable) through additional allowance payments covering the longer hours required and reflected in a higher average cost per FTE than budgeted for medical and nursing staff. Additional JRMO FTE within the General Surgery and Orthopaedic services, together with additional Nursing FTE recruited for the OEU (Orthopaedics Elective Unit, 11 staff additional), have also been a factor, while FTE savings of 24.90 have struggled to gain traction when patient volumes have been so much greater than contract.

Outsourced Personnel are $320k U reflecting additional resource required to meet annual targets. Significant costs in Ophthalmology $134k U, ORL $70k U, General Surgery $63k U and Oral Health $43k U make up the bulk of the overspend.

Outsourced Clinical Services are $375k U due in the main to

- 187 cataracts contracted to external contractors at a cost of $467k.
- But reduced by the favourable impact of the Orthopaedic ICS, $133k.

YTD result

The YTD result is $14.3M unfavourable, primarily reflecting higher expenditure driven by ongoing high base contract volumes, now 3.9% over YTD contract. These significant patient volumes represent $9.6M over delivered revenue YTD which is not reflected in these financials. The $9.6M over delivery is made up as follows:

1. $9.759M and 9.2% over the contracted acute inpatient volumes,
2. The balance of $179k U is a mixture of inpatient elective and Outpatient/procedure volumes.

Revenue

The unfavourable revenue variance of $2.722M continues to be primarily

- ACC of $1.541M which is being affected by significant acute patient volumes, impacting planning and availability of other patient types.
- General Surgical TPN contract funding not realised totalling $505k.
- The Funder managed Orthopaedic ICS totals $437k U (offset by an equivalent reduction in costs with a net nil bottom line effect).

Expenditure

Total expenditure is unfavourable $11.559M YTD, of which Personnel costs are $7.604M unfavourable.

- Medical staff costs of $3.768M U are impacted by additional hours' payments increasing the cost per FTE equivalent.
- Nursing costs are $3.386M U and have also been impacted by the high patient volumes, difficulties achieving FTE savings targets and the additional Orthopaedic Elective Unit staffing (funded by reduced outsourcing).

Clinical supplies spending of $926k U is driven by the increased patient volumes while specific areas worth note are

- Organ transplant transport costs of $609k U are due to higher transplant activity.
- Implants costs are $892k U increasing particularly in Neurosurgery (significantly over delivering on acute patient volumes) and Orthopaedics.
- Pharmacy eye drug costs in Ophthalmology are high due to the need to supply high cost pharmaceuticals in increasing volumes to patients at risk of blindness (macular degeneration), $784k U.
- The above have been mitigated by savings achieved in the Wards of $1.349M F.

Bad Debts ($600k U) on Non-residents is the major component of the $1.003M U Infrastructure overspend while the high patient volumes have also increased MRI, Nutrition and Radiology costs within Internal allocations totalling $1.939M U.

Business Improvement Savings

Despite the high patient volumes being treated specific savings of $189k were achieved for the month, just $1k less than the target of $190k. YTD savings totalled $2.207M, 95% achieved against a target of $2.311M and were primarily made within Wards clinical supplies.

Cardiovascular Directorate

Speaker: Dr Mark Edwards, Director

Service Overview

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

The Cardiovascular Team is led by

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

Directorate Priorities for 15/16

Over the 2015/16 year our Directorate contributed to the delivery of six Provider Arm work programmes in addition to our focus on the following Directorate level priorities:

1. Embed Clinician Leadership model including induction & orientation for new leadership team
2. Develop Clinical Governance and quality frameworks
3. Reconfigure service delivery for Cardiothoracic Surgery patient pathway
4. Improve our communication with Directorate staff
5. Plan for future service delivery
6. Financial sustainability

This work plan has been reviewed for the 16/17 year; some work streams have been retired as completed and new areas of focus that build on 15/16's work are introduced.

The following is a summation of the achievements for Q4 of the 15/16 year and signal the next priority areas for the 16/17 year.

Q4 Actions – 90 day plan

1. Embed Clinician Leadership model including induction & orientation for new leadership team

All Clinician Leadership positions are now filled, induction completed and leadership programme has commenced. A new Metric Dashboard to automate all metrics with the ultimate goal to develop an on-line, interactive tool with drill down capability for the monitoring and

management is being rolled out for use; the Cardiovascular Directorate is in line to adopt this late in July. We have engaged across the Directorate Leadership Team to develop the Metric Dashboard process for their service, working in conjunction with Business Intelligence over the next quarter.

2. Develop Clinical Governance and quality frameworks

We are rolling out regular integrated Clinical Governance and quality frameworks to strengthen reporting and feedback loops between service and Directorate levels. The new Metric Dashboard above will support our leadership team.

We reported last month that we are in the process of developing a framework for a business case to change from the CPR product to the Dendrite product for Cardiac Surgery reporting that will align us with the other cardiac surgery centres and address the risk the incumbent product poses by providing the ability to collect reliable and standard patient flow data, prioritisation scores and decisions, waitlist status, and risk adjusted outcome measures. The fourth iteration of this case for change is under review.

3. Reconfigure service delivery for Cardiothoracic Surgery patient pathway

We have aligned our workstream on care of the physiologically unstable patient with the organisational work programme for this strategic deliverable; this work will continue through 2016/17 year.

The Cardiothoracic Surgery satellite clinic as the first stage in reconfiguring the Nursing Model of care on Ward 42 commenced in June 2016.

Development of a shared Cardiothoracic Surgery/Cardiology care area for preoperative Cardiothoracic Surgery patients has established good buy-in from both local and regional cardiology services.

We are initiating the second piece of work aimed at improved flow and discharge planning for Cardiothoracic Surgery patients - Two nurse-specialist co-ordinated care pathways – one for routine patients and one for complex patients.

Work has also commenced on developing and implementing co-ordinated care pathways for complex chronic conditions – starting with diabetic foot ulceration. Scoping for this role and process is under way.

4. Planning for future service delivery

We continue with our implementation plan based on the business case submitted to the Ministry of Health relating to Heart and Lung Transplantation and Extracorporeal Membrane Oxygenation – we plan the first wave of staff resources should come on board by the end of Q1.

A plan to ensure sustainable delivery of non-DHB patient services has been redefined with a need to consider different partnership arrangements as the first step - we have started to scope this.

A Governance Committee group meeting to adopt a final set of recommendations from the Hybrid Operating Room (OR) project was held; revised governance structures have been adopted to take over from the project structure, utilisation of the Hybrid OR has been aligned with organisational OR capacity planning processes, and the model of care to support deployment of the hybrid OR as part of the organisational imperative to establish Vascular all day lists in level 4 was agreed. The next phases of work will focus on a pathway for non-accredited room requests, developing processes for considering extension of the use of the Hybrid OR for acute cases and afterhours work, and development of Hybrid OR specific measures for ongoing evaluation.

A number of workstreams are being initiated for the 16/17 year that build on work done to date and also on projects above in service redesign; our Q1 focus is on -

Planning for implementation of a regional roster for cardiology electrophysiology; this development has been a long term planning exercise under the governance of the Northern Regional Cardiac network;

Development of an in house model to assist in modelling of impacts of service change and production planning using existing expertise and knowledge of our staff is underway; continued refinement is likely to be iterative as we are able to factor in more variables;

Developing a sustainable delivery plan for managing delivery of the Transcatheter Aortic Valve Implantation (TAVI) programme; we are using work completed by the Northern Regional Practice Committee to assist with this.

Measures

Measure	Actual	Target End 2016/17)	2017/18
Adverse events: number of outstanding recommendations by due date	TBA	<10	0
Adverse events: median number of days from Reportable Events Brief – A submission to report ready for Adverse Events Review Committee (working days)	177	<70	<70
% of patients with email address submitted at admission	28%	50%	95%
Inpatient experience very good or excellent	Achieved	>90%	>95%
Number of recommendations off track without remedial plans	0	0	0
Directorate remains within budget (with 5% variance)	Unfavourable	On Budget	On Budget
Savings plan projects favourable to budget	Unfavourable	Favourable	Favourable

Scorecard

Auckland DHB - Cardiovascular Services

HAC Scorecard for June 2016

	Measure	Actual	Target	Prev Period
Patient Safety	Central line associated bacteraemia rate per 1,000 central line days	0	<=1	1
	Medication Errors with major harm	0	0	0
	Number of falls with major harm	0	0	0
	Nosocomial pressure injury point prevalence (% of in-patients)	6.9%	<=6%	5.7%
	Nosocomial pressure injury point prevalence - 12 month average (% of in-patients)	4.5%	<=6%	4.5%
	Number of reported adverse events causing harm (SAC 1&2)	2	0	0
Better Quality Care	HT2 Elective discharges cumulative variance from target	0.93	>=1	0.97
	(ESPI-1) % Services acknowledging 90% of FSA referrals within 10 working days	R/U	100%	100%
	(ESPI-2) Patients waiting longer than 4 months for their FSA	0%	0%	0%
	(ESPI-5) Patients given a commitment to treatment but not treated within 4 months	0%	0%	0%
	% DNA rate for outpatient appointments - All Ethnicities	10.59%	TBC	13.04%
	% DNA rate for outpatient appointments - Maori	25.58%	TBC	28.7%
	% DNA rate for outpatient appointments - Pacific	22.44%	TBC	31.28%
	Elective day of surgery admission (DOSA) rate	15.38%	TBC	10.99%
	% Day Surgery Rate	10.96%	TBC	14.29%
	Inhouse Elective WIES through theatre - per day	17.51	TBC	24.52
	Number of CBU Outliers - Adult	54	0	66
	% Very good and excellent ratings for overall inpatient experience	R/U	>=90%	97.8%
	% Very good and excellent ratings for overall outpatient experience	R/U	>=90%	68%
	Number of complaints received	2	No Target	2
	28 Day Readmission Rate - Total	R/U	TBC	10.28%
	% Adjusted Theatre Utilisation	83.52%	>=80%	82.38%
	% Theatre Cancellations	10.9%	TBC	14.6%
	Cardiac bypass surgery waiting list	84	52-104	92
	% Accepted referrals for elective coronary angiography treated within 3 months	97.87%	>=90%	99.54%
Improved Health Status	% Hospitalised smokers offered advice and support to quit	97.1%	>=95%	98.98%
	Vascular surgical waitlist - longest waiting patient (days)	121	<=150	126
	Outpatient wait time for chest pain clinic patients (% compliant against 42 day target)	100%	>=70%	96.8%
Engaged Workforce	Excess annual leave dollars ($M)	$0.6	0	$0.57
	% Staff with excess annual leave > 1 year	30.1%	0%	34.57%
	% Staff with excess annual leave > 2 years	13.4%	0%	12.01%
	% Staff with excess annual leave and insufficient plan to clear excess by the end of financial year	100%	0%	100%
	Number of Pre-employment Screenings (PES) cleared before the start date	0	0	1
	Sick leave hours taken as a percentage of total hours worked	4.5%	<=3.4%	4.2%
	% Voluntary turnover (annually)	13%	<=10%	12.5%
	% Voluntary turnover <1 year tenure	2.9%	<=6%	3.1%

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

R/U Result unavailable

(ESPI-1) % Services acknowledging 90% of FSA referrals within 10 working days
Result unavailable until after the 12th of the next month.

% Very good and excellent ratings for overall inpatient experience
% Very good and excellent ratings for overall outpatient experience
These measures are based on retrospective survey data, i.e. completed responses for patients discharged or treated the previous month.

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

Scorecard commentary

Increased Patient Safety

There were no SAC 1 events reported and two SAC 2 events reported for the month of June for the Directorate, however one SAC 2 currently being investigated is likely to be downgraded.

There were two complaints recorded for the month of June. One concerned dissatisfaction with care and the consumer has received a detailed response. The second related to an incorrect address and failure to receive an appointment letter. This has been rectified and the consumer has received a response. Medication errors, pressure injuries and falls are in line with previous trends - none resulted in serious harm.

Better Quality Care

The Cardiovascular Service is meeting the 4 month target in elective service delivery targets, ESPI /2 and ESPI 5.

In June the cardiac surgery eligible bypass waitlist dropped from 92 to 84; we continued to see higher than planned inflows onto the waitlist however production remained close to plan therefore reducing waitlist numbers. The service had no transplant activity in June but 5 extracorporeal membrane oxygenation (ECMO) patients.

ESPI2 in Cardiology has stabilised and we are meeting demand despite SMO vacancies. The Cardiology Electrophysiology waitlist is still trending up due to higher inflows but we are introducing a change to procedural Lab scheduling to meet the demand.

The ESPI5 Cardiology Surgical Waitlist has grown in recent months due to higher inflows and capacity constraints across the service. We will have a new cardiology interventionist in place by Q1 2016/17 to help alleviate this.

Heading into winter there is likely to be continued high inflows onto the waitlist which will challenge the service, plans are in place for managing this. The continued challenge of long stay complex patients in the cardiovascular intensive care unit (CVICU) may further impact on our ability to manage our patient flow across the Directorate.

Improved Health Status

The Cardiovascular Directorate continues to work on improving performance in the three targeted areas.

Engaged Workforce

- Excess annual leave rates remain at similar levels – a renewed focus has been launched this month. It is anticipated that there will be more of a reduction with a number of employees having leave plans for winter and over the current school holidays.
- Turnover is higher than Auckland DHB average with one area sitting at 30%; this has been reviewed to understand any key issues or trends with recruitment well underway.

Key achievements

- Implementation of our Cardiovascular Leadership meeting programme and strengthening reporting and feedback loops between service and Directorate levels.
- Implementation of new process for a Cardiothoracic Surgery satellite clinic as the first stage in reconfiguring the Nursing Model of care on Ward 42.
- Management of high number of inflows to our cardiothoracic surgery and cardiology services and overall reduction in the eligible cardiac surgery wait list.
- Framework in place for linking current Cardiothoracic Surgery Action Plan into delivery of 2016/17 Directorate plan

Areas off track and remedial plans

- The number of patients waiting for surgery remains higher than we would like for this time of year, placing our maintenance of clinically appropriate wait times under pressure. We continue to monitor this closely.

- The financial result for the year end will challenge us to continue looking for further efficiencies whilst maintaining our waiting list.

Key issues and initiatives identified in coming months

- Meeting clinical treatment targets for Surgery and Cardiology Interventions along with maintaining focus on our Quarterly objectives remains a key tension for the service.
- Monitoring progress against the savings plan and making budget in the context of our waitlist challenges.

Financial Results

Auckland DHB - Cardiovascular Services

Statement of Financial Performance for June 2016

($000s)	MONTH			YEAR TO DATE (12 months ending Jun-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
REVENUE						
Government and Crown Agency	99	123	(23) U	1,202	1,433	(231) U
Funder to Provider Revenue	10,887	10,887	0 F	129,745	129,745	0 F
Other Income	524	568	(44) U	7,525	6,801	724 F
Total Revenue	**11,511**	**11,578**	**(67) U**	**138,472**	**137,979**	**493 F**
EXPENDITURE						
Personnel Costs						
Medical	2,524	2,336	(187) U	27,286	27,945	659 F
Nursing	2,242	2,244	2 F	26,935	26,651	(284) U
Allied Health	535	518	(17) U	6,339	6,184	(155) U
Support	16	13	(3) U	159	156	(3) U
Management/Adminstration	209	186	(23) U	2,376	2,234	(142) U
Total Personnel Costs	**5,525**	**5,297**	**(228) U**	**63,095**	**63,170**	**75 F**
Outsourced Personnel	41	50	8 F	522	594	72 F
Outsourced Clinical Services	250	58	(192) U	1,252	680	(571) U
Clinical Supplies	2,587	2,512	(75) U	32,074	29,941	(2,133) U
Infrastructure & Non-Clinical Supplies	157	164	7 F	1,675	1,969	295 F
Total Expenditure	**8,561**	**8,080**	**(480) U**	**98,618**	**96,356**	**(2,262) U**
Contribution	**2,951**	**3,498**	**(547) U**	**39,854**	**41,624**	**(1,769) U**
Allocations	1,093	966	(128) U	11,736	11,527	(210) U
NET RESULT	**1,857**	**2,532**	**(674) U**	**28,118**	**30,097**	**(1,979) U**

Paid FTE

	MONTH (FTE)			YEAR TO DATE (FTE) (12 months ending Jun-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	93.2	92.1	(1.0) U	90.6	92.1	1.5 F
Nursing	310.3	315.6	5.3 F	309.1	315.7	6.6 F
Allied Health	65.8	67.0	1.2 F	65.3	66.9	1.6 F
Support	3.0	3.0	(0.0) U	3.0	3.0	(0.0) U
Management/Administration	32.7	33.1	0.4 F	32.3	33.1	0.8 F
Total excluding outsourced FTEs	**504.9**	**510.8**	**5.8 F**	**500.2**	**510.7**	**10.5 F**
Total Outsourced Services	1.1	1.7	0.7 F	1.3	1.7	0.4 F
Total including outsourced FTEs	**506.0**	**512.5**	**6.5 F**	**501.6**	**512.5**	**10.9 F**

Comments on Major Financial Variances

The YTD result is $1,979k U. While overall inpatient discharges are 0.9% above contract, WIES is 5.1% below contract equating to $6.0M (not recognised in the Directorate result), but 2.0% above last year. Actual 15/16 WIES are lower than contract due to both a new (lower) WIES version implemented in 15/16, and a change in case-mix driving a lower average WIES.

YTD elective WIES is at 98.1% of contract whilst acutes are 92.9% of contract mainly in cardiothoracic surgery.

1. Revenue

Overall revenue variance YTD is $493k F due to:

- Favourable variance from Non-Resident patients with a volume higher than budget.

2. Expenditure

Total Expenditure (including Allocations) YTD is $2,472k U, this is mainly due to

- Personnel and Outsourced personnel costs are net $147k F; mostly from being 10.9 FTE below budget arising from vacant management.
- Outsourced Clinical is $571k U YTD. Cardiac outsourced 6 lead extractions and 6 bypass cases. We are attempting to manage future outsourcing downward as lead extraction work is now back in-house through using the new Hybrid theatre. However there is still some on-going risk with high transplant numbers in April reducing local capacity and requiring outsourced over-flow volumes. We have experienced high cardiac wait-list numbers through the last quarter and as a result outsourced expenditure has actually increased slightly in the last quarter (however this has also resulted in higher non-resident revenue).
- Clinical Supplies are $2,133k U, this arises from three sources:
    - The increase in TAVI cases – June YTD 67 compared with 41 for the same period last year (this equates to $780k). Developing a sustainable delivery plan for managing delivery of the Transcatheter Aortic Valve Implantation (TAVI) programme is a work stream in our 16/17 business plan.
    - The hA savings programme relating to Cardiac Implants has not materialised to date. We are reviewing purchase information to ensure robustness of the financial information, and there will be on-going dialogue with supply chain management to verify the outcomes of the hA savings programme
    - Also contributing to the unfavourable variance are two unbudgeted LVADs in February ($238k).
    - Clinical equipment depreciation is $533k U the 2016 17 budget takes account of this higher level or depreciation
- Infrastructure & Non-Clinical Supplies is $295k F; mostly from lower building depreciation for the Hybrid OR charged to Facilities
- Internal Allocations are $210k U due to higher Radiology charges (5% higher than the same period last year) and higher Nutrition charges (21% higher than the same period last year). These variances have been partially offset by vascular research overhead recovery for prior years.

The financial result this year emphasises the need to fundamentally consider and change the way we are working whilst continuing to look for further efficiencies that support our service delivery and savings assumptions into the 16/17 year. The latter does depend on the both the clinical activity and timing of the national Heart and Lung transplant service review and how that relates to our wait list recovery plan.

Commercial & Non Clinical Support Directorate

Speaker: Clare Thompson, General Manager

Service Overview

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

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

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

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

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

Directorate Priorities for 15/16

In 2015/16 the Commercial & Non Clinical Support Directorate will and work programmes contribute towards the delivery of both the Provider Arm and Corporate Services key priorities including regional and national initiatives. The 2015/16 priorities are;

1. Enhance the Directorate's 'readiness to serve' framework to align with the Provider Arm and Corporate Services planning protocols.
2. Develop an enhanced leadership model for single point of accountability for key service teams to improve quality of stakeholder engagement and decision making.
3. Provide values training to align with enhanced patient safety and better quality care.
4. Improve culture and team engagement to develop the workforce to improve performance and deliver on agreed plans.
5. Engage in integrated service planning and monitoring of service delivery against key performance targets.
6. Develop systems at local, regional or national level as enablers to improve accountability and transparency within all services.

7. Identify commercial revenue generation and other value for money opportunities.
8. Develop the sustainability framework.

Q3 & Q 4 Actions – 90 day plan

Strategic Initiatives for Commercial and Non Clinical Support include the following actions which are currently being progressed.

Service Group	Deliverable/Action	Q1	Q2	Q3	Q4	16/17
Contracts	Contracts Database				√	
Contracts	Contracts Management framework				√	
Contracts	Transforming Food Service Delivery			√	√	
Commercial Services Bus Imp	Motor Vehicle – Service Review				√	√
Commercial Services Bus Imp	Motor Vehicle Fleet Strategy				√	√
Commercial Services Bus Imp	Sustainability - CEMARS Certification				√	
Commercial Services Bus Imp	Sustainability Strategy					√
Commercial Services Bus Imp	Sustainable Transport					√
Operations NCS	Security Access Control & CCTV System			√	√	√
Operations NCS	Security-for-Safety work programme			√	√	√
Operations NCS	Security Strategy			√	√	√
Operations NCS	Waste Transformation Project				√	√
Procurement & Supply Chain	healthAlliance/Procurement Framework			√	√	√
Procurement & Supply Chain	Supply Chain Framework				√	√
Procurement & Supply Chain	Auckland Regional Supply Chain Review				√	
Procurement & Supply Chain	Gap analysis for National Oracle system				√	

Scorecard

Auckland DHB - Non Clinical Support

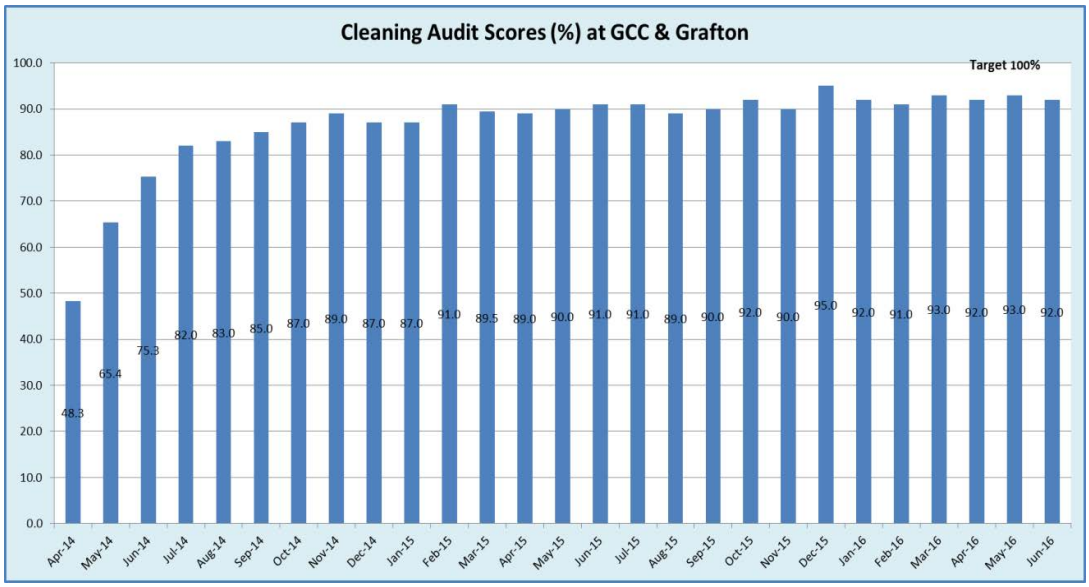
HAC Scorecard for June 2016

	Measure	Actual	Target	Prev Period
Engaged Workforce	Excess annual leave dollars ($M)	$0.02	0	$0.02
	% Staff with excess annual leave > 1 year	32.3%	0%	29.26%
	% Staff with excess annual leave > 2 years	6%	0%	7%
	% Staff with excess annual leave and insufficient plan to clear excess by the end of financial year	85.7%	0%	81.25%
	Number of Pre-employment Screenings (PES) cleared before the start date	0	0	0
	Sick leave hours taken as a percentage of total hours worked	5.9%	<=3.4%	6.93%
	% Voluntary turnover (annually)	13.9%	<=10%	9.9%
	% Voluntary turnover <1 year tenure	24.1%	<=6%	22.6%

Key achievements in the month

Cleaning Services

- Combined average audit score at Auckland Hospital and Greenlane Clinical Centre is 92% for the month of June 2016. The break-down by site; 91% Grafton & 96% GCC.



- Stock Room Par Levels and allocation process have been reassessed to ensure tighter control of inventory management for consumables, chemicals and equipment.
- From 1 July 2016, Cleaning Services has introduced a dedicated Isolation Discharge Cleaning team who will respond to Red and Amber cleans. By streamlining this process, this will remove the need for contacting multiple parties during a discharge cleaning request and speed up the process of bed availability.

Compliments (June)

- Cleaning staff continue to maintain high standards. This is reflected by the number of written compliments received from various end users.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2014				1	9	2	7	6	5	3	9	5
2015	4	1	5	3	5	14	4	8	5	2	10	7
2016	3	11	6	9	5	8						

- New GCC Workplace Literacy Course scheduled to commence in July.
- IS training on basic computing skills has been completed for 30 staff. Exploring options to develop a more comprehensive IT training programme.
- Time card approvals in Workforce Central increased to 79% in June (previous average 64%); the fortnightly rate increased to 70% (previous average 63%). Continued focus on this area will also include refresher training which is scheduled in July to further support staff.
- International Cleaners Day Celebrations were held in June at ACH and GCC as an opportunity for cleaning staff to be recognised for their continued hard work. Members from the Senior Leadership team also attended to personally thank staff on behalf of the organisation for their continued commitment and support in delivering a high standard of cleaning within ADHB.

- A “Bright Ideas” Campaign has been devised to focus on specific improvement opportunities such as continuous improvement, waste reduction, customer satisfaction, safety, fatigue reduction etc. Suggestions will be actively encouraged through staff monthly meetings and the ‘Bright Ideas’ suggestion box will be located on Level 3.
- KPIs for Cleaning Supervisors have been established focussing on: Customer Satisfaction, Operations, Health & Safety, and Quality & Compliance.

Patient Experience Portal (June)

Rating	Comment	Site/Department
10	The Totora Ward was beautifully clean. Hand sanitiser everywhere. Very clean bathrooms	Totara Ward
10	Rooms were clean bathrooms and toilets clean. Bedding changed when needed.	Ward 72
10	Room *was cleaned every day*, rubbish taken 2x a *day* it was very clean	Ward 23B
10	Really clean all over. Lovely clean ward.	Ward 61
10	Excellent level of cleanliness and hygiene - at the right level for a hospital - no smells.	Women's Assessment Unit
9	The bathroom was always clean and I regularly saw *the* floor mopped. The operating room was *very clean* and *the* ward had no dust	Ward 97

- Ongoing project 'Behind the Scenes with Hand Hygiene' being conducted by IPC, focussing specifically on the Cleaning staff.

Staff Residences

- Staff Residence occupancy was 75% for the month of June.
- Daily cleaning duties are carried out to good standard positive feedback from residents.
- Positive feedback received from residents regarding the upgrade to furniture and fittings.
- Health Alliance have installed a new Wi-Fi access point on Level 8 to improve Wi-Fi reception

Supply Chain & Procurement

- ADHB, CMDHB and WDHB continue discussions on the Northern Region Supply Chain review and recommendations.
- Participating with all 20 DHBs and NZHPL on National Procurement Strategy.
- NZHPL National Procurement Plan released to DHB Lead for feedback
- ADHB Financial End of year stock-take ongoing.
- Multiple Procurement standardisation and rationalisation activity on Health Alliance, Pharmac and All of Government Contracts in the non-clinical arena; resulting in compounded savings and removal of duplicate catalogue items.
- Annualised $85k savings from removal of duplicate catalogue items.

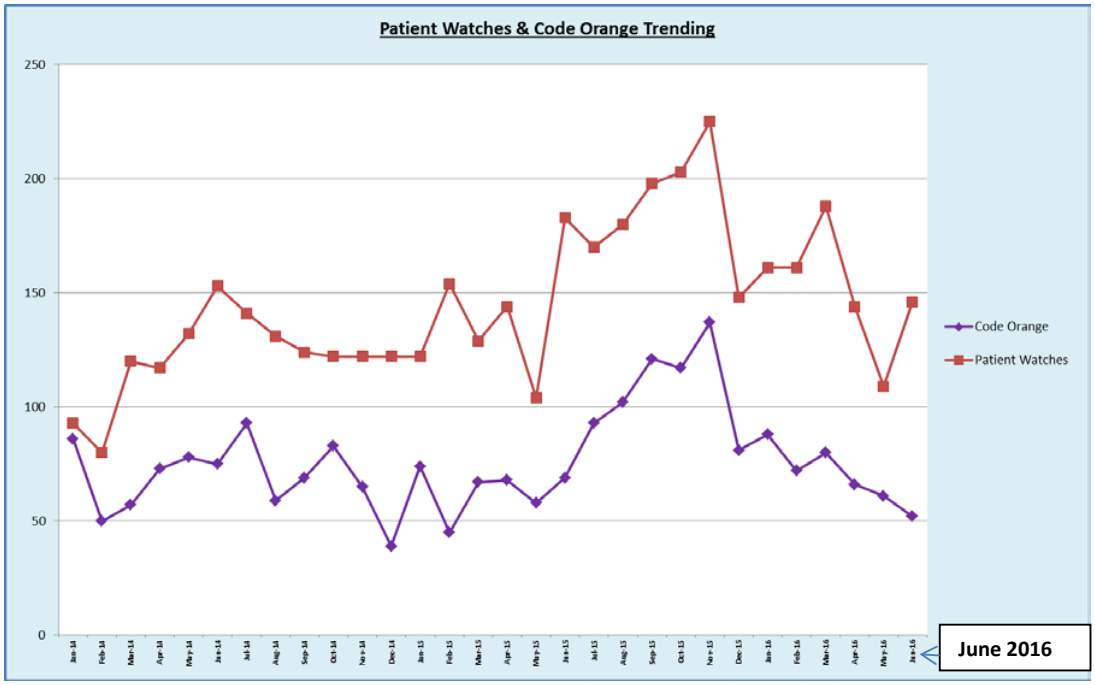
Security for Safety Programme

- Key progress updates for the Security for Safety programme as follows:

Work-stream	Key Milestone
Code Black	• Policy and emergency response development well underway
Security Access Plans	• Plans for SSH have been reviewed and accepted ready for sign-off by Steering Group in July • Plans for Adult and Children's Emergency departments are being matured for review by directorates
CCTV system upgrade	• Production Server build is in progress • Planning for go-live and transitioning CCTVs for Car Park A and B onto the new server
Access Control System	• Specification and testing of configuration for security access groups is continuing with SSH as the priority • Card holder data input continuing as part of the ID card rollout
Security Control Room	• Construction nearing completion for relocated Security Control Room at Auckland City Hospital • Handover to Security Team to be scheduled for late July
ID/Security card project	• Security ID card rollout underway and over 7000 cards have been issued to date • New ID cards being well received by staff, external contractors and partner organisations • Security ID policy drafted ready for review by Steering Group • Planning for handover of ID card issuing to business as usual is underway
Performance and Culture	• Training content development is work in progress • Workshops with key stakeholders to provide input to training content have been completed.
Security Staffing and Services	• Vision workshops with key stakeholders completed • Vision document completed for endorsement by Steering Group • CCTV policy approved by Steering group and out for wider consultation • Security ID card policy drafted for review by Steering group

Security – Operations

- Code Orange calls: 52 Code Orange responses were attended in June, compared to 61 in May (decrease 14.7%) Patient Security Watches: There were 146 requests during June compared to 109 in May (increase 33.9%).
- Patient Security Watches: There were 146 requests during June compared to 109 in May (increase 33.9%).



- Security department is working closely with the Police service in an attempt to stem the theft of bicycles across the ACH and GCC campuses. Police advised this issue is becoming widespread across the city.
- Auckland City Police are taking an active interest in crime events at ACH and are conducting random and regular patrols in support of ADHB security staff.

Security – Parking

- Non-compliant parking during nights and weekends remains a challenge. Security are focussing on the ambulance bays, cars parking on yellow lines, disabled car parking areas and LabPlus parking areas. Security personnel actively enforce parking restrictions throughout both sites where possible. Towing of non-compliant vehicles remains in force. A zero tolerance approach to parking in the drop off area has eased parking issues on Level 4.

Waste Services & Sustainability

- Introduction of the 'Sustainable Office' concept -Positive feedback has been received following the replacement of floor bins with desk cubes. The desk cubes are sized to collect small waste items from desks, this initiative has been implemented in Building 32, Level 5 Admin Suite and Building 37 Executive Suite, and will now rollout to all office areas. It helps demonstrate to staff how much waste we generate at our desks. By being more aware, this helps staff to think differently about the waste we produce, and how to eliminate it.

- Changes have been made to docks following IPC audit recommendations, including spill kits, eye wash stations and mop holders, at ACH, Support, Starship and GCC.
- PVC recycling is being implemented in theatres and other services. The intention is to achieve uniformity in processes for PVC recycling. Collection of PVC recycling material from wards is constantly increasing. Education sessions commenced in early June; areas currently rolled-out are: Theatres Level 4, 8, & 9, Wards 48, 65, 66, 67, 68 & 77, Building 56 Dialysis, and GCC Level 2 Theatres.
- PVC sent off site is sent to a recycling agency that converts the PVC into children's playground safety mats 3kg of product = 1 play mat (50cm by 50cm):

used PVC

playground mat

- So far 125kg (41 playground mats) of PVC has been sent off site. Which also means 125kg of product not taken to landfill!

Property Leases

- School of Medicine lease extension for a further 3 year period approved by the Board.
- Confirmation received for the 8 month lease extension (from July 2016) for the Thrive service located in Parnell. The service requested a further extension to December 2017 (awaiting outcome).
- The Youth Transition Program team identified a possible alternative building on Mt Eden Road. Discussions are ongoing with the landlord.
- St Luke's Community Mental health lease expires in October 2017. Alternative buildings being sought.

Retail Outlet Tender

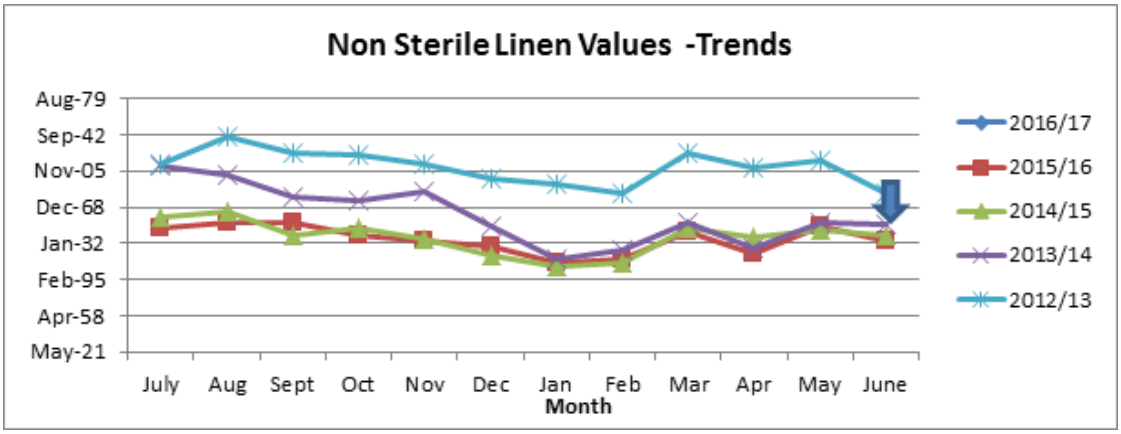
- Tenders for retail outlets for level 5, level 3 at ACH, and GCC site concluded.
- Recommendation made to the Board for retail outlets on the ACH and GCC site with the exception of the Hospital Bookshop and Florist where there is ongoing discussion.

Parking

- The number of days where there are traffic queues on Park Road has reduced significantly and queues are more sporadic. We believe this is due to the extra 69 public car parks added to Carpark A, a (so far) warmer winter than usual, and Wilsons parking opening a public car park on the Grafton Oaks Site.
- The increase in staff parking charges announced in June 2016 has resulted in a number of queries from staff to change their parking practices from fixed weekly charges to flexi pass charges and / or offsite parking.
- Commercial Services and the Sustainable Transport project team continue to work on car-parking options to meet the increased demand.
- There has been a notable increase in public demand for car parks at Greenlane caused by the Trotting Club partially closing its public carpark due to construction activity.

Contract Management Linen

Item	Status	Savings if applicable	Comments
General Linen Supply	95%	-2%	-
Disposable and Sterile Supply Rates	100%	-	-
Linen Utilisation - May	72%	-	A full review of imprest levels for completed. Reviewed imprest levels will be implemented at ACH over the next 2 weeks.
Non-sterile linen sales	-	-	Continued to trend favourably.
Non-sterile linen	-	$21,656	-
Sterile linen	-	$1,962	-
Small Sterile packs expiry timeframes proposal paper	-	$50k p.a. projected conservative	Good progress made with a proposal to improve savings on sterile linen spends.
Other			
• The regional approach to review and approval of national linen catalogue is progressing well, with a workshop scheduled for 21 July 2016.			



Food & Nutrition Services

- A new Operations Manager commenced with Compass Group for ADHB Food Services, and recruitment is underway for a Food Production Manager.
- Two Patient Experience Coordinators have been engaged in the collection of patient feedback this feedback will assist Compass in focusing on areas for service improvement..
- An online tool has been introduced by ADHB Contracts Team to provide direct feedback to Compass Group Food Service Team to provide direct feedback of minor operational issues.

Key issues and initiatives identified in coming months

Area	Timeframe
Cleaning Services	
• Staff development and training programme	On-going
• Implement staff PDRs	Ongoing
• Cleaning staff recruitment	Ongoing
Sustainability – Waste Reduction Programme	Sep 16
Security for Safety Programme	Jun 17
Security CCTV & Access Control upgrade	Jun 17
Motor Vehicle Fleet Strategy	Dec 16
HealthAlliance Regional Supply Chain Review	Dec 16
Oracle V12 Upgrade	Ongoing
Oracle V12 Upgrade - data Integrity audits and recovery of moneys due	Ongoing
DHB/HealthAlliance review of OneLink contract	Jun 17
Taylor's Linen Contract – savings initiatives	Nov 17
Food Services – review of Standing Orders	Sept 16
Mail Services – Investigation of Mail House Service	Oct 16 Ongoing
Sustainable Transport Programme	Jul 16

Financial Results

STATEMENT OF FINANCIAL PERFORMANCE
Non-Clinical Support Services

Reporting Date Jun-16

($000s)	MONTH			YEAR TO DATE (12 months ending Jun-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
REVENUE						
Government and Crown Agency	23	0	23 F	162	0	162 F
Funder to Provider Revenue	0	0	0 F	0	0	0 F
Other Income	711	724	(12) U	9,488	9,434	54 F
Total Revenue	**734**	**724**	**11 F**	**9,650**	**9,434**	**216 F**
EXPENDITURE						
Personnel						
Personnel Costs	852	945	93 F	9,375	11,335	1,960 F
Outsourced Personnel	229	8	(221) U	2,469	99	(2,370) U
Outsourced Clinical Services	(245)	0	245 F	(245)	0	245 F
Clinical Supplies	10	12	3 F	152	145	(6) U
Infrastructure & Non-Clinical Supplies	2,402	2,226	(176) U	28,328	26,751	(1,577) U
Total Expenditure	**3,248**	**3,192**	**(56) U**	**40,078**	**38,330**	**(1,749) U**
Contribution	**(2,513)**	**(2,468)**	**(46) U**	**(30,429)**	**(28,896)**	**(1,533) U**
Allocations	(895)	(811)	84 F	(11,424)	(9,731)	1,693 F
NET RESULT	**(1,618)**	**(1,657)**	**39 F**	**(19,005)**	**(19,165)**	**160 F**

Paid FTE

	MONTH (FTE)			YEAR TO DATE (FTE) (12 months ending Jun-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical	0.0	0.0	0.0 F	0.0	0.0	0.0 F
Nursing	0.2	0.2	0.0 F	0.2	0.2	0.0 F
Allied Health	0.0	0.5	0.5 F	0.3	0.5	0.2 F
Support	179.7	222.2	42.4 F	173.7	222.2	48.5 F
Management/Administration	27.8	20.8	(7.0) U	23.3	20.8	(2.5) U
Total excluding outsourced FTEs	**207.8**	**243.7**	**35.9 F**	**197.4**	**243.7**	**46.2 F**
Total :Outsourced Services	56.7	0.0	(56.7) U	55.3	0.0	(55.3) U
Total including outsourced FTEs	**264.4**	**243.7**	**(20.8) U**	**252.7**	**243.7**	**(9.1) U**

Comments on major financial variances – Non- Clinical Support Services

The full year result was very close to budget at $160k F. The key drivers of this result were:

1. Personnel/Outsourced Personnel costs were $410 k U. This was largely due to outsourced personnel being used to reduce the high leave liability that the cleaners transferred with.
2. Infrastructure and Non–Clinical Supplies were $1,577k U. Food costs during transition period being significantly higher than budget driving this variance. This was offset by allocations due to the recharging of patient meals and savings due to the management of the linen contract.

Patient Experience Reports

Recommendation

That the Hospital Advisory Committee receives the Patient Experience reports.

Prepared by:	Sarah Devine (Online Participation Manager)
Endorsed by:	Dr Andrew Old (Chief of Strategy, Participation and Improvement)

Report 6 June 2016

Report on InPatient Experience

Auckland District Health Board

7.1

TOP THREE

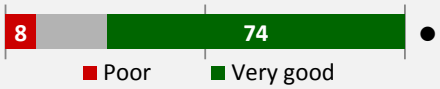
Our inpatients are asked to choose the three things that matter most to their care and treatment.

1. Communication (51%)

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

"I found there was quite a bit of repetition every different doctor saying the same thing to me..." (Rated very good)

How are we doing on communication?

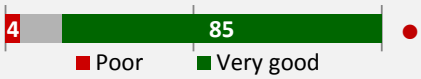


2. Confidence (43%)

For one in four of our patients (43%), feeling confident about their care and treatment is one of the top three things that matter to the quality of their care and treatment.

"The staff at all times were doing their checkup rounds, asking if I had any concerns and giving reassurance that they were available to answer any questions." (Rated excellent)

How are we doing with patients feeling confident about their care and treatment?

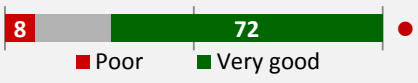


3. Consistency (41%)

Four out of every 10 patients (41%) rate getting consistent and coordinated care while in hospital as one of the things that make the most difference.

"Each doctor / consultant / nurse had obviously read and discussed my patient notes and case history and all gave consistent advice..." (Rated excellent)

How are we doing with consistent and coordinated care?



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Communication

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

It's also an aspect of care that is critical to patient safety and outcomes as good communication creates opportunities for team members to speak up, for errors to be identified and corrected early, and for patients, families and carers to take a positive, active and informed role in their own care

It is clear this is an important place to try and make an impact. And we are.

In reviewing our results over the last year we have looked back to previous results and can see some significant improvements.

Respondents are asked to rate how often they got answers they could understand when they had important questions to ask. There are significant improvements in the data across all staff groups when compared to our previous report in June 2013.

Of the more than 2000 people who commented on our communication with them three quarters (76%) made positive comments. Patients appreciate direct, clear and respectful communication and information in formats that is suitable for their situation and that they are able to share with others.

People value being listened to and being engaged in discussions about their care and being updated with new or changing information.

Patients not only want information on their condition, they want to be informed about what is happening, why and when. When is very important – patients don't like feeling like they have been forgotten. The other important aspect is the how.

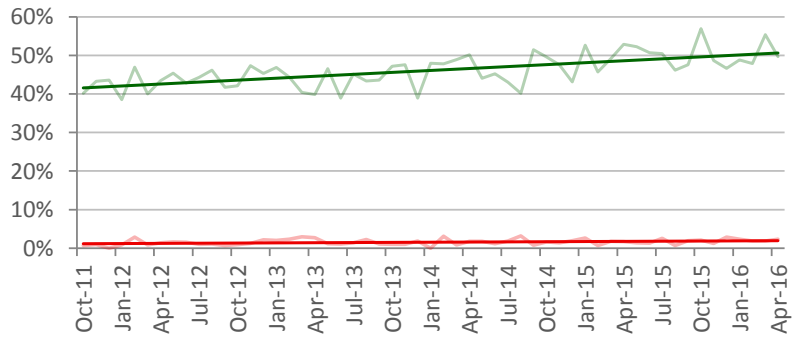
Our values: Welcome *Haere Mai* | Respect *Manaaki* | Together *Tūhono* | Aim High *Angamua,* collectively describe the process of effective communication. Patients value the courteous, friendly and empathetic manner of our staff and the way we communicate makes a significant difference to people's experiences.

Dr Andrew Old
Chief of Strategy, Participation & Improvement

OVERALL RATINGS

Our "excellent" ratings have continued to rise over time, from an average of 43 percent in the first year of the Inpatient Experience Survey (Oct 2011 to Sept 2012), to an average of 50 percent in the 12 months to April 2016. The differences are significant and sustained when demographic factors such as the age and gender of respondents are controlled for.

INPATIENT OVERALL EXPERIENCE OF CARE RATING, OCT 2011 TO APRIL 2016 (n=14,666)



Communication

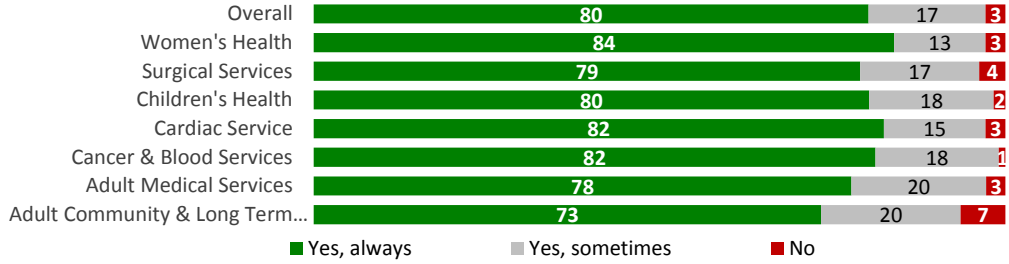
More than half of all respondents to the Inpatient Experience survey (51%) tell us that communication is one of the dimensions of care that matters most to them.

The following data are from April 1, 2015 to March 31, 2016.

Asking important questions and understanding answers

Respondents are asked to rate how often they got answers they could understand when they had important questions to ask. There are significant improvements in the data across all staff groups when compared to the previous report in June 2013.

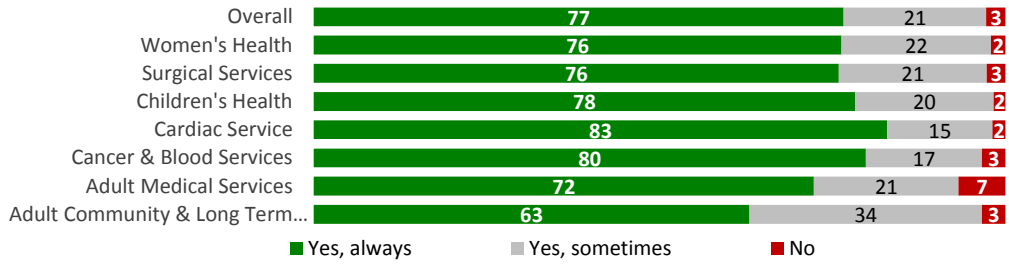
Percentage of patients who say they got answers they could understand from doctors.



3% improvement in doctors' overall ratings since June 2013. The differences are significant (p<0.05).

Adult community & long term conditions n=124; Adult medical services n=395; Cancer & blood services n=131; Cardiac service n=381; Children's health n=926; Surgical services n=1206; Women's health n=514 Overall n=3677

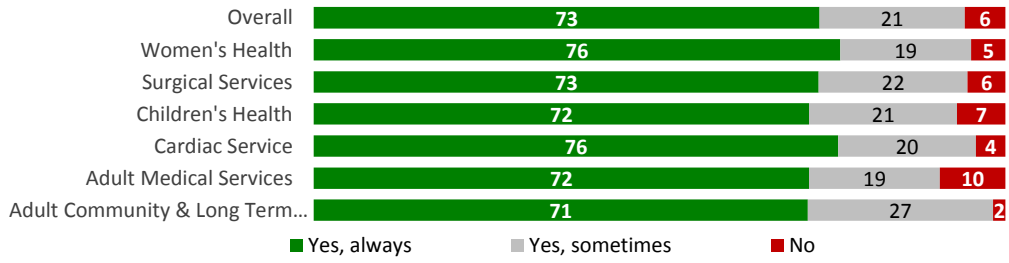
Percentage of patients who say they got answers they could understand from nurses/midwives.



4% improvement in nurses/midwives' overall ratings since June 2013. The differences are significant (p<0.05).

Adult community & long term conditions n=116; Adult medical services n=383; Cancer & blood services n=119; Cardiac service n=363; Children's health n=897; Surgical services n=1144; Women's health n=523 Overall n=3545

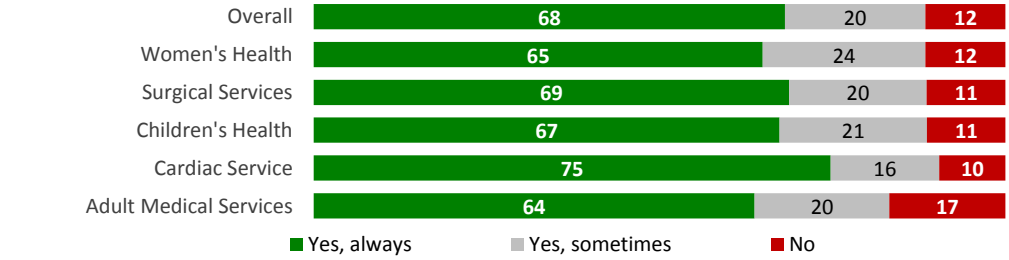
Percentage of patients who say they got answers they could understand from other members of the healthcare team (i.e. physiotherapists, radiographers, dietitians, or occupational therapists)



4% improvement in other staff overall ratings since June 2013. The differences are significant (p<0.05).

Adult community & long term conditions n=112; Adult medical services n=264; Cardiac service n=277; Children's health n=560; Surgical services n=803; Women's health n=302 Overall n=2402. Note that services with <100 respondents have been omitted from the data.

Percentage of patients who say they got answers they could understand from administration staff.

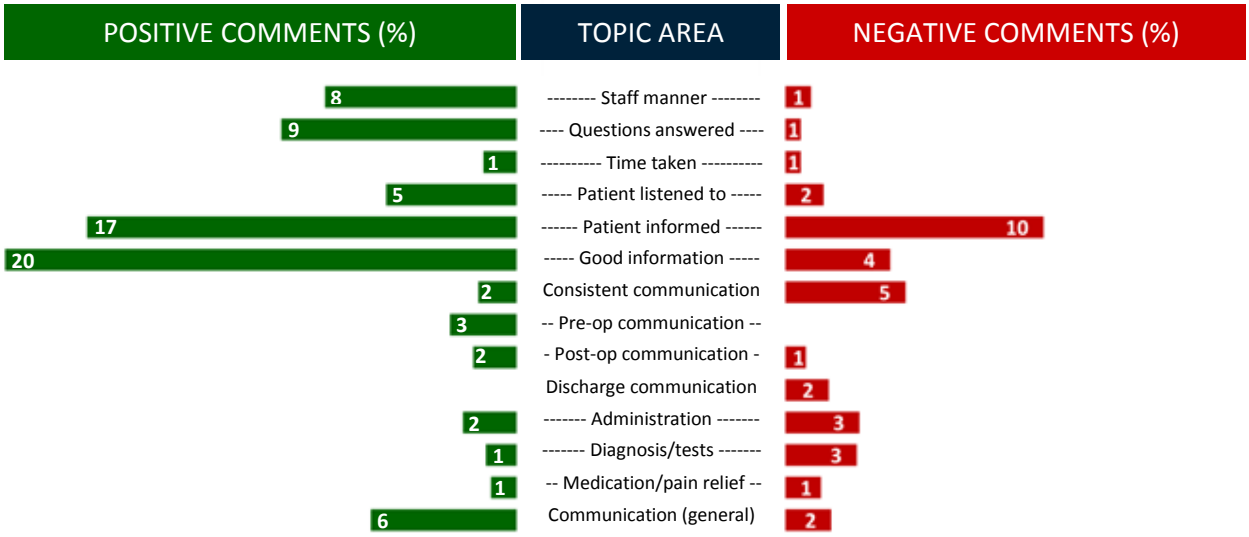


5% improvement in administration staff overall ratings since June 2013. The differences are significant (p<0.05).

Adult medical services n=266; Cardiac service n=261; Children's health n=668; Surgical services n=885; Women's health n=370 Overall n=2616. Note that services with <100 respondents have been omitted from the data.

A CLOSER LOOK AT PATIENT COMMENTS

A total of 2134 patients commented on communication. More than three quarters (76%) of the comments were positive, with 34 percent of comments negative (note that some patients made both positive and negative comments, which is why the total is greater than 100 percent).



PATIENT COMMENTS

GOOD INFORMATION (20%)

One in every five comments (20%) were from respondents who said that information was explained clearly and/or was given in other forms (e.g. written) when needed or requested. Many of these patients appreciated having their care and treatment explained in plain language, with little use of jargon or complicated clinical terms.

[The doctor] helped us enormously just by telling us the unblemished truth about what was happening, what we could expect and importantly what to expect this to do as far as impacting on us and our family. … His experience and humanity was on show and was very apparent…

I really appreciated the written information that I got sent home with. Helpful to have that nearby and be able to show others it and re-read it which I did on a number of occasions.

POOR INFORMATION (4%)

A small number of respondents (4%) felt they weren't given adequate information, that the information given was too clinical or not explained in simple terms or, at times, was inaccurate.

The doctor literally said "I would rather not have to explain that" when I asked about [my surgery].

The [staff] were talking about the next steps with me, and I had to ask them a few times to explain the lingo.

Writing information down would help someone with dementia to have something to refer to.

The doctors don't always volunteer information. You have to kept asking them questions even when they should realise you want to know in detail about your case.

PATIENTS KEPT INFORMED (17%)

Respondents who commented favourably on communication said they felt informed about what was happening with regards to their care and treatment (17%). This involved being told what was going to be done, what had been done and what the next steps were. Respondents also appreciated being updated when things changed.

The staff I dealt with through my ordeal were very good at telling me about everything that was about to happen or following up.

[There was] constant updating of what was happening as things changed.

I was told who would see me and in what order. Time was also communicated to me clearly.

It is nice to be kept in the loop so you know where you stand and are aware of any treatments being carried out.

PATIENTS NOT KEPT INFORMED (10%)

One in 10 respondents (10%) say they were not informed or updated about their condition, or they were not informed about waiting times and/or felt forgotten or ignored. Some patients said they felt anxious and distressed when this happened.

I was told my daughters MRI would take 40 mins and no one came and saw me for 2 hours - so I was beside myself with worry. When someone did come and get me she had already woken up in recovery - she is 3 years old - and was very upset and frightened that she woke up in a strange place with doctors etc. around her and no mother.

I was told I was having surgery … then in the early hours surgery was cancelled … [I] ended up in tears as no one would could tell me anything and each time the doctors changed shifts the story would change.

PATIENT COMMENTS (cont…)

QUESTIONS WERE ANSWERED AND PATIENTS FELT LISTENED TO

Our respondents (8%) tell us that they value communication that invites and encourages them to ask questions and when those questions are answered.

Any time I asked a question of any of the staff, I received an answer that was clear and completely honest.

Felt I could ask questions and they would be answered. Didn't feel as though I was a nuisance.

Our patients appreciate being asked, consulted or listened to (5%); many said that when this happens they feel respected, safe and cared for. They also appreciate when staff take time with them (1%).

My doctor … was amazing. He [was] always checking and asking questions about how I was feeling. The nurses were fantastic too. I felt safe and well looked after...

Doctors and nurses always took the time to listen and answer my questions in a way I could easily understand. I felt they genuinely cared about me getting better which is the main thing to help keep my positivity up.

I was very impressed when one of the busy doctors took quite some time to sit with me not only to answer my questions but also to put me more at ease.

GOOD STAFF MANNER (8%)

Eight percent of respondents who commented on communication spoke positively about how they were treated by staff. These respondents used words such as considerate, kind, empathetic, friendly, dedicated, humorous, approachable and courteous to describe the manner of the staff they interacted with.

From the friendly reception nurse to the attending doctors in emergency with smiling faces … to the wonderful nursing staff who were consistent and dedicated … every step of the way everyone was attentive caring and supportive.

All reception staff and medical team members whom I spoke with were friendly reassuring and informative in their dealings with me.

GOOD PRE- AND POST-OP COMMUNICATION

Some respondents commented favourably on our pre-op (3%) and post op (2%) communication. They appreciate it when procedures are explained clearly and when they know what to expect both during the procedure and afterwards.

The surgeon explained what the surgery was going to entail and also provided me with information on what was done following the surgery … I was given clear instructions on post-operative care.

Clear information in the pre op correspondence I received. Very relaxed and friendly discussions with nurses pre and post op. Clear discussions with anaesthetist and surgeon.

QUESTIONS WERE NOT ANSWERED, STAFF WERE TOO RUSHED OR PATIENTS DID NOT FEEL LISTENED TO.

Some respondents (2%) felt they were told, rather than asked or consulted and/or were not listened to.

The doctors did not listen to what I was saying, as a result I was told that no further investigation would be undertaken to find out what is causing the pain. I got very little information about a diagnosis. As a result, I left the hospital feeling ignored, stressed and very upset.

A small number of respondents (1%) felt that their questions went unanswered.

My questions [and] queries weren't answered by doctors during morning consultations it was very vague and short.

Many of those who felt their questions weren't answered also felt that staff were too rushed to spend any time with them (1%)

The doctors and surgeons, when I asked questions regarding my treatment etc. they gave the impression they were in a rush and hurried their answers that I couldn't understand or they avoided my questions.

POOR STAFF MANNER (1%)

A small minority of respondents commented (1%) felt that staff communication skills were lacking. First interactions are important; more than half of these respondents commented that they felt reception staff had poor communication skills.

The receptionist … was rude and unfriendly - she was very reluctant to tell me answers of the things I asked her, for example where should I park the car … where to find a wheelchair etc.

I really didn't like it when people didn't introduce themselves. Not that pleasant having a complete stranger wake you in the middle of the night to poke and prod you.

POOR POST-OP AND DISCHARGE COMMUNICATION

Some respondents commented on poor post-op (1%) and discharge (2%) communication. Patients ask us not to explain information when they are still drowsy after anaesthetic and to ensure that they are given the correct and adequate discharge information and details.

Following surgery on recovering consciousness, I was briefed by the Registrar about the procedure and pictures were presented to me. Without my glasses and in a bit of a fog, I was challenged to follow the de-brief. A take-home packet of those [photos] would have been appreciated.

Report on **OutPatient Experience**
Auckland District Health Board

Communication

Effective communication is a critical underpinning of good clinical care. It is the basis on which rapport and trust are built, and therapeutic relationships are developed and maintained. As well as being an important driver of patient experience, it is also essential for patient safety and outcomes as good communication is necessary for patients, families and carers to take an active role in their own care.

Almost 1500 outpatients have now commented on our communication with them, with 77% of these comments being positive. Many (19%) of those positive comments describe the manner in which staff communicated. They describe staff who are friendly, caring, helpful, professional and efficient – all wonderful examples of staff living our values.

What is clear is that staff manner is very important for our patients and families. They want to know that their wellbeing, care and treatment matters to staff. For these patients, good communication is underpinned by empathy, kindness and compassion.

Information is also important; outpatients especially like to be given written or visual information to take with them, either to refer to again or to share with family or other providers.

It's great to see a big improvement for nurses and midwives since our previous report in July 2014. A whopping 9%, nearly an additional 10 patients in every 100, tell us that nurses and midwives ALWAYS listen to what they have to say, and an additional five in every 100 tell us they talk to them about condition and treatment in ways that are easy to understand. That's an amazing result and one our nursing and midwifery teams should be really proud of.

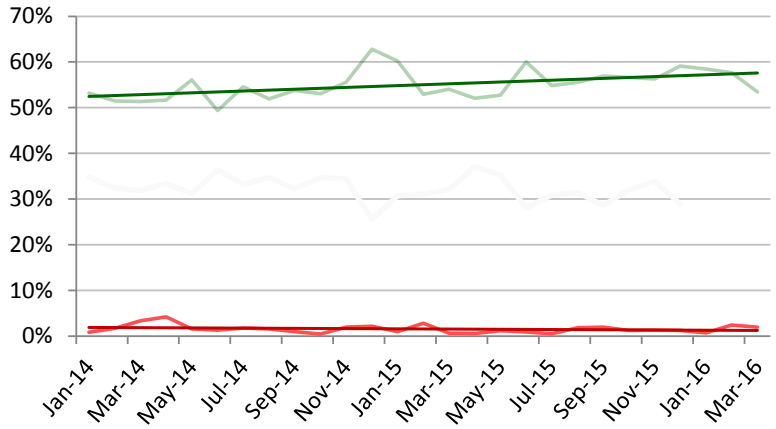
Our values: Welcome *Haere Mai* | Respect *Manaaki* | Together *Tūhono* | Aim High *Angamua,* collectively describe the process of effective communication and it's great to see the commitment of our staff reflected in these results.

Dr Andrew Old
Chief of Strategy, Participation & Improvement

OVERALL RATINGS

Our "excellent" ratings continue to rise, from an average of 53 percent in 2014, to an average of 55 percent to March 2015.

OUTPATIENT OVERALL EXPERIENCE OF CARE RATING, JAN 2014 TO MARCH 2016 (n=9838)



TOP THREE

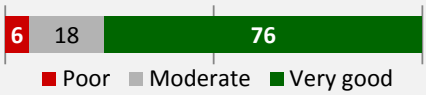
Our outpatients are asked to choose the three things that matter most.

1. Information (67%)

Getting good information is the aspect of our care most patients (67%) say makes a difference to the quality of their care and treatment.

"The main things I wanted to know were about when my operation might be scheduled and what the recovery would look like. All my questions were sympathetically answered. And I was told I could ring the clinic if my condition deteriorated. That was the most important piece of information."

How are we doing on information?

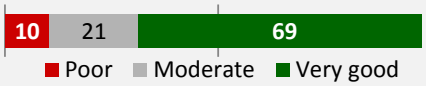


2. Organisation (53%)

For more than half of all our patients (53%), organisation, appointments and correspondence matter to the quality of their care and treatment.

"I am very fortunate to have a breast care nurse to help me liaise on appointments. Without her, it was previously more difficult."

How are we doing with organisation?

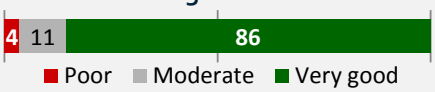


3. Confidence (51%)

Half our patients (51%) rated having confidence in their care and treatment as one of the things that make the most difference.

"Communication with the doctor was good and her explanation of my condition made me able to make a considered decision as to the treatment that I wanted."

How are we doing with confidence?



A focus on Communication

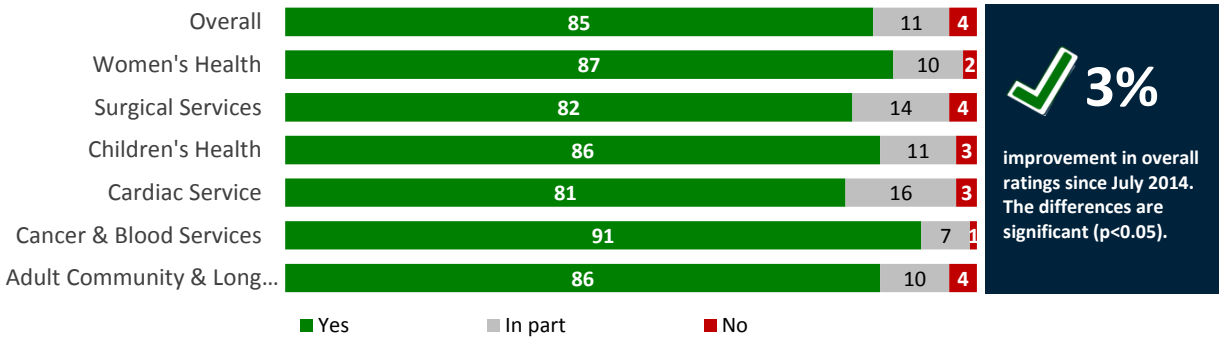
Outpatients who take part in the Outpatient Experience survey are asked if they had time to discuss their health and treatment, if they felt staff listened to what they had to say, and if they thought staff talked to them about their condition and treatment in ways that were easy to understand.

The following data are from the period April 1, 2015 to March 31, 2016. These data have been compared with data from the previous outpatients communication report, in July 2014, in order to establish whether there have been any significant changes.

Time to discuss health and treatment

The percentage of patients who say they were given enough time to discuss their health and treatment has improved by three percent when compared to the previous outpatient communication report in July 2014.

Percentage of patients who say they had time to discuss health and treatment (by directorate)

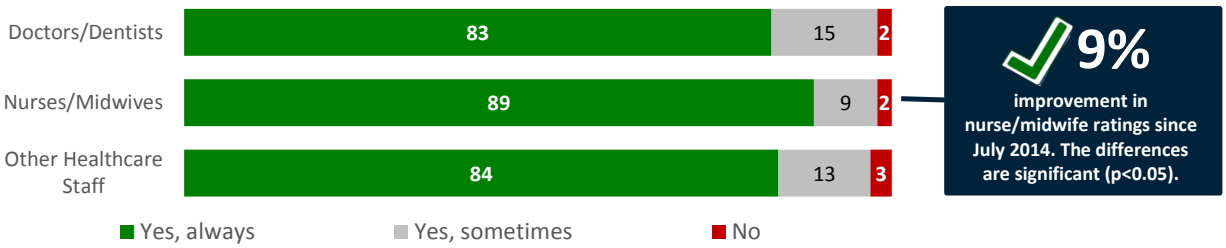


Adult community and long term conditions n=480; Cancer and Blood services n=1027; Cardiac service n=180; Children's health n=631; Surgical services n=2221; Women's Health n=672, Overall n=5211

Listening

There has been a nine percentage point increase in the numbers of patients who say that nurses and midwives listen to what they had to say, when compared with July 2014. Note that although there have been small improvements in listening ratings for doctors (2%) and other healthcare staff (2%), the differences are not significant.

Percentage of patients who say they felt staff listened to what they had to say

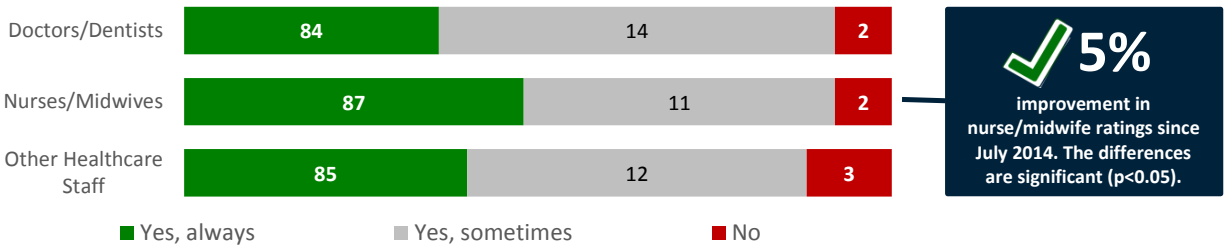


Doctors/Dentists n=4071; Nurses/Midwives n=1034; Other Healthcare Staff n=1057. Note that although there have been increases in doctors (2%) other healthcare staff (2%) ratings since July 2014, the differences are not significant.

Talking in ways that are easy to understand

Five percent more patients say that nurses and midwives talk to them in ways that are easy to understand, than in July 2014 (from 82% to 87%). Note that although there has been increase in other healthcare staff (3%) ratings since July 2014, the differences are not significant.

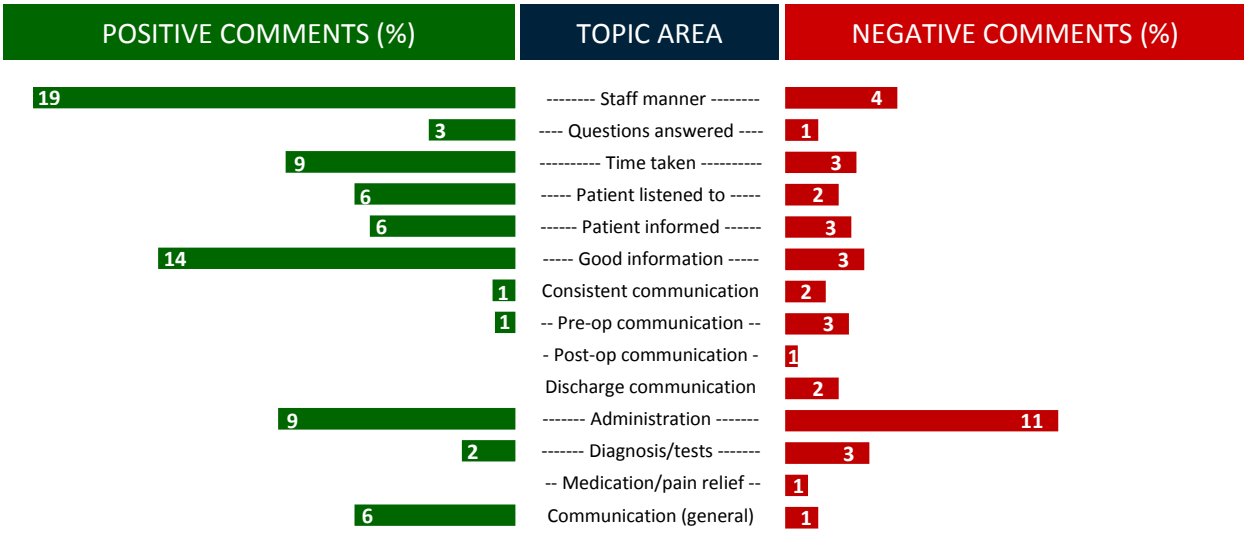
Percentage of patients who say staff talked to them about their condition and treatment in ways that made it easy for them to understand



Doctors/Dentists n=3910; Nurses/Midwives n=974; Other Healthcare Staff n=1022.

A CLOSER LOOK AT PATIENT COMMENTS

A total of 1439 outpatients commented on communication. More than three quarters (77%) of the comments were positive, while 39 percent of the comments were negative (note that some patients made both positive and negative comments, which is why total is greater than 100 percent).



PATIENT COMMENTS

GOOD STAFF MANNER (19%)

Patients were most likely to comment positively on staff manner (19%). A word frequency analysis shows that respondents use words such as friendly (n=148), caring (n=115), helpful (n=115), professional (n=54) and efficient (n=30) to describe the qualities they believe contribute to good staff manner and communication skills.

The [doctor] had a quiet and gentle demeanor thereby enabling me to speak honestly and confidently about my health issue. I felt empowered to join in the decision process.

I felt there was time, care, patience and a fundamental respect for who I was and [what] my needs were in the approach to communicating with me, by everybody.

The receptionist was very friendly and made me feel at ease. The [allied staff member] I saw was an excellent communicator - friendly, easy to talk to, a good listener, and didn't talk down to me. It was like talking to a friend!

GETTING GOOD INFORMATION (14%)

Patients appreciate it when they are given clear explanations about their care and treatment using terminology and language that is easy to understand. Many spoke about feeling more confident and as though they could make more informed decisions when this happened. A number of patients also commented on the value of having written information or diagrams.

Information conveyed in written or oral form was clear, focused and adequate.

Explanations were clear and included visuals to help.

Very clear info in laymans speak, upfront and reassuring.

POOR STAFF MANNER (4%)

Patients who commented negatively on poor staff manner (4%) mostly did so when they felt staff were disinterested, pre-occupied, or not engaged. This includes actions such as staff not introducing themselves, taking phone calls throughout the consultation, or not making eye contact. Several patients spoke about feeling ignored at reception.

The doctor seemed preoccupied and it was difficult to get straight answers from him as though he had decided and that was that.

Reception staff … are rude look totally disinterested in their role and talk to you and others in the waiting area with no respect…

[The] doctor just read from the screen. he made very little eye contact. I didn't feel like he was interested in really talking through things.

POOR INFORMATION (4%)

Patients felt they were given poor information when the types of language and terms used meant they couldn't understand what was being said, it was not detailed enough or they didn't feel comfortable or confident enough to ask questions.

Consultant used words and descriptions at a high level. Only understandable by people working in the area.

No detail was given by doctor, just a few words.

Doctor spoke to the Nurse on further action required instead of talking to me using medical terms which made it hard to understand.

I did not ask [questions] because I felt intimidated…

PATIENT COMMENTS (cont…)

GOOD ADMIN COMMUNICATION (9%)

Almost one in 10 patients (9%) commented positively on how clear the communication was around appointments, particularly the text or phone call reminders and the details in the appointment letters. Those who had to change appointments found it easy to do so. Patients also appreciated being kept up to date on waiting times whilst at the appointment.

The receptionist was amazing. She came and asked me after a while who I was there to see and then she told me she was very sorry but his clinic is running an hour behind schedule and she would see where they were up to. She followed this up and came back and informed me.

Some examples of good communication I have had are being phoned when my appointment is changed by the hospital then receiving a new letter to confirm this [and] being able to email the appointment receptionist to advise what dates are going to be unsuitable for me prior to my appointment being sent.

TIME TAKEN (9%)

Nearly one in 10 patients commented that staff took time to explain what was happening, and that they were given time to digest explanations and consider questions or choices they needed to make.

Those talking with me did not seem hurried or dismissive in any way, but gave opportunity for further questions if needed.

There was enough time in the appointment to thoroughly discuss my options. I was not rushed at all.

Didn't feel rushed and kept asking questions until I understood.

PATIENTS INFORMED (6%)

Patients appreciate it when they are informed and kept up to date on what is happening. They feel confident when they know what is happening, why it is happening and when it is happening. Patients also appreciated being kept advised on delays or waiting times.

[Staff] always made things clear as to what the next steps would be and how [things were] tracking. It made everything so much easier…

PATIENTS FEEL LISTENED TO (6%)

Patients commented positively when they felt they had been heard, that their care and treatment had been discussed with them, and when they felt in control of the decision-making process.

I was concerned re treatment plan over the long term and the doctor listened very carefully and gave relevant information to help with decision making.

I was spoken to as an adult with the ability to process information and make decisions, my questions were answered, when I left I felt that I had been fully informed.

POOR ADMIN COMMUNICATION (11%)

Most of those who commented negatively on administrative communication did so because of confusion around appointments and scheduling e.g. they were expecting a follow up appointment/letter/phone call but didn't receive one. A number of respondents requested that email is used as well as text and postal communication.

The letter that gives the first appointment at the clinic does not make it especially clear that the appointment is for a preliminary assessment. So far as the patient knows, it could be for the operation itself. This is not a big deal, but it affects mental preparedness.

At follow ups waiting time has been appalling with no explanations (50-60mins before being seen). I work and it is not appropriate to need to take that much time off work.

PATIENT FELT RUSHED (3%)

A small number of patients (3%) felt hurried or rushed. As a result, many of these patients felt that they left their appointment with unanswered questions, or little clarity around next steps.

The staff seemed overwhelmed by the number of patients they had to deal with and did not seem to be interested in me at all.

I felt rushed so don't feel I got all the info I needed & it was all very negative & not very helpful with my recovery.

It sometimes feels rushed, and it is sometimes uncomfortable to ask questions.

PATIENTS UNSURE OR UNINFORMED (3%)

Some patients (3%) felt they were not kept informed or updated about their care and treatment, and were unsure what the next steps were. A number of those who commented negatively did so because of waiting times, with many having to wait more than one hour past their scheduled appointment time.

I would like to see more care given to [children's] needs … in particular MUCH SHORTER waiting times. Young ones can't handle the 2 hour waits that other patients have to see a clinician.

PATIENTS DO NOT FEEL LISTENED TO (2%)

A small number of patients (2%) felt that they had not been listened to, or that their concerns had been brushed off or were seen as unimportant. Some of these felt as though they had limited say in their care and treatment, and that what they wanted didn't matter.

I felt the doctor wasn't listening or trying to understand my concerns. He seemed disinterested.

[I felt] talked down to and really did not listen as to what I wanted

Auckland and Waitemata District Health Board Joint DNA Strategy and 'Roadmap' of Actions

Recommendation:

That the Hospital Advisory Committee endorse the Auckland and Waitemata District Health Board joint DNA Strategy and roadmap of actions.

Prepared by: Karen Bartholomew (Public Health Physician, Health Gain Team, Auckland and Waitemata DHB); Aroha Haggie (Manager, Māori Health Gain Team Auckland and Waitemata DHB); Lita Foliaki (Pacific Health Gain Manager), John Paterson (Manager, He Kamaka Waiora, Auckland and Waitemata DHB); Bruce Levi (General Manager, Pacific Health Auckland and Waitemata DHB), Julie Helean (Assistant Director Strategy, Auckland DHB); Debi Lynch (Quality Improvement Manager, Waitemata DHB).
Endorsed by: Debbie Holdsworth (Director Funding), Simon Bowen (Director Health Outcomes).

Glossary

DHB	-	District Health Board
DNA	-	Did Not Attend
FSA	-	First Specialist Appointment
FU	-	Follow up Appointment
HAC	-	Hospital Advisory Committee
PFB	-	Patient Focused Booking
PSC	-	Patient Service Centre

1. Executive Summary

This paper presents the full Auckland District Health Board (DHB) and Waitemata DHB joint strategy to reduce inequalities in Did Not Attends (DNAs).[1] The strategic framework was endorsed at Manawa Ora in February 2016, with a request to return to Manawa Ora with a full strategy and 'roadmap' of actions. The strategic framework contains four high level areas of focus (domains) and 10 specific elements under these. The recently completed stocktake and gap analysis undertaken at both DHBs have generated a set of recommendations associated with each of the 10 strategic framework elements. These have been prioritised and the DNA strategy project team have presented a prioritised set of nine recommendations as the 'roadmap' of actions. This work has an explicit focus on equity of access, improving patient experience and patient/whanau centric services. The DNA strategy and recommended actions are system solutions intended to reflect this focus.

2. Strategic Alignment

This work has been designed to address the Waitemata DHB promise of 'Best care for everyone' and the Auckland DHB vision of world-class healthcare. The work specifically aligns with the Board priorities of better outcomes and improved patient experience.

[1] A DNA is defined by the Ministry of Health as an appointment not attended by the patient where there was no communication before the appointment.

The purpose of the DNA strategy is to address the Board strategic mandatories of equity of access to services and outcomes, cultural awareness and sensitivity, and patient safety.

The contribution to the seven Board strategic themes is provided below.

Community, whanau and patient centred model of care	The central recommendation in this paper is to implement Patient Focused Bookings (see commentary in section 4 below). This puts patients' needs at front and centre of any activity to increase equity and reduce Did Not Attend (DNA) rates.
Emphasis and investment on both treatment and keeping people healthy	The recommendations cover activities that will ensure Māori and Pacific patients in particular get greater access to the specialist assessments and treatments they need to get well and stay well. Prioritised actions address the high volume of Māori and Pacific missing out on the specialist services they need.
Service integration and/or consolidation	The DNA project has investigated ways to have GP practices more engaged with the DNA status of their referred patients. The project has suggestions for ensuring that GPs are active partners with specialist services in monitoring and increasing their patients uptake of hospital treatments.
Intelligence and insight	Recommendations cover ways in which DNA data can be better and more consistently defined and recorded. The project team also suggest ways in which the various disaggregated systems for communication, and for booking and scheduling appointments can be streamlined.
Evidence informed decision making and practice	This paper presents a detailed stocktake and gap analysis as the starting point for a comprehensive approach to the longstanding problem of high DNA rates for Māori and Pacific.
Outward focus and flexible, service orientation	The paper, although concentrated on reduced DNA rates, sets this objective within a higher goal of reducing inequity. The service reorientation offered in the recommendations demonstrates a patient/whanau-centric view that builds flexibility (particularly around appointment times) to meet patient needs.
Operational and financial sustainability	DNAs represent lost time and opportunity costs for patients and for clinicians, as well as the potential for health benefits foregone and increased future costs due to delays in diagnosis and management. This DNA project aims to reduce loss and maximise efficiencies in our booking and scheduling system.

3. Introduction/Background

Board members of the Hospital Advisory Committees (HAC) and Manawa Ora receive routine reporting on DNA rates, and have noted the significant inequalities for Māori and Pacific (two to four times higher rates than for 'Others'). There is recognition that a range of analyses and DNA reduction activities have been undertaken within both DHBs over time, with some evidence of success, but without demonstrated and sustainable overall reductions.

The Board requested that the Funder (Māori Health Gain Team) develop an evidence-based comprehensive strategy to address inequalities in DNA rates for Māori and Pacific across both Auckland and Waitemata DHB. The Funder was also asked to provide a 'roadmap' of prioritised activities to achieve this. The strategy document presents the strategic framework, the stocktake and gap analysis and the prioritised recommendations.

4. Recommendations

The DNA working group have provided recommendations on activities to address each of the 10 strategic framework elements. These have been prioritised to provide the nine recommendations below. There is one overarching policy recommendation and then the recommendations are split into four high impact but high resource recommendations, and four quick wins or lower resource recommendations. Further detail is provided on recommendation 2 (Patient Focused Bookings) and recommendation 3 (Tailored DNA Navigation Service) below.

Overarching recommendation	
1. Endorse a joint DHB explicit DNA policy addressing measurement, monitoring and management with an equity focus.	
High impact, high resource	**Quick wins or lower resource**
2. Implement Patient Focused Bookings. 3. Create a tailored DNA Navigation Service. 4. Accelerate the development of clinically appropriate alternate delivery approaches, and systematically offer these to patients. This includes a requirement to determine the medical value/necessity of an appointment. 5. Improve all communication to patients: Conduct health literacy review of standard letters and service specific letters; develop standardised transport/parking and wayfinding (map) information.	6. Ensure standardised and optimised text reminder across all services. 7. Resolve the issues limiting use of email as a contact modality for appointments. 8. Mandate cultural competence/CALD training for booking and scheduling staff (in Patient Service Centre and services who book their own clinics). 9. Review and optimise cultural competence component and assessment of values in Human Resource processes for booking and scheduling positions.

It is noted that the landscape of current activity and readiness to implement the recommendations (including IT and call centre functionality) is different at each DHB. The working group acknowledge that progression of the recommendations will potentially be over different timeframes. It is intended that business case or proposal development will progress separately for each DHB and include an assessment of current resource to achieve the recommendation. A shared evaluation protocol is proposed to assess the impact of the recommendations.

Recommendation 2: Patient Focused Booking

Patient Focused Booking (PFB) puts patients at the heart of the booking process by engaging them in a dialogue about their appointment. Previously, patients would be sent an appointment letter, with

the date and time of their appointment, no matter how far ahead in time that may have been. They may or may not have been reminded about their appointment.

With PFB patients are sent a referral acknowledgment letter or email, which confirms that they are on a waiting list. This explains that the patient will be contacted again nearer the time they are due to attend to arrange their appointment. It may also indicate the likely wait for their appointment. Urgent patients are clinically prioritised to by-pass this process, and will always be seen first, their appointment time will be immediately negotiated over the phone rather than letter. Approximately six weeks before they are due to attend; the patient receives the second letter or email inviting them to telephone to arrange an appointment. When the patient phones, the call operator offers a choice of dates and times and the patient chooses the most convenient to them.

The above process is described as 'partial' PFB in comparison to electronic PFB (self-book appointment times online). Electronic PFB is being investigated at both DHBs (proposed timeline of 2-3 years, although this may be accelerated). The DNA strategy proposes implementation 'partial' PFB because the service redesign process is the same for both models and can be undertaken with patients benefiting from 'partial' PFB while awaiting electronic PFB.

The DNA working group recommend implementation of PFB with equity built in from the start through the establishment of a Tailored DNA Navigation service.

Recommendation3: Tailored DNA Navigation Service
The strategy proposes establishment of a formal Tailored DNA Navigation Service. Currently both DHBs have an un-coordinated series of reminder phone calls (call to remind) and post DNA contact/management. There is a variable approach to targeting resource to these DNA prevention and management activities, with substantial person resource investment and probable duplication of effort. Patient Service Centre, service administrative staff, service clinical staff (nursing and allied health), and Māori and Pacific Health teams may be contacting the patient for the same appointment (or multiple service appointments).

Māori and Pacific health teams in particular have had variable targeting of their call lists and volumes and their ability to provide this service is dependent on staff availability/illness and other ward activities.

The Tailored DNA Navigation service would conduct the following activities:

- Contact management for targeted patients who have not self-booked in PFB, to avoid these patients being selected out of a Patient Focused Bookings process.
- Call to remind activities for targeted patients.
- Post DNA management for targeted patients.

The DNA strategy proposes targeting of patients by a range of factors including 'high flier' status, ethnicity, clinical criteria, First Specialist Appointment and other flags (eg high medical and/or social complexity). Further work needs to be undertaken on the appropriate 'risk matrix.' The strategy also proposes dedicated, skilled and culturally competent staff located to allow access to schedulers to reschedule appointments to meet the needs of patients and whānau.

Transparency of current resource allocation, and planned allocation in the context of Patient Focused Booking, is requires to establish an efficient Tailored DNA Navigation service model. Potential primary care involvement in DNA prevention and management activities is considered under the Tailored DNA Navigation service.

5. Alignment with current work programmes

The proposed DNA strategy recommendations links to the following current or proposed activity at each DHB:

Waitemata DHB

- The Patient Focused Booking and administration process redesign (Medical outpatients). Led by the Improvement team within the Institute of Innovation and Improvement.
- Proposal development for electronic Patient Focused Booking, led by the Institute of Innovation and Improvement.
- The Better Outpatient Follow up Project under the Leapfrog programme.
- The Outpatient Outcome Process Project under the Continuity of Care programme Waitemata DHB.

Auckland DHB work signalled in the 2016/17 Provider Plan:

- Outpatient redesign includes DNA as an outcome measure. Led by Clinical Support Services.
- Development of electronic Patient Focused Booking under the Northern Electronic Health Record (NHER) work programme.
- Community and Long Term Conditions directorate reduction of DNA target of <9% as an explicit measure in their workplan.
- The development of a 'Was Not Brought' policy in Child Health.
- Relationship to both Faster Cancer Treatment tumour stream specific patient pathways and the work programme using the Hospital Wisely (improved use of hospital and community services to reduce acute demand).

6. Transition planning

The Funder (Māori Health Gain Team) has undertaken the strategic framework development and developed the recommended activities. It is intended that after feedback and endorsement of the strategy and recommendations at Manawa Ora and both DHB the Hospital Advisory Committees, that this work is returned to the Provider for further action. The working group have suggested that several of the recommendations require further development; investment proposals or business cases. This work would align with the programmes of outpatient redesign at both DHBs.

7. Risks/Issues

As noted above there is a range of work underway, particularly in the Outpatient redesign, Outpatient follow ups and Patient Service Centre redesign areas. The project team have identified projects underway in these areas and recommended their support in relevant elements. For example there is a planned rollout of 'partial' Patient Focused Bookings at Waitemata DHB in Medicine from October 2016. This activity requires telephone upgrades (currently on hold due to technical and security issues) and ideally call centre functionality. There is no customer service staff resource currently available; however this would be a requirement for successful scale-up of Patient Focused Bookings.

Auckland DHB IT capability is limited to provide technological solutions to support Patient Focused Bookings at this time, although process redesign and improvements can be supported.

In systems solution to address DNAs equity needs to be built in from the start. The project team have recommended a Tailored DNA Navigation service as one way to explicitly address equity with large scale systems improvements such as Patient Focused Bookings.

The recommendation regarding accelerating the development of alternate delivery methods is another high impact activity that is related to current in-flight projects and programmes of work. Through this work however the project team has identified opportunities to further develop and systematically offer patients these alternate delivery approaches.

8. Conclusion

The DNA strategy document sets out an evidence-based framework and comprehensive assessment of current state and opportunities for high impact activities to reduce DNAs across both DHBs. The project team recommends all activities to reduce inequalities in DNAs; however nine recommendations have been prioritised to form a 'roadmap' of actions. Reducing DNA rates will ensure that Māori and Pacific patients will get better access to the assessment and treatment services they need, and consequently be supported to get well and stay well.

Auckland and Waitemata District Health Board
Joint DNA Strategy
July 2016

Endorsed by

Name	Role	DHB
Debbie Holdsworth	Director Funding	ADHB/WDHB
Simon Bowen	Director Health Outcomes	ADHB/WDHB

Project Team

Name	Role	DHB
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John Paterson	Manager, He Kamaka Waiora	ADHB/WDHB
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Julie Helean	Assistant Director Strategy	ADHB
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Our thanks also go to the patients who have provided such valuable feedback to help us improve our services and focus our efforts.

Our thanks also to Jeremy Muirhead for his assistance with the thematic analysis and data interpretation, and to Tony O'Connor and Jay O'Brien for their assistance with highlighting patient experience.

The evidence base for this project was greatly assisted and built upon by the following work:

- Outpatient Improvement Project – DNAs; Waitemata DHB Surgical & Ambulatory Service; Lael Meredith Project Manager
- The DNA service redesign work at:
    - Bay of Plenty DHB, commentary and further analyses and background provided by Dr Richard Vipond
    - Counties Manukau DHB, commentary by Dr Gloria Johnson, Chief Medical Officer
    - Hawkes Bay DHB, reports by Dr Caroline McElnay
    - Hutt Valley DHB, reports by Dr Saira Dyal
    - Canterbury DHB, discussion by Dr Melissa Kerdemelidis

Abbreviations

B&S	-	Booking and Scheduling
CALD	-	Culturally and Linguistically Diverse
CNS	-	Clinical Nurse Specialist
DHB	-	District Health Board
DNA	-	Did Not Attend
FSA	-	First Specialist Appointment
FU	-	Follow Up Appointment
HAC	-	Hospital Advisory Committee
LTC	-	Long Term Conditions
PFB	-	Patient Focused Booking
PSC	-	Patient Service Centre
VFSA	-	Virtual First Specialist Appointment

Executive Summary

This document contains an evidence-based strategic framework to reduce inequalities in clinic Did Not Attend (DNA) rates. The framework was developed by the Funder (Māori Health Gain) at the request of Auckland District Health Board (DHB) and Waitemata DHB Board Committee members.

The strategic framework contains four high level areas of focus:

1. Systems and Value
2. Access
3. Experience
4. Outcome

Under the four high level areas of focus sit 10 specific elements. All elements are focused on patient/whānau centric systems solutions, and are aligned with the Board priorities, DHB values, and the joint DHB strategic themes and mandatories.

The selection of language in the strategic framework was intended to address two key decisions:

- That the strategy would focus on system solutions rather than patient factors.
- That it would not be titled a Māori and Pacific DNA reduction strategy in order to reinforce the system solution perspective and to avoid stigma.

The strategic framework establishment was followed by the development of set of activities with the highest impact for reducing inequalities in DNA rates. The method undertaken to achieve the prioritised list of activities was a stocktake and gap analysis at both DHBs. This work was led by a small project team and the recommendations were developed and confirmed with key stakeholders. From the larger set of recommendations to address each element of the strategic framework the project team developed a set of 'roadmap' activities prioritised by impact and resource requirement which is presented in this document.

Auckland DHB and Waitemata DHB DNA Strategy Prioritised 'Roadmap' of Activities.

Overarching recommendation	
1. Endorse a joint DHB explicit DNA policy addressing measurement, monitoring and management with an equity focus.	
High impact, high resource	**Quick wins or lower resource**
2. Implement Patient Focused Bookings. 3. Create a tailored DNA Navigation Service. 4. Accelerate the development of clinically appropriate alternate delivery approaches, and systematically offer these to patients. This includes a requirement to determine the medical value/necessity of an appointment. 5. Improve all communication to patients: Conduct health literacy review of standard letters and service specific letters; develop standardised transport/parking and wayfinding (map) information.	6. Ensure standardised and optimised text reminder across all services. 7. Resolve the issues limiting use of email as a contact modality for appointments. 8. Mandate cultural competence/CALD training for booking and scheduling staff (in Patient Service Centre and services who book their own clinics). 9. Review and optimise cultural competence component and assessment of values in Human Resource processes for booking and scheduling positions.

The proposed DNA strategy recommendations links to the following current or proposed activity at each DHB:

Waitemata DHB

- The Patient Focused Booking and administration process redesign (Medical outpatients). Led by the Improvement team within the Institute of Innovation and Improvement.
- Proposal development for electronic Patient Focused Booking, led by the Institute of Innovation and Improvement.
- The Better Outpatient Follow Up Project under the Leapfrog programme.
- The Outpatient Outcome Process Project under the Continuity of Care programme Waitemata DHB.

Auckland DHB:

- Outpatient redesign includes DNA as an outcome measure. Led by Clinical Support Services.
- Development of electronic Patient Focused Booking under the Northern Electronic Health Record (NHER) work programme.
- Community and Long Term Conditions directorate reduction of DNA target of <9% as an explicit measure in their workplan.
- Relationship to both Faster Cancer Treatment tumour stream specific patient pathways and the work programme Using the Hospital Wisely (improved use of hospital and community services to reduce acute demand).

Introduction

Measurement and monitoring of local clinic Did Not Attend (DNA) rates is established practice within District Health Boards (DHBs). Although DNA rates are not routinely monitored as an indicator by the Ministry of Health, and there are no national targets, there is an established Ministry of Health definition "an appointment not attended by the patient and there was no communication before the appointment."[1] Where DNA rates are monitored there are a number of ways these can be reported. The standard reporting limits DNA rates to Consultant First Specialist Appointments (FSA) and Follow Up (FU) Appointments only (therefore excludes nursing clinics, allied health and other clinic types).

Board members of the Hospital Advisory Committee (HAC) for both DHBs and the joint DHB Manawa Ora Committee receive routine reporting on DNA rates, and have noted the significant inequalities for Māori and Pacific (two to four times higher rates). The Committees have visibility of a range of analyses and DNA reduction activities that have been undertaken within both DHBs over time, with some evidence of success, but without demonstrated sustainable overall reductions.

The Funder (Māori Health Gain Team) was requested to develop a comprehensive evidence-based strategy to address inequalities in DNA rates for Māori and Pacific across both Auckland DHB and Waitemata DHB. In addition the Funder was requested to provide a set of recommended activities (a 'roadmamp') for both DHBs to achieve meaningful and sustainable reductions in DNAs.

This document presents the:

1. Strategic framework.
2. Stocktake and gap analysis.
3. Recommendations and prioritised 'roadmap' of activities.

1. The Strategic Framework

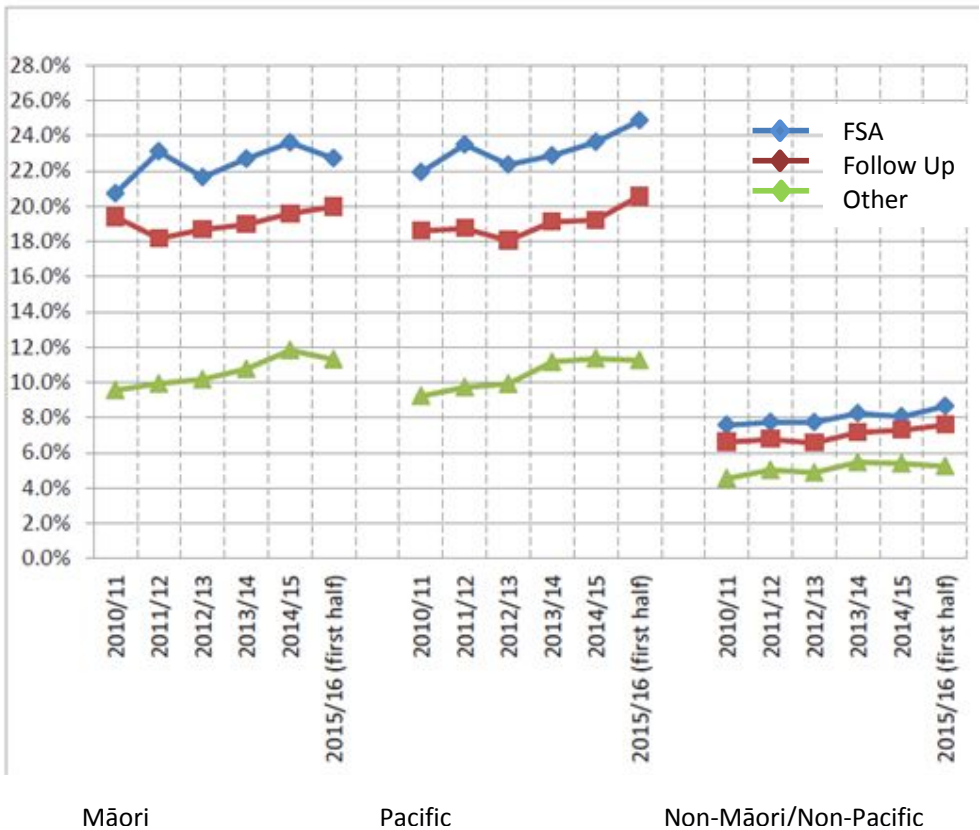
Evidence-based strategy development

The international literature, national and local experience was reviewed to develop an evidence-based strategic framework. This included published literature, grey literature, key informant interviews, internal and public DHB document review and review of similar compiled assessments from other sources, for example other literature views on the topic eg Te Tumu Whakarae literature review[2] and the literature review for the Waitemata DHB Outpatient Improvement Project.[3] The key high level features from these assessments that shaped the strategy development are discussed below.

DNA rates

Overall First Specialist Appointments (FSA) have higher DNA rates than Follow Up Appointments (FU) and this difference is much larger for Māori and Pacific (see Figure 1 below). In terms of volume approximately 75% of outpatient attendances are for Follow Up Appointments. Consultant FSA and FU appointments (the DHB measure of DNA rates reported to Board Committees) both have substantially higher DNA rates than other clinic types (eg allied health, nurse clinics, procedure clinics).

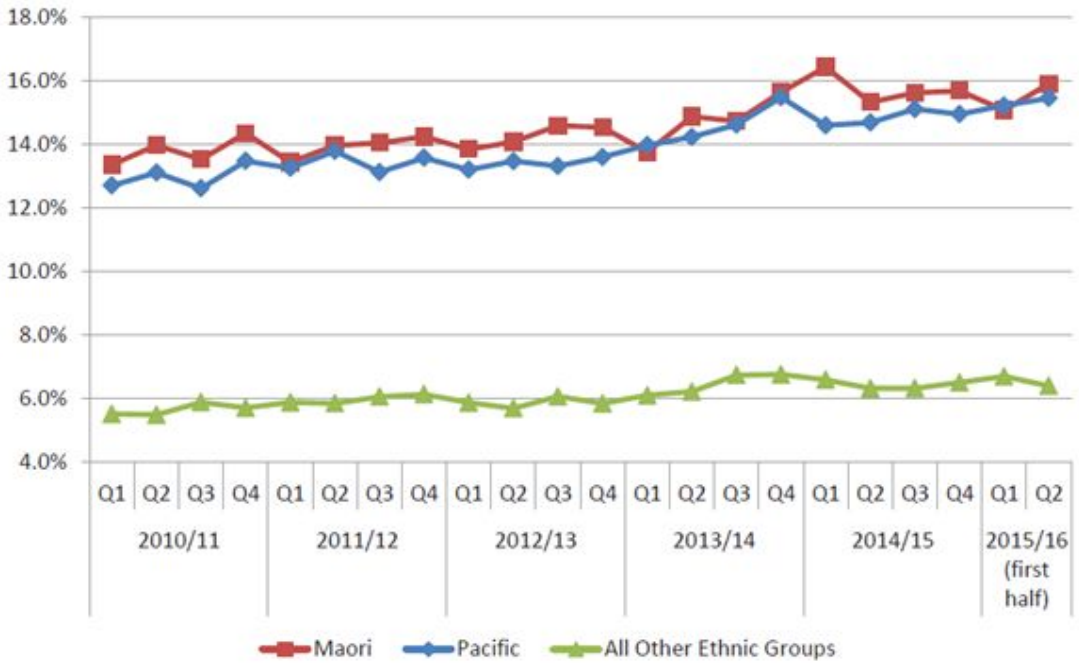
Figure 1. DNA rates by ethnicity and appointment type, Auckland DHB



Source: Analysis presented to Auckland DHB Hospital Advisory Committee March 2016

Māori and Pacific DNA rates are consistently higher than other ethnicities (2-3 times higher) and have not sustainably reduced over time. For example recent Auckland DHB analyses indicate that DNA rates per year for the Māori and Pacific overall sit at 14-15%, with other populations groups DNA rates of 5-6% (see Figure 2).

Figure 2. Auckland DHB DNA trend by ethnicity 2010/11 to 2015/16 (year to date).



Source: Analysis presented to Auckland DHB Hospital Advisory Committee March 2016

Specific services have much high inequalities in DNA rates than the DHB average, in the order of 30-40% DNA rates for Māori and Pacific. Both DHBs have identified directorates, services and clinics with the highest DNA rates.

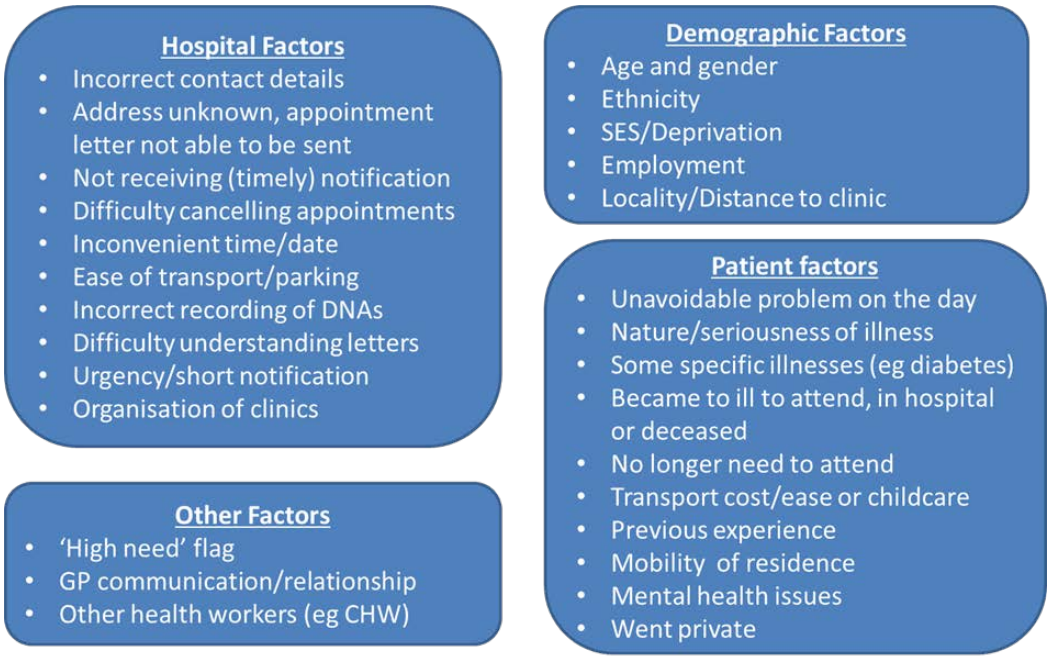
While deprivation is an important factor related to DNA rates, Auckland DHB in-depth analysis demonstrates that the least deprived Māori and Pacific patients still have higher DNA rates than the most deprived European patients.

Most of the high DNA rate for Māori and Pacific are driven by multiple missed appointments. For example in Waitemata DHB on average per year for the last five years approximately 3,000 Māori and Pacific patients generated approximately 6,500 DNAs. Approximately 80% of DNAs for Māori and Pacific patients were generated by 20% of patients (approximately 600-800 per year) who had DNA'd more than twice ('high fliers').[3]

Factors related to DNA

Most narratives around DNA tend to focus on patient related factors such as motivation, value placed on appointments, demographics (ethnicity/deprivation/location), opportunity costs and 'chaotic lives.' What is clear from the substantial literature[4-6] on the topic (including Māori and Pacific specific analysis in a DHB context)[3] is that we know why people DNA, and although patient factors are important the majority of the reasons for DNA are systems issues. Issues include current inability to book appointments that suit people, booking and scheduling issues and variable reminder systems. Parking, transport, confusion and time off work are also substantive issues. Factors related to DNAs are outlined schematically in Figure 3.

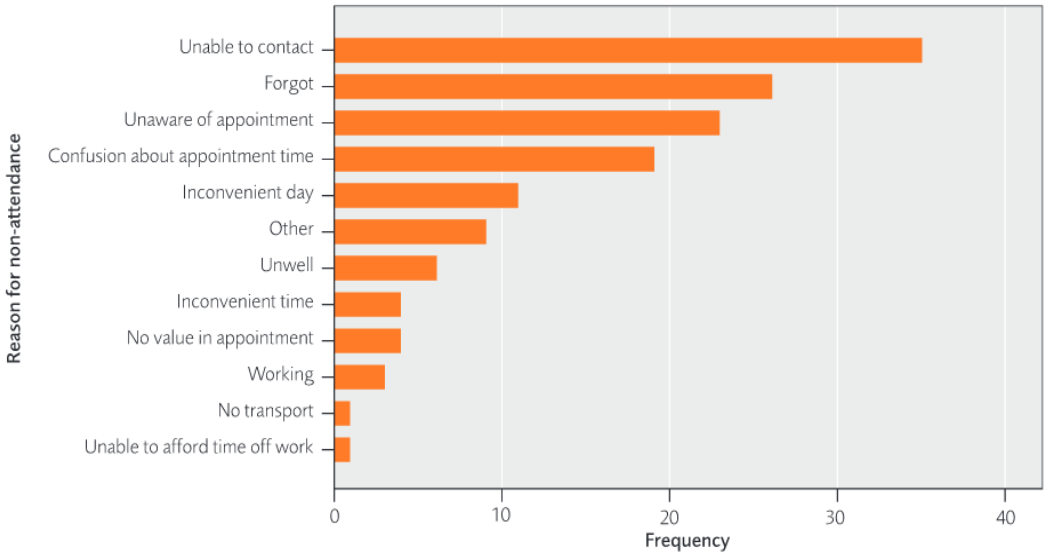
Figure 3. Evidence based factors identified related to DNAs



Reasons for DNA

When patients are asked what the primary reason for DNA is the response is consistent internationally and between services, and these are the very similar in a DHB context in New Zealand and for Māori and Pacific.[7-10] An example of New Zealand evidence is shown in Figure 4. The category of 'forgot' (the primary or secondary reason in all analyses) has been explored in a range of qualitative work, including locally[11] and through experience in the Māori and Pacific teams at Auckland and Waitemata DHBs. This category reflects primarily systems issues when examined in more depth: suboptimal or no reminder, inconvenience, confusion, unclear value, opportunity cost, previous negative experience. Several other reasons for DNA generally described as 'patient factors' (see Figure 3) are also intimately related to systems issues. One of these illustrated in the Waitemata DHB Outpatient Improvement Project 2014 was that 40% of patients surveyed had attempted to reschedule their appointment, and many were surprised they had been categorised as a DNA as they believed that they had left messages with booking clerks which would be actioned.

Figure 4. Primary reason for DNA at a Wellington diabetes clinic. Source: Wilkinson & Daly 2012.[12]



Evidence base for interventions

The international literature, and local DHB experience, demonstrates that Patient Focused Bookings (PFB) is the single initiative that substantially reduces DNAs.[13] Pre-appointment phone call (call to remind)[14, 15] and text reminders have high quality evidence to support their effectiveness in reducing DNAs; text reminders are more cost effective and rescheduling can be conducted with a phone contact. Summarised high level evidence for the effectiveness of interventions is outlined in Table 1.

Table 1. High level evidence summary of intervention effectiveness

- Overall summary DNA interventions result in an average absolute reduction 10% (relative reduction 40%).
- Patient Focused Bookings
  - Covers a spectrum from partial PFB (hospital or service generated) to open-access patient scheduling (eg Choose and Book in the NHS).
  - Is the most effective intervention, 16% overall absolute DNA reduction.
- Reminder systems
  - Texts and phone call equally effective; 8-10% absolute DNA reduction.
  - Text is more cost effective than phone reminders. Depends on having a mobile and well maintained contact details. A few privacy concerns and wrong numbers noted.
  - Texts cost 40-60% less than phone reminder (NHS estimate of £9-13 per DNA avoided).
  - Automated phone reminders also effective, slightly less than manual (29% vs 39% relative reduction). Benefit of manual phone is immediate rebooking.
  - Of note, there was no difference in DNA rate between a text or phone reminder at 1 day or 1 week before the appointment.
  - Letters are the least effective, 7% reduction, but the cost is between text and phone.
- Only outcome for the reviews was DNAs, authors recommend also looking at increased cancellations (ie rescheduling) as a positive outcome – earlier reminder (eg 1 week before appointment) allows rescheduling whereas 1-3 days may be more problematic for rescheduling.

Source: Systematic reviews 2011,[16] 2012[17, 18] and 2015;[19] Cochrane review 2013[20]

There are standalone evidence based packages[21] of interventions for hospitals to reduce DNAs as well a comprehensive guidance available from the United Kingdom National Health Service (NHS)[22] and the Ministry of Health (Electives DNA reduction guidance 2013).[1] The bundles of interventions recommended in these evidence based documents are noted in Appendix 1.

Strategic framework

The Funder developed and presented a DNA strategic framework containing four focus areas (domains) and 10 elements. This was endorsed by Manawa Ora in February 2016.

The premise of the framework is that DNAs are primarily a systems problem requiring systems solutions. The focus of the work is on DNAs as an issue of equity of access and poor patient experience (recognising that issues of health care benefits foregone and cost are associated with these) but the strategy is not called a Māori and Pacific DNA reduction strategy in order to maintain the focus on requiring systems improvement and to avoid stigma. The four areas of focus are (see Figure 5 below):

1. Systems and Value
2. Access
3. Experience
4. Outcome

The focus areas reflect the aims and values of both DHBs in terms of improved outcomes and patient experience. Manawa Ora requested that the committee receive the full strategy, including an agreed 'roadmap' of prioritised activities, and clarity on areas that may require investment for the 13 July 2016 meeting.

Figure 5. DNA Strategic Framework

2. Stocktake and Gap Analysis

A stocktake and gap analysis was undertaken by the Funder in collaboration with both Auckland DHB and Waitemata DHB Provider over a 6 week period in April-May 2016. The purpose of the stocktake and gap analysis was to clearly articulate the range of activity already existing or planned, identify key related in-flight projects, and describe any relevant previous DNA analytical or project work to reduce DNAs and their impacts where known. Relevant patient experience work has also been a focus.

Method

The stocktake and gap analysis were conducted with identified managers and clinical leads in the services already identified by both DHBs with the highest DNAs and inequalities in DNAs (12 services at Waitemata DHB and three directorates at Auckland DHB). Other key staff were also included, for example Patient Experience, Quality Improvement, Patient Service Centre and Māori and Pacific cultural support staff. The analysis was limited to the prioritised service areas due to the short timeframe and the potential for highest impact. Despite the time limitations this piece of work has been a substantial exercise and has resulted in a comprehensive review of DNA activities.

The method was either a semi-structured face to-face interview or an electronic questionnaire based on the 10 elements of the strategic framework (tool provided in Appendix 2). These were undertaken by Julie Helean (Assistant Director Strategy Auckland DHB) and Debi Lynch (Quality Improvement Manager Waitemata DHB) and discussed in a series of workshops with key Provider staff including the Provider Māori and Pacific health managers.

Summary of Findings

The high level assessment of the stocktake and gap analysis indicates a large and variable range of activities across both DHBs, with a number of in-flight projects as well as previous initiatives that have not been sustained or received further investment. The highlights of the stocktake and gap analysis are provided in Appendix 3. Comprehensive assessments against the framework by service are available on request.

<u>Waitemata DHB</u>

The large Outpatients Improvement Project in 2014 included extensive in-depth DNA analysis (DHB and national rates and activities), patient and provider surveys and assessment of current DNA reduction work. These assessments were included in the evidence to inform the strategic framework as noted above. Text reminders, letters and transport were also reviewed as part of the project. Clinics had already been moved to Whānau House (Te Whānau O Waipareira co-located centre in West Auckland; for example diabetes and paediatric clinics). The Outpatients Improvement Project resulted in a series of recommendations many of which have been on hold or have not been progressed due to additional funding requests being declined (for example the staff service centre business case).

The work Outpatient Improvement Project included a GP pilot in West Auckland in late 2014 which included call to remind activity in primary care (supported by the project manager), as well as the co-benefit of primary care insight into patient groups and access to primary care contact details. The GP pilot was not sustained for a number of reasons, including resource requirements and primary care capacity. Results of this pilot suggest lower DNA rates for those patients contacted, however it is not clear if the call to remind activity was contributory to attendance as there was no comparison group. The pilot included other activities than call to remind, including community network liaison, whanau engagement and patient transport support with Te Whānau O Waipareira. Contactability of patients was noted to be an issue in the GP pilot (able to contact and speak to approximately 50% of patients; 30% incorrect phone or no voicemail, 15% voicemail and no further contact). Contactability is noted

in call to remind activities from the provider as well as patient experience surveys undertaken by the provider and the Funder in other service areas. Contactability was an issue considered under the framework element 1.3 in the stocktake and gap analysis, and specifically noted in the Patient Focused Booking section below.

Service action plans have been instituted and DNA reporting by a variety of service and patient metrics has been available since the project. A range of related projects have been undertaken including planning for roll out of Patient Focused Booking in Medicine from late 2016 (including the specialties with high DNA inequalities for Māori and Pacific diabetes, respiratory and cardiology). This substantive project includes the requirements to develop and standardise clinic profiles, the need to plan a reduction in future clinic appointment availability in order to have spaces to allow patients to choose from and the telephone system upgrade in the Patient Service Centre (PSC) in order to manage the volume of calls direct to scheduling staff.

Other relevant work includes the roll out of the 'Patient Services Guidelines and Process Management for Scheduled Care' to the wider provider arm elective services; workup of an electronic Patient Focused Booking concept and proposal; determining the value of outpatient Follow Up and consideration of alternate modes of clinic delivery under the Outpatient Leapfrog project; outpatient outcomes coding proposal (under the Continuity of Care programme); virtual FSA (VFSAs) in Women's Health and Clinical Nurse Specialist (CNS) call phone follow up in several services. Some services conduct call to remind activity via the service (eg liaison staff in Women's Health, CNS in diabetes) and via Māori and Pacific Health services. Māori Health attempts to call approximately 60% of the patients on the prioritised lists (limited to specific services and a focus on FSAs).

Auckland DHB

As part of Acute Patient Flow and reducing wait times work an assessment of outpatient Follow Up Appointments was conducted via Concord projects in 2014-15 focused on the necessity of Follow Up appointments and the possibility of introducing a systematic assessment for alternatives (eg GP Follow Up, Clinical Nurse Specialist, virtual or phone Follow Up). ORL and neurosurgery conducted audits which indicated up to 60% of appointments could be done differently. Rheumatology conducted a similar a review and found 15-35% could have been done differently. Similar work was undertaken in cardiology. These recommendations however do not appear to have been taken further, or adopted more broadly in other services.

Recent analytical work has indicated that three directorates have the highest DNAs: Adult Community and Long Term Conditions (LTC; the diabetes clinics are the driver of the highest rates), Children's Health and Surgical Services and that these have (on average) been increasing over the last four years. A range of service specific activities have been undertaken in each directorate, with the most sustained focus in Adult Community and LTC achieving a successful 10% relative reduction in diabetes clinics over the last year. A small number of services reviewed in the stocktake (eg Cancer and Blood, Women's Health, Children's Health, and renal) have tried to allow some flexibility in appointments within current parameters; however the largest component of activity is service specific reminder (phone/text) activity and post DNA management via Clinical Nurse Specialists and Māori and Pacific health teams. The demand for calling exceeds the resource to conduct call to remind activities, and Māori Health note that due to the large call volume for Auckland DHB even when prioritised lists (by service and FSA) they are only able to undertake to call 20-40% of patients.

At Auckland DHB there is currently no policy to implement Patient Focused Bookings but there are initiatives that allow greater flexibility for patients, in particular the recent changes to the Patient Service Centre (extended hours, call to remind activity, letter and text reviews, increased capacity).

Child health is developing a pathway for managing missed appointments, referred to as 'Was Not Brought'. The pathway will set expectations for everyone involved in the care pathway, including GPs, and will introduce booking, choice and access guidelines. A key element in the approach is establishing a relationship with an active supporter in the child's life and conscripting their help in getting the child to all appointments.

A programme work is underway at Auckland DHB to redesign outpatient systems, and similarly at Waitemata DHB under the Leapfrog Outpatient Follow Up project. The redesign aims to provide a high quality outpatient service and experience that is patient centric, timely, and in an appropriate setting. At Auckland DHB the initial focus will be on making rescheduling of appointments much easier, with better use of technology and through improved links with primary care. The DNA work signalled in this document will align closely with, and support the work within the Outpatients Redesign.

3. Recommendations and Prioritised 'Roadmap' of Activities

Each of the 10 framework elements have a list of recommended high impact activities associated with them and then recommendations from the DNA project team, (see Appendix 3). The project team consider that all activities are required to achieve a comprehensive approach to reducing inequalities in DNA rates.

The project team considered a range of options for prioritisation of the recommendations to be included in the 'roadmap' of activities. Nine recommendations have been prioritised in the following way: An overarching recommendation related to DNA policy, four recommendations considered to be high impact but high resource and four recommendations considered to be quick wins or lower resource. The prioritised recommendations are provided in Table 3.

Table 3. Summary of prioritised recommendations for 'roadmap' of activities, prioritised by impact and resource

Overarching recommendation	
1. Endorse a joint DHB explicit DNA policy addressing measurement, monitoring and management with an equity focus.	
High impact, high resource	**Quick wins or lower resource**
2. Implement Patient Focused Bookings. 3. Create a tailored DNA Navigation Service. 4. Accelerate the development of clinically appropriate alternate delivery approaches, and systematically offer these to patients. This includes a requirement to determine the medical value/necessity of an appointment. 5. Conduct health literacy review of standard letters and service specific letters; develop standardised transport/parking and wayfinding (map) information.	6. Ensure standardised and optimised text reminder across all services. 7. Resolve the issues limiting use of email as a contact modality for appointments. 8. Mandate cultural competence/CALD training for booking and scheduling staff (in Patient Service Centre and services who book their own clinics). 9. Review and optimise cultural competence component and assessment of welcoming values in Human Resource processes for booking and scheduling positions.

Commentary on prioritised activities

Recommendation 1: Explicit DHB DNA policy

Both the NHS and the Ministry of Health Elective Guidance for DNAs recommend an organisational policy on DNAs which addresses measurement, monitoring and management. Such a policy fits with both organisation's themes of patient, community and whanau-centric care. Neither DHB currently has an organisational policy although Waitemata DHB is currently expanding (for non Patient Service Centre Team Leaders) and refreshing (for PSC Team Leaders) training on the 'Patient Services Guidelines and Process Management for Scheduled Care' which are business rules that include DNA management.

Recommendation 2: Implement Patient Focused Bookings

Patient experience surveys and interviews/surveys conducted by the DHBs on why people DNA indicate a frustration with lack of flexibility in booking and scheduling systems, particularly the inability to choose the time and date of the appointment. Below is a selection of the large amount of feedback on this topic.

"I feel like it is a lottery to get an appointment date and it feels as though I'm in a black hole with no hope of knowing when or if I might hear from the clinic. I personally feel the clinic is impossible to reach when trying to confirm or change an appointment. It is very stressful wondering when the next appointment might be." Auckland DHB

"It would be so much better if we had the option to pick a date and time by ourselves." Waitemata DHB

Patient Focussed Booking (PFB) puts patients at the heart of the booking process by engaging them in a dialogue about their appointment. Previously, patients would be sent an appointment letter, with the date and time of their appointment, no matter how far ahead in time that may have been. They may or may not have been reminded about their appointment.

With PFB patients are sent a referral acknowledgment letter or email, which confirms that they are on a waiting list. This explains that the patient will be contacted again nearer the time they are due to attend to arrange their appointment. It may also indicate the likely wait for their appointment. Urgent patients are clinically prioritised to by-pass this process, and will always be seen first, their appointment time will be immediately negotiated over the phone rather than letter. Approximately six weeks before they are due to attend, the patient receives the second letter or email inviting them to telephone to arrange an appointment. When the patient phones, the call operator offers a choice of dates and times and the patient chooses the most convenient to them.

There are two forms of Patient Focused Bookings. The first is 'partial' and the second is electronic. The above process is described as 'partial' PFB in comparison to electronic PFB (self-book appointment times online). The two forms are compared in Table 4 below. In most jurisdictions 'partial' PFB is implemented prior to electronic PFB. Both forms require a substantive managed change process regarding changes to scheduling, administrative and clinical components of outpatient workflow.

Electronic PFB is being investigated at both DHBs (proposed timeline of 2-3 years, although this may be accelerated). The DNA strategy proposes implementation 'partial' PFB because as noted above the service redesign process is the same for both models and can be undertaken with patients benefiting from 'partial' PFB while awaiting electronic PFB.

Table 4. Comparison of forms of Patient Focused Bookings		
	'Partial' Patient Focused Bookings	**Electronic Patient Focused Bookings**
High level process	• Patients advised of probable clinic visit (usually by letter) • If appointment not to be booked immediately then re-contact at 6 weeks prior to book into clinic in next 6 weeks • Offered to choose appointment time/date within that 6 weeks • Appointment date/time confirmation (usually by letter) • May also receive an appointment reminder (text/phone)	• At the point of clinic acceptance the GP gives patient an online clinic booking code to proceed • Patients book clinic appointment directly online once referred • Offered available appointment selection and self-book • Appointment date/time confirmation • May also receive an appointment reminder (text/phone)
Comments	• Risk of self-selection of patients most contactable and these patients are not counted as DNAs (therefore DNA rates may improve in part from patients who DNA not engaging in PFB) • In other jurisdictions, including the NHS partial PFB was initiated in FSA then extended to FU • Requires contact centre functionality, particularly to manage the increased incoming call volume • Strict no hospital clinic cancellation policy • Requires standardised clinic protocols ('profiles') which is substantive work • Requires enforcement of clinician leave restrictions (contract)	• Even higher risk of self-selection of patients most able to take up the opportunity of online systems and these patients are not counted as DNAs (therefore DNA rates may improve in part from patients who DNA not engaging in PFB) • Still requires contact centre functionality but this changes to a clinic management function (ensuring that slots are filled, clinics run efficiently and clinicians are available) • Requires standardised clinic protocols ('profiles') which is substantive work • Requires enforcement of clinician leave restrictions (contract)
Examples	• Counties Manukau DHB PFB • Waitemata DHB planned PFB in Medicine	• uBook Hutt Valley DHB • Choose and Book NHS

Patient Focused Booking is clearly demonstrated in the literature to be the highest impact activity in reducing the DNA rate with achievement of 3-5% DNA rates demonstrated in some jurisdictions. A four month diabetes trial of PFB at Waitemata DHB demonstrated a reduction in DNAs for Māori patients from 45% to 15%. Counties Manukau DHB implemented a package of DNA measures including PFB and bus transport changes and saw a significant reduction in DNAs including for Māori and Pacific. There is otherwise limited literature on PFB impact in DNA inequalities[24] and the working group has recommended building equity into the PFB parameters via the Tailored DNA Navigation Service.

PFB requires contact centre functionality. Currently Waitemata DHB has no contact centre and very limited customer service functionality within the Patient Service Centre (elective surgical focus; other calls come direct to schedulers or answer phones). Auckland DHB has contact centre functionality however the scheduling service is dispersed across a wider range of clinics and sites.

Waitemata DHB also has the majority of scheduling staff in the services, however there is a higher degree of co-location in the Patient Service Centre than at Auckland DHB. There are opportunities in considering either form of PFB to consider co-location of all schedulers (such as in Counties Manukau DHB PFB) in one team or dispersed schedulers in services.

As noted earlier, Auckland DHB has already instigated a redesign of outpatients in order to make, amongst other things, the process of scheduling appointments much easier for patients.

As noted in Table 4, in jurisdictions where both forms of PFB have been implemented there has not been a decrease in the requirement of contact centre management in the move from 'partial to electronic PFB, however the emphasis of the work shifts from inbound booking call management to rescheduling management and clinical optimisation (ensuring that the clinic appointments are utilised and clinicians available).

In the planned Waitemata DHB 'partial' Patient Focused Booking rollout in Medicine outbound calling is required for Urgent Priority (P1) patients to negotiate a time and date and inbound calling for Semi-Urgent or Routine (P2-3) as patients respond to the letter inviting them to call and choose a time and date) and manage reschedules.

It is clear from international and local experience in call to remind activity (and limited PFB trials) that outbound calling needs to be outside usual business hours (Māori and Pacific health teams report a contactability rate in-hours of approximately 50%[i] and after hours 80-95%). Auckland DHB has significantly improved Patient Service Centre capacity that would allow PFB however Waitemata DHB has very limited contact centre Patient Service Centre customer service capacity at present. A business case to increase customer care representatives in the PSC was recently declined. The demand for this service was demonstrated in a 2015 trial of including the PSC number on reminder texts (in the few services managed by the PSC) and call volumes increased from 500 per week to 2,500 per week and the service had to be discontinued due to inability to secure the additional resource to manage call volume. An upgraded phone system for the PSC was approved however this is pending at present due to technical and security issues. Resolution is expected for the PFB pilot to go live from October 2016.

Patient experience surveys reflect frustration at the current inability to reschedule appointments easily, and DNA patient interviews also note patient's frustration at being labelled a DNA when they had unsuccessfully attempted to reschedule.

"It's very difficult to contact the help desk to get the information about appointments. Most of the time I've left messages I am not getting back a return call."
Waitemata DHB

[i] Contactability is a key issue for PFB, call to remind and post DNA management activities (as well as clinical requirements to contact patients). There are many issues around phone contactability (after hours is covered in text above, letter branding and mobile caller ID are others) including the currency of hospital contact details. This was one area raised by Manawa Ora in terms of the framework, and it has been considered under 1.3 (We ensure that patients know about and value the appointment). The current in-flight national roll out of the National Enrolment Service (NES) will mean that the NHI national database will become the source of truth for demographic and contact information and that this will update from primary care and into hospital databases. The recommendation is to support NES rollout. Also noted that early work around use of email rather than letter or phone contact has suggested privacy and confidentiality issues and the need for consent. Recommend continuing to pursue this option for example via e-referrals.

"You get answerphones and leave messages a lot (not helpful)."
Waitemata DHB

"Being able to speak with a real person would be wonderful. I've had some very frustrating phone calls without ever managing to speak to anyone."
Waitemata DHB

Electronic PFB systems are operational in other jurisdictions (eg Hutt Valley DHB and NHS Choose and Book). There is an in-flight project at Waitemata DHB investigating an electronic PFB system, and the Northern Regional Electronic Health Record process includes the ability to book online. Both systems may not be available for 2-3 years. Even if they were available the evidence as outlined above is that the service change requirement is similar for both, and contact centre functionality is not eliminated with electronic PFB.

Both forms of PFB would be at risk of self-selecting the patients most able to take up the option. Although early indications are that PFB trials work for Māori, the project team recommends any PFB approach includes inbuilt equity to ensure that there is a safety-net for Māori and Pacific patients who do not self-book.

The project team propose staged introduction of 'partial' Patient Focused Booking in both DHBs within the following high level parameters. Please note that this proposal requires a full work up and is likely to require a business case and significant investment in the required change management processes:

- PFB in a 6 week window. No hospital rescheduled clinics in this window.
- Flexibility for schedulers to work after hours to ensure patient contact.
- Triage priority P1-3 used in order to meet Ministry of Health and clinically assessed timeframes for appointment.
- P1 patients are called directly and an appointment negotiated over the phone (outbound calling ability required).
- P2-3 patients are sent a letter (or email when issues resolved as per Recommendation 7) with call centre details to contact and choose an available time and date (receipt of inbound calling required)
- Patients who do not respond to the letter enter an active call contact process within PFB where a specified contact approach is conducted. If this is unsuccessful patients will be referred to the Tailored DNA Navigation Service.

Recommendation 3: Create a Tailored DNA Navigation Service

In-depth DNA analyses indicate that the high rates of DNAs for Māori and Pacific Patients are generated by a by a small number of patients ('high fliers' with two or more DNAs) and are also driven by systems issues. Currently both DHBs have an un-coordinated series of call to remind and post DNA contact/management and a variable approach to targeting resource to these activities, with substantial person resource investment and duplication of effort. Patient Service Centre, service administrative staff, service clinical staff (nursing and allied health), and Māori and Pacific Health teams may be contacting the patient for the same appointment (or multiple service appointments). Māori and Pacific health teams in particular have had variable targeting of their call lists and volumes and their ability to provide this service is dependent on staff availability/illness and other ward activities. It was noted in the Waitemata DHB West Auckland GP pilot that approximately 10% of patients were already known and in contact with Community Health Workers and other navigators who provided a similar service in the community.

The patient contact within the Māori and Pacific Health teams sits outside the booking and scheduling functionality, and staff are therefore unable to immediately reschedule an appointment or offer flexibility in timing. This is a significant limitation. In addition Māori and Pacific Health team staff report a lot of time required on case management activity and attempting to align multiple appointments without easy visibility of appropriate systems. Clinical expertise is often requested as patients are unclear why they are required to come to clinic and staff are unsure what the purpose of the visit is from clinical notes, or whether patients know their diagnosis (eg in the oncology service).

Further investigation of closer primary care relationships, such as call to remind activity and other co-benefits in patient engagement and contactability can be progressed under a Tailored DNA navigation approach. This could include approaches such as the West Auckland GP pilot, however primary care have indicated that this activity would require additional resourcing and assurance of sustainability. Recent work with primary care in the smokefree area demonstrated that there are barriers related to patient contactability which require an approach supported by Primary Health Organisations as well as at a General Practice level.

The project team proposes a Tailored DNA Navigation service which would have the following high level parameters. Please note that this proposal still requires a full work up and is likely to require a business case:

- Clarity in tasks:
    - Contact management for targeted patients who do not self-book in PFB.
    - Call to remind activities for targeted patients.
    - Post DNA management for targeted patients.
- Focus of service on 'to and through' services eg co-ordination of care and some case/whānau management functionality with appropriate referral, however not including a formal psychosocial assessment or whanau ora assessment.
- Staff located within booking and scheduling (and trained) in order to be able to directly/easily reschedule when they are in contact with patients.
- After hours calling (majority of the time).
- Dedicated navigation staff with support from the Māori and Pacific Health teams but without other duties.
- Culturally appropriate staff highly skilled in building rapport and engagement.
- Targeted allocation of patients to the service by ethnicity for FSA (for health benefit; limited set of services/clinics) and by 'high flier' status for FU (some services also have 'social DNA' status for complex patients and 'multi-morbid whanau' where multiple members and ages are patients with DHB services). Other targeted groups could be considered over time.
- Call to remind activity much more targeted and transparent than at present. If call centre staff, service administrative and service clinical staff will continue to provide call to remind services outside of the Tailored DNA navigation service then a transparent process for who is calling which patients is required. If primary care call to remind activity (eg the West Auckland pilot) is to be reconsidered then this should occur within a more systematic approach to call to remind, and be adequately resourced.
- Strong relationships with services, community providers, NGOs, whanau ora and Pacific providers (including Community Health Workers).
- Ability to assist patients with key enablers of attendance where required (taxis, parking vouchers, Community Health Worker support)

The Tailored DNA Navigation service could be implemented without PFB however the resource requirements and targeted allocation to the service would be much clearer with PFB.

Recommendation 4: Accelerate the development of clinically appropriate alternate delivery approaches, and systematically offer these to patients. This includes a requirement to determine the medical value/necessity of an appointment.

Both DHBs have conducted analyses and projects in the areas of outpatient efficiency improvement, Follow Up improvement, wait time reduction and acute patient flow which has included DNAs. The sum of this work indicates that a substantial proportion of current 'routine' Follow Up is either medically unnecessary or could be done another way (up to 60% in Auckland DHB Concord audits). The ability to easily introduce clinical pathways for specific conditions or referrals is limited by the lack of outcome coding by symptom/diagnosis, for which there is a current proposal at Waitemata DHB (under the Continuity of Care programme, however this activity has not been prioritised at this time).

Assessment of medical value/necessity is currently done either via audit (eg Concord audits), by case review (eg cardiology wait time review Waitemata DHB) or by clinical pathway introduction (changing the model for a subset of patients eg Leapfrog Better Outpatient Follow Up in-flight project (ORL, general surgery and orthopaedics) Waitemata DHB). This is a resource intensive process with clinicians however the volume of appointments that could be reduced is substantial. There is currently no systematic approach at either DHB to assessing Follow Up medical value/necessity.

Development and systematic offer of alternate delivery approaches is also not occurring at either DHB. Ad hoc and service specific approaches have developed over time. The potential ways to provide alternate delivery approaches could be considered in the following ways, all of which address patient/whanau centric models of care and consideration of care closer to home and models which better meet the needs of patients:

- Alternate mode – patient contact (phone or video (mindful of funding, privacy and potential access issues)) or paper review "virtual assessment" (eg letter and management plan with return to GP Waitemata DHB Women's Health who return 25% referrals to GP via this method).
- Alternate provider – return to usual GP, refer to GP sub-specialist (eg skin or new services), CNS or allied health.
- Alternate location – DHB outpatient clinics (eg Waitakere/Greenlane), DHB community clinic, Integrated Family Health Centre (IFHC), whanau ora/Pacific health centre, other community locations (pop up clinics, marae, churches, mobile vans), GP clinics with GP sub-specialists (eg skin or new services).
- Self referral/ Symptomatic/Patient directed – SOS card at inpatient discharge or as OP outcome form option (WDHB pilot Upper GI National Health Board funded initiative, which includes an alert if in ED), triggered clinics (COPD/CHF/specific recurrence, "Walk-ins" eg diabetes clinic Whanau House.
- Alternate service hours – after hour or weekend clinics (eg renal and eye clinics Auckland DHB, colposcopy, cardiology, renal, gastroenterology Waitemata DHB). Services report that after hours clinics rarely have DNAs.

The working group recommends linking medical value and alternate approaches (as proposed in the Concord projects) and doing so systematically across the clinics with the highest DNA rates. This could be supported by PFB (direct booking into alternate approaches if indicated at triage or outpatient outcome coding) and with the Tailored DNA Navigation Service. The project team recommend a Chief Medical Officer led approach with the relevant service clinical leads and under the larger outpatient improvement work programmes.

Recommendation 5. Conduct health literacy review of standard letters and service specific letters; develop standardised transport/parking and wayfinding (map) information

Review and standardisation of Patient Service Centre standard letters has been completed at Waitemata DHB and is underway at Auckland DHB. However the PSC at each DHB does not provide scheduling services for the majority of DHB clinics, and service specific letters are currently hugely variable. Standardisation (including meeting Ministry of Health and clinical requirements) of all DHB the letters, with additional health literacy and cultural competency review is a large exercise but with high impact. Inclusion of standardised brochures related to wayfinding and transport as part of this process is also a recommended activity. Electronic versions of standard letters and collateral will also be able to be emailed (if issues can be resolved see Recommendation 7).

Recommendation 6: Ensure standardised and optimised text reminder across all services

Both DHBs utilise text reminders. Auckland DHB currently does this internally and is in the process of moving to an external provider to improve the automation and quality of the service. Not all services at either DHB use text reminders and loading of the system is still manual in many cases. Content of reminder have been reviewed (and approved including by legal services) at Waitemata DHB but are still not optimal, and do not offer the ability to reschedule. Auckland DHB text content is limited characters and therefore has limited wayfinding information. When reminders are sent and how many is also variable across services at both DHBs, although Waitemata DHB tends to send two texts (at 7 days prior to the appointment and again at 2 days prior), while Auckland DHB sends one at 3 days prior. The evidence is clear that text and phone reminders work, text reminders are much more cost effective. Patient experience data also supports this.

"This time all good, I got a text reminder. Last time I had no notification, didn't know I had an appointment, and didn't turn up."
Waitemata DHB

Comment regarding opportunity to improve call to remind activities

It is clear that the majority of DNA activity at both DHBs has centred on call to remind activity and some post DNA management. Call to remind activity is not systematically generated, prioritised and allocated (see notes in Tailored DNA Navigation Service above). Only a small amount of the activity is conducted within the Patient Service Centre (which currently an elective surgical focus). Outside of the PSC services conduct their own booking and scheduling and call to remind activities with a range of administrative and clinical resource.

It is unclear how substantial the FTE resource performing call to remind activities is across both DHBs actually is. For example at Auckland DHB it is reported that 17FTE is used for diabetes confirmation and call to remind across the DHB hospital and community sites. There is evidence of duplication of call to remind activities between provider services and Māori and Pacific health teams.

In preparation for PFB and a Tailored DNA Navigation Service (for example in business case development), if PFB and the Tailored DNA Navigation Service were not implemented (or were delayed) a review of call to remind activity with the purpose of improved transparency, better allocation and reduced duplication would be beneficial. This would be a large piece of stocktake work, but the project team recommend that this work is conducted before progressing individual one-off non-sustainable projects such as GP call to remind service development (outside of the Tailored DNA Navigation service above).

Recommendation 7: Resolve the issues limiting use of email as a contact modality for appointments

There is opportunity for email distribution of invitation, appointment, and reminder letters (with or without Patient Focused Bookings). Patient experience work confirms patient demand for this service. Privacy and Security Groups have been examining the issues related to email use which include a requirement for patient consent), privacy issues, proxy access (eg family members, caregivers) and other issues. It has been suggested by stocktake respondents that e-referrals could be examined as an opportunity to provide consent and email contact details.

Recommendation 8: Mandate cultural competence/CALD training for booking and scheduling staff

Booking and scheduling staff and managers have requested a range of training opportunities including 'phone etiquette,' strategies for rapport building, DHB values training and cultural competence support. Training is available however there is no formal process for monitoring or mandating attendance at training.

Recommendation 9: Review and optimise cultural competence component and assessment of welcoming values in Human Resource processes for booking and scheduling positions

Hiring processes for booking and scheduling staff offer an opportunity to assess and value cultural competence and welcoming values in these important roles.

Summary

This document outlines the joint Auckland and Waitemata DHB DNA strategic framework, stocktake and gap analysis and a prioritised set of nine recommendations forming a 'roadmap of activities' to achieving equitable outpatient clinic access.

Appendix 1. Evidence-Based Intervention Bundles

Summarised NHS Guidance (2013)[22]

Guidance: • Multiple interventions are required • Recommend a structured quality improvement process

Bundle of interventions:
• Make sure appointment is necessary
• Reduce patient anxiety and effort required
• Communication content, tone, clarity, consistency
• Ease and experience of cancellation
• Multiple reminders
  o Letters
  o Texts (consider timing)
  o Phone calls (targeted for some groups/high fliers)
• Convenience/choice in booking time/date and ease of booking system (self book or PFB),
• Includes importance of welcome/experience
• Contact GPs regarding the appointment as matter of course and consider provision of practice level DNA rates (positive frame more effective – how many patients had attended vs DNA rate)
• If booking only by phone or in person then request patient repeat back time/date (understanding check)

Summarised Ministry of Health Guidance (2013)[1]

Guidance: • Objective: optimise clinic efficiency/use of staff • Recommend <5% but not a target, monitor quarterly • Have a policy, tailored 'chances' for rebooking (the Ministry of Health does not support '2 strikes and you are out' policy) • Follow up all DNAs by phone to collect reasons for DNA and offer to reschedule • Confirmation and reminder systems – review and optimise
Recommended interventions: • Patient focused booking • Use of acknowledgement letters • Improved appointment letters • More timely scheduling • Reminder letters and phone calls • Booking by telephone to negotiate appointment time, with letter confirmation • Information brochures and maps • Text reminders • Transport options/support, ensure easy to understand location and transport messages in written material • Transparent process for DNA management available on hospital website and promoted to GPs • Use of interpreters, or appointment letters translated into different languages

Appendix 2. DNA Strategy Gap Analysis: Interview Question Guidance

High level	Critical elements	Potential activities	Questions
1. **Systems and Value**	1.1. We ensure that the appointment is necessary and of value	Inappropriate appointments	Do you have standardised plans or care pathways to support decision making to determine the need for an FSA and/or follow up appointment? If yes, obtain specifics/examples Do you ask patients if they would like to attend a FU appointment?
			What activities are being undertaken to reduce the number of potentially inappropriate/ unnecessary appointments (e.g. 'routine' FU where this may not have benefit)?
			If appropriate: Do you consider private practice follow up pathways when determining patients need for a follow up appointment?
			Can patients self-refer to your service? If yes, when and how? If no, is there any work in progress to introduce this? If yes, what and when?
	1.2. Patients choose an available appointment at the best time for them	Patient focussed booking (PFB; also called open-access scheduling)	Do you allow (within the scope of what's available) a patient to choose their appointment date and time? If yes, how? If no, is there any work in progress to introduce this? If yes, what and when?
	1.3. We ensure that patients know about and value the appointment	Contactability	What steps do you take to ensure patient contact details are correct? How could we improve our ability to have up-to-date patient contact details?
		Appropriateness of communication GP and clinician clearly communicate	How do you (and the referring GP) make sure the patient is aware of the health value to them personally from this appointment? How are patients made aware of the resource value of the appointment i.e. time is precious?

High level	Critical elements	Potential activities	Questions
		a) The health value to be gained from the appointment b) The value of the appointment in terms of clinical time and opportunity cost	What methods do you use and when? Has any written communications been reviewed by the health literacy team? Has there been any training (or awareness raising) about face to face approaches?
			Please provide copies of all communication templates and scripting used Have you ever tried other initiatives/approaches, even for a short time?
		Patient confirmation system:	
			Does your service require confirmation from the patient that they are able to attend the appointment? If yes, What methods are available for them to confirm? What happens if confirmation is not received? Do confirmed patients still DNA at the same rate as non-confirmed? Is there any work in progress to change this approach?
			How do patients cancel or reschedule their appointment?
			What action do you take with "Return to Sender' correspondence?
	1.4. We optimally remind people	Describe current reminder system at service/clinic level	How do you contact the patient to remind them of their appointment? eg letter, text, phone How many reminder(s) do you give? What is the timing of the reminder(s) eg xx weeks before, xx days before?
2. **Access**	2.1. We make getting to the appointment easy	Content of appointment (+/- reminder letters)	NOTE: Review copies of communication templates and scripting used to determine if patient knows where to go, and what to expect Has this content be reviewed/revised for health literacy, understandability or other reasons recently?
		Alternative options	Do you have any alternative clinics that are not single clinician face2face? If yes, what are they and how do they work?

High level	Critical elements	Potential activities	Questions
2. Access			Can patients self-refer to your service? If yes, when and how?
		Transport options	What transport option/ parking do we offer to enable access to appointment?
	2.2. Where appropriate, we change where and how services are delivered	Telemedicine or virtual clinics	Besides the traditional hospital on site clinics, what other options are available to patients in your service? Have you ever tried pilots or initiatives, even if for a short time?
			What satellite clinics do you offer, where are they located and how frequent? If yes, what, where and when? If no, is there any work in progress to introduce this? If yes, what, where and when?
			Do you offer any clinics outside standard business hours, Monday to Friday? If yes, what, where and when? If no, is there any work in progress to introduce this? If yes, what, where and when?
	2.3. We have tailored solutions for groups with the highest DNA rates	Any group specific/targeted DNA activity	Have you undertaken any targeted DNA prevention for specific groups? If yes, what and how successful was it? If no, is there any work in progress to do this? If yes, what, where and when?
			Are any “pre-call” (Pre-appointment) activities undertaken?
		Post-DNA activities	If a patient DNAs what actions do you take? (after the first, after the second, ...)
3. Experience	3.1. We have a culturally competent booking and scheduling	Patient experience data on cultural competence/ meeting cultural needs	How do you know whether your service is culturally competent?

High level	Critical elements	Potential activities	Questions
3. Experience	workforce		
		Activities to improve cultural competence. Consider: • Training e.g. eCALD, cultural competence workshops, treaty workshops • Refreshers • Patient experience feedback • Scenarios • Complaints?	Do your staff receive any cultural competency training? If yes, what? Do you know what matters most to Maori and Pacific people in regards to booking and attending appointments? If not, how will you find out?
		Specific booking and scheduling activities on post DNA follow up	What happens when a patient doesn't attend an appointment? Do you contact the patient to find out why they did not attent? If yes, is this recorded anywhere?
	3.2. We welcome, listen and explain	Patient experience data (e.g. Friends and Family Test) any specific questions on: • Welcoming – particularly on the phone/by booking and scheduling	How much flexibility is there to respond to individual circumstances? If yes, do you have an example that demonstrates how we do this? How do you monitor standards of communication and customer service? How do you know whether the team communicates well with Maori and Pacific Island

High level	Critical elements	Potential activities	Questions
3. Experience		• Feeling listened to and conditions explained	people?
		Activities to improve welcoming	Have you done any work to understand whether people feel welcome? If so, what? If not, how will you do this?
		Activities to improve clinician communication of conditions/results	Tell us how you have tried to improve clinician communication of conditions/results?
4. Outcome	4.1. We use a common definition to monitor by service and we follow up	What is a DNA?	How do you classify that a patient is a DNA? Do you have a target for your service?
		Performance measurement	What measurement systems do you have to understand? - Reason for DNA - # of patient initiated cancelled and rescheduled appointments - # of service initiated cancelled and rescheduled appointments - Number of repeats DNAs - Ethnicity/Gender - Other

Appendix 3. High level summary of Stocktake and Gap Analysis: Findings and Recommendations

	Current state stocktake		Gap analysis commentary	Proposed high impact activities	Recommendations
	ADHB	WDHB			
1. Systems and Value					
1.1 We ensure that the appointment is necessary and of value	• Concord audits ORL (60% FU could have been done differently), Meningioma (20-62% could have been done differently) • Rheumatology a review of follow up appointments found 15 -35% could have been done differently	• Leapfrog Outpatient Follow Up project and work on agreed pathways (ORL, general surgery, orthopaedics) and wait list reviews eg cardiology	• Triage process for FSA managed by services (complexity in number of triage categories urgent/routine P1-3 WDHB and A-E ADHB) with local access criteria • Key area is FU which are approx. 75% outpatient clinics and many are "routine" FU from inpatient or ongoing outpatient (note contribution of defensive medicine/junior staff, "routine" FU without clear clinical purpose, and provider behaviour (including the want to "keep my patients"). Also currently no clinical outcomes coding either DHB so can't monitor by condition/symptom within clinics eg to do Best Practice Pathways easily. • Lots of FU audit –and outpatient project work suggest large % of FU are unnecessary or could be done differently (up to 60% - patients no longer need, medically not required, could be done by another mode or provider see 2.2)	• Determine medical need for appointment (ADHB Concord activities; WDHB in-flight project Better Outpatient Follow UP) • Determine whether the activity could be conducted via an alternate delivery approach (see 2.2) • Consider re-prioritising the coding outpatient clinics project (under Continuity of Care WDHB) to determine disease/symptom groups for pathway/best practice follow up • Note that this should be part of high quality PFB	• Support in-flight projects (and link with acute patient flow initiatives) • Consider recording the reason for the appointment in the discharge summary and/or clinic letter or clinic outcome form (potentially a Quick Win) • CMO lead for this module
1.2 Patients choose an available appointment at the best time for them (Patient Focused Booking; PFB)	• No PFB, some early work in Children's Health • Ca and blood services limited flexibility for "negotiated" offer of FSA clinic appointment (approx. 80% FSAs) • Respiratory services noted limited clinic times as problematic with high DNAs • Multiple appointments same service or multiple services confuse people, no visibility of these within system • Currently there is a lot of tolerance for hospital rescheduled clinics (eg clinician leave) which are problematic • Maori Health team try and offer some choice of appointment time where possible, but limited / unsuitable times • Call centre function recently changed to be able to perform call to remind activities, after hours calling – currently no scripts for schedulers • Note that for some services, eg Ca and Blood, the patient may not actually know they have Ca or high suspicion of cancer, schedulers request clinical support	• In-flight PFB trial Medicine (4 month diabetes trial Maori DNAs reduced 45% to 15%), also Ortho PFB pre calling trial with reduction DNA 11% to 5% • Designed to meet MoH and clinical compliance (clinician determined timeframe to be seen) • DHB contactability for patients is critical, required telephone additional functionality as no current Contact Centre resource • PFB requires investment in clinic profiles (current state and requirement to standardise and reduce historic clinic setups in order to optimise ability to implement PFB efficiently. This requires resource to assess and change and clinician buy-in. Currently underway under the PFM in Medicine and Leapfrog Outpatient Follow Up (in surgery).	• Contact / Customer Service centre extended hours and after hours functionality critical to contactibility of patients for PFB • P1 patients (urgent) tend to get the ability to book their appointment as they are called directly by schedulers to meet priority urgent timeframe • Due to change to plan for dedicated FSA (and FU) roles as part of in flight PFB have identified an upgraded phone system functionality being required to support for call management; • Currently all Specialities do own scheduling at WDHB: o Diabetes o Renal o Paediatrics o Pain o Health of older adults o Mental Health o Maternity o Allied Health o Surgical and Ambulatory Service o Child, Women and Family o And similarly at ADHB	• Patient Focussed Bookings (PFB) within well specified parameters • Online PFB (in-flight proposal WDHB, Northern Regional Electronic Health Record EPIC ADHB) • Reduce pre call duplication of effort (B&S, service calling, Maori and Pacific team calling) • Need to manage the risk that some patients are selected out of PFB with lack of initial response therefore link with tailored DNA navigation service • PFB also requires review of current multi-priority system in triage to be able to manage compliance	• Well-resourced PFB as priority overarching recommendation with well specified parameters including call management (ideally call centre functionality), robust monitoring and tailored DNA navigation service included

	Current state stocktake		Gap analysis commentary	Proposed high impact activities	Recommendations
	ADHB	**WDHB**			
1.3 We ensure that patients know about and value the appointment	• Patient Service Centre doesn't require confirmation of appointment anymore (made no difference to DNA rates), some services still do eg eye clinic • Appointment letters felt to be not fit for purpose, recent review with large reduction in information and simplification, do not explain why going to appointment though in terms of value	• No confirmation of appointment required (made no difference to DNA rates) • Standard letters have been approved for PSC and all new request for changes / new letters PSC letters are now managed through a formal process – however it is that significant resourcing and ongoing management is assessed to manage letters through a centralised system with formal processes and core standards (note that non PSC letters have no requirement for this process and have large variability – there are currently more than 600 non PSC letters)	• Contactability a big issue noted in both GP call to remind pilots, PSC/B&S calling and Māori and Pacific calling. Can be 50-60% uncontactable, markedly improves with after hours calling 80-95%. • Screening calls re no caller-ID (unknown number) is reported, also shared cell phones, recurrent changing numbers (due to phone company debt). • Mail contact where letters unbranded are problematic, and returned mail no consistent process for managing in the DHBs. • Timing of mail becoming more problematic (WDHB audit indicated 90% receipt in 3 days in 2015, 2016 data 90% not reached until 7 days). • Cost of mail delivery is also significant, confirmation by email would significant reduce this cost. • Centralised ability for a 'letter folding and stuffing' function of, particularly if including wayfinding and transport collateral should be investigated.	• PFB would be the single most important solution, with a tailored DNA navigation service. • Remove confirmation as a process as no benefit, and superceded by PFB. • Contactability improvements (in-flight National Enrolment Service (NES) primary care updating NHI and consider further work on consent process for email use, NOK etc • Reminder campaigns for administrative staff to check contact details at every patient contact. • Consider alternate methods of contact rather than letter eg email – investigate systems to "consent" to email usage at e-referral • Scripts for schedulers (PSC or service) to address value • Health literacy letter content review • Translation of letters • Access to Interpreters via Contact Centre • Consider who does the contact eg booking/scheduling vs CNS for some services (eg Diabetes Whanau House, WDHB MIDAS), tailored DNA navigation service	• Stop confirmation processes. • Support implementation of NES Clarify requirements and enablers of e-mail consent and contact option eg e-referrals (could also do for translation requirements, disability, cognitive impairment, communication issues eg deaf) - review addendum to e-referrals, kiosks, portals • Reminder to administrative staff to check patient contact details at every patient contact (Quick Win) • Standard letter health literacy review • Tailored DNA navigation service
1.4 We optimally remind people	• Some services call to remind 1-2 days prior eg LTC diabetes, rheumatology • Some services text remind 2-3 days prior to allow reschedule and manage volumes required (cannot manage 7+2days prior as per WDHB). Use of text reminders are increasing, but certainly not all services (approx. 50% LTC) • Internal system text using a mail merge function, only allows 123 characters and issues with Americanisation of dates, currently looking at move to external provider • Call centre number included in text	• Text remind at 7 days prior (for reschedule) and 1-2 days prior (for reminder), name and NHI, but variable across services and still have to manually upload lists (staff dependent) • Text reach approx. 75% appointments, approx. 90% of texts received by the patient • Use dial hog external provider and can have longer texts, content variable sometime wayfinding information eg site, building, level, reception name • No return phone number to reschedule (trialled it however no call centre and call volume increase	• Variation in content, wayfinding, contact centre numbers and usage across services. Not currently optimised. • ADHB currently considering moving to external provider, PSC have requested scoping of external mail provider also	• Currently letters, phone and text could be optimised in terms of content, variation and duplication = PFB would supercede much of this • Text message reminder ensure all services, standard timings, content • Ability for individual computer to text tailored messages for specific patients (as part of tailored DNA navigation or specific clinics eg hepatitis clinics) • Ability for patients to reschedule easily is an important component – part	• PFB • Tailored DNA navigation service • Text message standardisation process (may include vendor change; quick win) • Ability to individually text in specific circumstances (quick win)

	Current state stocktake		Gap analysis commentary	Proposed high impact activities	Recommendations
	ADHB	**WDHB**			
		500 -> 2500 in one month), no way to measure missed calls currently • Could drop 7 day (Why?)prior text if PFB, don't know if second text makes a difference		of timing of text message reminder is to allow rescheduling but WDHB currently cannot manage call volume if include phone numbers; ADHB call centre but still goes to schedulers	
2. Access					
2.1We make getting to the appointment easy	• Parking a huge issue at ACH site and now at GCC too; LTC says at least 1 patient a week reports driving around endlessly looking for a park then driving away • Some dedicated parking eg oncology, dialysis, some dental • Some free parking eg Women's Health, Starship can offer, and some discounts but not transparent and no dedicated parks • Some volunteers drivers for cancer patients, taxi for some dialysis patients	• Shuttle services from Rodney take all day to travel, whole day off work • Some dedicated parking eg dialysis	• Transport and parking remain very significant issues for patients particularly at ADHB and between North and West WDHB sites • Variable ability for access to free or subsidised parking and dedicated patient parking.	• PFB parameters scripted requirements for location, time, transport discussion and understanding check • Health literacy content • Improve wayfinding instructions in letters and texts, and via PFB scripts • Transport – link with alternate clinic locations and delivery approaches 2.2 • Address variable, inequitable and non-transparent free parking application – link with Tailored DNA navigation service 2.3	• PFB component • Standard letter health literacy review – reduce unnecessary information, improve readability / understanding, review tone and communication of value • Standardised approach (eg leaflets added to letters) to transport and wayfinding / map information • Improve transparency and visibility of free parking, include ability to utilise free parking within tailored DNA navigation service
2.2 Where appropriate, we change where and how services are delivered	• Diabetes satellite community clinics including CNS clinic but not found big DNA reduction • LTC Diabetes phone FU since 2015 • LTC 17 FTE on appointment confirmation activity • Renal IV infusions in afternoon / evenings once a month, could do more but no overtime provision • Sat eye clinic • Work in Neurology on cue cards for MS patients (with the Design Lab) as part of patient education symptom guides, Note this was resource intensive but there are now templates available if want to use this for self-directed follow up work.	• Whanau House for diabetes including CNS clinic (DNA reduction for Maori) and paeds clinics (no DNA reduction for Maori), looking at more services moving (awaiting Whanahu House HNA report) • Nurse phone clinics Diabetes, Gastro (IBS and hepatology), Gynae Nurse Practitioner • "Virtual Assessment" management plan has been in place in Gynae with 25% of FSA referrals managed in this way (no FU or monitoring of whether these women are re-referred or seen in ED/acutely) • Registrars in Gen Med have formal document guidance on FU clinics, and ability to phone FU if tests normal • Sat breast screening • Sat colposcopy clinic (Gynae) to manage wait time compliance • Sat/Sun cardiology clinic • Sat and Thurs nurse clinic in diabetes but not sustainable • Sat renal live donor clinic and procedures	• Many definitions for "Virtual clinics" (confusion between a funded VFSA and "virtual" communication eg video/phone) The latter are not currently funded by MoH esp issue for CNS FU. (There are clear definitions of VFSA by the MoH and this is also outlined in the Patient Services Guidelines and Process Management for Scheduled Care • Virtual clinic outcomes not currently clearly defined expectations management plan/plan of care dictated and returned to GP vs e-triage note • Opportunity with localities model and better integration with general practice • Consider the significant of concerns around MECA for medical involvement in after hours clinics given already in place for some services	• Where determined medically necessary (and purpose of follow up) at triage or FU review consider alternative delivery approach: o Mode – patient contact (phone, video mindful of funding, privacy and potential access issues) or paper review "virtual assessment" (eg letter and management plan with return to GP WDHB Gynae) o Provider – return to usual GP, GP sub-specialist, CNS/allied health service o Location – DHB outpatients clinics (eg Waitakere/GCC), DHB community clinic, IFHC, whanau ora/Pacific health centre, other	• Institute systematic process for consideration of alternate delivery approach for specific clinics based on Concord activities package • PFB • Tailored DNA navigation service • Clarify whether/where after hours clinics are feasible • Evaluate VFSA WDHB Gynae service

	Current state stocktake		Gap analysis commentary	Proposed high impact activities	Recommendations
	ADHB	WDHB			
		• Sat gastro procedures , minimal if any DNAs		community locations (pop up clinics, marae, churches, mobile vans), GP clinics with GP sub-specialists (eg skin) o Self referral/ Symptomatic/ patient directed – SOS card at inpatient discharge or as OP outcome form option (WDHB pilot Upper GI NHB funded initiative, alert if in ED), triggered clinics (COPD/CHF/specific recurrence, "Walk ins" eg diabetes clinic Whanau House) = need o Service hours – after hour or weekend clinics • Recommend systematic approach to determining this via triage and PFB processes and integration of tailored DNA navigation service	
2.3 We have tailored solutions for groups with the highest DNA rates	• ADHB Women's Health have Community Health Worker who calls women who DNA FU colposcopy appointment • ADHB/WDHB Maori and Pacific provider teams provide call support which is person dependent (eg calls stop if team member sick or unavailable), and often in addition to other work – ADHB call volumes make % able to be called on lists difficult (approx. 20% ADHB, 60% WDHB) • Not enough resource to do all high impact clinics, focus on limited set of clinics (HSC first) and FSAs. Kaiatawhai calling 4-9pm gets best contact rates consistently. • Quite resource intensive mostly precall (call to remind) activity, some post DNA activity • Spend time on what people need to overcome barriers (transport, support, encouragement) and	• In addition to left WDHB Women's Health service has Maori and Pacific Liaison roles to improve engagement, and this includes call to remind and DNA management	• Currently no system to manage multiple DNAs even though we know that 20% people generate 80% DNAs for Maori and Pacific • Call to remind activity being duplicated as not visible to each other, and often no access to be able to reschedule when do contact • Currently some services have dedicated resource for call to remind or DNA management activity, and some Maori and Pacific team person dependent resource – large opportunity to streamline, integrate and dovetail with PFB systematically • May include some specific targeted populations (eg immunology young men (17-25 referred by ED) with targeted interventions	• Tailored DNA navigation service with specified parameters (prioritised patients) ideally within PFB o Targeted patients (ethnicity, FSA/FU, clinic type) o PFB initial contact and call to remind (focus) and then post DNA activities o GP and community provider relationships • Needs to be linked with booking and scheduling and have ability to reschedule in all relevant systems • Needs clinical upskilling with clinical staff to be able to contribute safely to the 'patient value' component 1.3 • Holistic approach/whanau	• Tailored DNA navigation service • PFB

	Current state stocktake		Gap analysis commentary	Proposed high impact activities	Recommendations
	ADHB	WDHB			
	emphasising the value of appointment (people often don't know what appointment is for), want more clinical training around specific clinics to assist with this • Not currently linked with B&S and limited, if any, ability to reschedule while have people on phone (call or email B&S) • Duplication with B&S pre call activity and some service specific reminders noted • Contactability still a really big issue – variable but can be 20-40% not contactable, spend time calling GP and other avenues			ora – multi morbid family, high fliers, multi-service users • Needs to be allocated FTE not on top of usual duties • Consider requesting more than one NOK at admission	
3. Experience					
3.1 We have a culturally competent booking and scheduling workforce	• Diverse workforce a big advantage, including with languages • Poor cultural competence is an issue for medical staff as well as B&S • Request cultural competency training for schedulers and culturally matched staff, have had some with Maori Health team and one in flight project with dental assistants • Pacific training is available online CALD EP, and Pacific Best Practice training also delivered but both are voluntary • No current monitoring of call quality	• Diverse workforce a big advantage, including with languages • CALD courses encouraged, not mandatory or monitored • No current monitoring of call quality	• Cultural competency in person and online training available but not mandatory or monitored • Call quality (all call to remind activity) is not monitored	• Needs to be part of PFB parameters • Mandatory online training Tailored in person training for B&S and frontline admin, including Treaty and Tikanga training Investigate monitoring quality of calls (eg CMH does mystery callers, corporates note ability to record for training and QALink with HR processes for B&S re cultural competency, values (link 3.2) and correct ethnicity question for staff	• Mandate CALD courses, invest in rapport/telephone etiquette training existing staff • Investigate call quality monitoring • PFB scripts – health literacy and cultural review • HR processes – B&S and Tailored DNA navigation staff rapport building critical component and cultural competency • Complete collection of correct ethnicity question for all HR processes • Support ongoing values work (3.2) including in HR processes for B&S
3.2 We welcome, listen and explain	• Part of values work and patient experience feedback • 5 case descriptions for Maori Health complex cases	• Part of values work and patient experience feedback			• Support ongoing importance of welcoming in the values work, specifically for B&S and reception • Patient experience examination of alternate locations and alternate approaches eg virtual; evaluate pilots
4. Outcome					
4.1 We use a common definition to monitor by service and we follow up	• ADHB recently moved (early 2016) to MoH definition for DNAs (reduced DNA rate, increased reschedule rate as expected) but no organisational policy. Children's health developing a policy, LTC developing a repeat DNA policy.	• HAC reporting as per ADHB • Decision Support have developed top 10 DNA services report 2015-2016 which has detail on ethnicity, FSA/FU, clinic/clinicians, numbers and % (no age or gender)can filter by HAC report definition or all	• Although both DHBs now use MoH definition of DNA, and HAC report only on consultant FSA and FU, this is still not consistently applied at a service level and confusion was reported on what "counts" as a DNA. This persists despite it being clearly outlined in the Patient Services Guidelines and Process Management for Scheduled Care document • Variable on "2 strikes and you are out" unwritten policy in	• Currently Consultant FSA and FU therefore if change provider may reduce DNAs • All services should report DNA rates for all clinics, including uncontactability for "virtual clinics" – need to be	• Organisational policy applied at all levels • Report DNAs for all clinics, filter by HAC Consultant and Clinics • Begin to collect the primary reason why people DNA (in

	Current state stocktake		Gap analysis commentary	Proposed high impact activities	Recommendations
	ADHB	**WDHB**			
	• Business Intelligence doing the reporting except for Mental Health who are reporting their own DNAs, Women's Health note that they report nursing DNA rates standardly • Services track their own DNAs (including by ethnicity but not age, gender etc) but HAC reporting is just for Consultant / Specialist FSA and FU (not registrar clinics, nursing clinics, allied health) and not at clinic level – work is underway in LTC to do this level of reporting • Variable DNA management process, note that in Womens' Health a "dire consequence" letter is sent for repeat DNAs	• Have been using the MoH definition for some time • In-flight rollout of refresher training for PSC Team leaders and extension of business rules via Team Leaders for non PSC services which includes DNA management and reporting • Variable DNA management processes	some areas (this is not policy – please refer to Patient Services Guidelines and Process Management for Scheduled Care document , repeat DNAs allowed in other areas, flexibility on this which is service / consultant dependent. • WDHB is expanding (for non PSC Team Leaders) and refreshing (for PSC Team Leaders) training on the 'Patient Services Guidelines and Process Management for Scheduled Care' which includes DNA management. • Hospital rescheduled appointments should not be classified as a DNA (this is still reported to happen at both DHBs)	able to track whether alternate modes change the actual ability to contact the patient or just changes the Consultant DNA rate • Common organisational policy (MoH definition) for measuring and monitoring DNAs (and reschedules) which is applied by all clinics	a constructive and non-threatening way) and use this data to support system improvement

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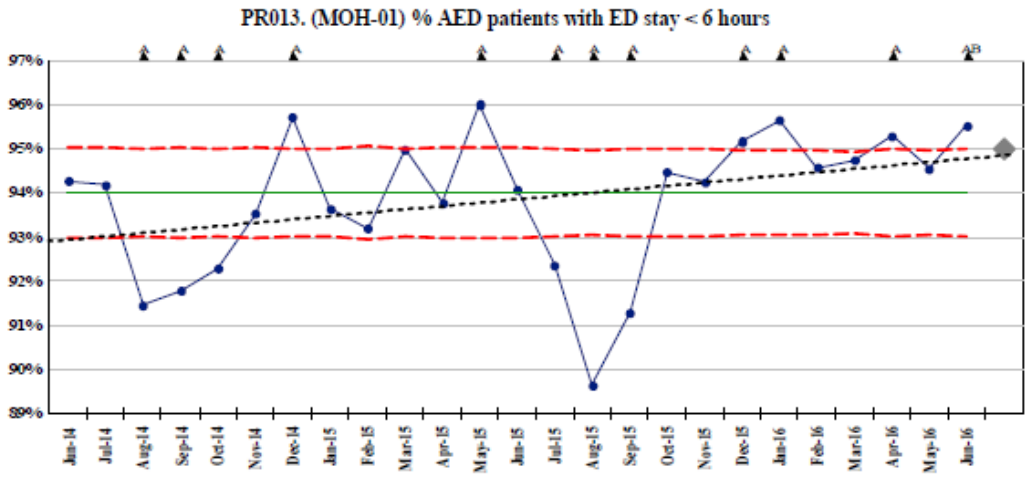
Shorter Stays in Emergency Departments

Adult Acute Patient Flow

Target: 95 per cent of patients will be admitted, discharged, or transferred from the Adult Emergency Department within six hours.

Target Champions – Brenda Clune, Dr Barry Snow



Current Target Performance

- >95%.

Current/Planned Improvements

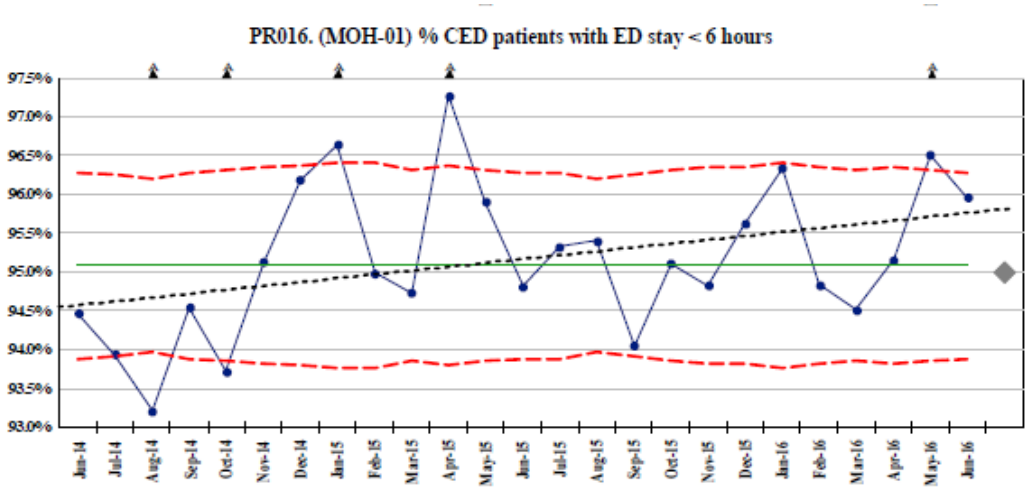
- Opening extra beds depending upon demand.
- Surge shifts in ED.
- Recruiting more RMOs for evening work.
- Developing a business plan for a Decision Support Unit.

Shorter Stays in Emergency Departments – continued

Children's Acute Patient Flow

Target: 95 per cent of patients will be admitted, discharged, or transferred from the Children's Emergency Department within six hours.

Target Champion – Mike Shepherd



Current Target Performance

- Achieving target – 96%.
- Ongoing opportunities to improve acute patient flow identified.

Current/Planned Improvements

- Activity to increase acute patient flow continues, including
    - Streamlined referral processes.
    - Reducing documentation duplication.
    - Streamlining workflows.
    - Ward transfer.
    - Estimated Date of Discharge.

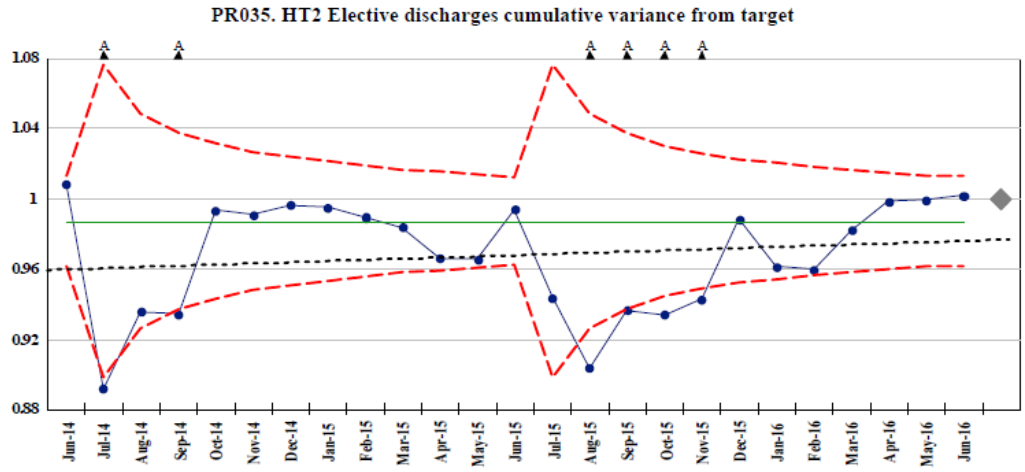
Improved Access to Elective Surgery

Target: The volume of elective surgery will be increased by at least 4,000 discharges per year nationally.

DHBs have negotiated local targets taking into consideration the health needs of their communities. Collectively these targets contribute to a national increase in elective surgery discharges.

ADHB's objective is to deliver the MoH target for elective surgical discharges (14,372).

Target Champions – Wayne Jones, Paul Browne, Tara Argent



Current Target Performance

- Coding is not yet completed, however final result is expected to be just over 100%.

Current/Planned Improvements

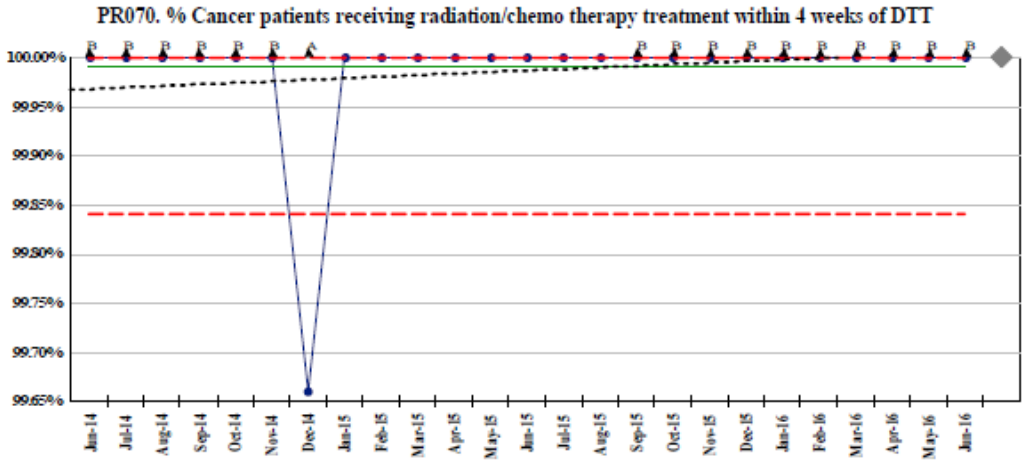
- Updated session allocation has been released for new financial year. 34 half day sessions have been converted to 17 full day sessions to enable improved productivity.

Shorter Waits for Cancer Treatment

Target: All patients, ready for treatment, wait less than four weeks for radiotherapy or chemotherapy.

The policy priority is for patients who are ready to treat. It excludes patients who require other treatment prior to radiotherapy or chemotherapy, who are not fit to start treatment because of their medical condition, or who choose to defer their treatment.

Target Champions – Giuseppe Sasso, Fritha Hanning, Richard Doocey, Deirdre Maxwell



Note:

One patient not treated in December 2014 causing drop in percentage to 99.66%.

Current Target Performance

Chemotherapy

- We continue to provide service in accordance with required timeframes.

Radiation Therapy

- We continue to provide service in accordance with required timeframes.

Current/Planned Improvements

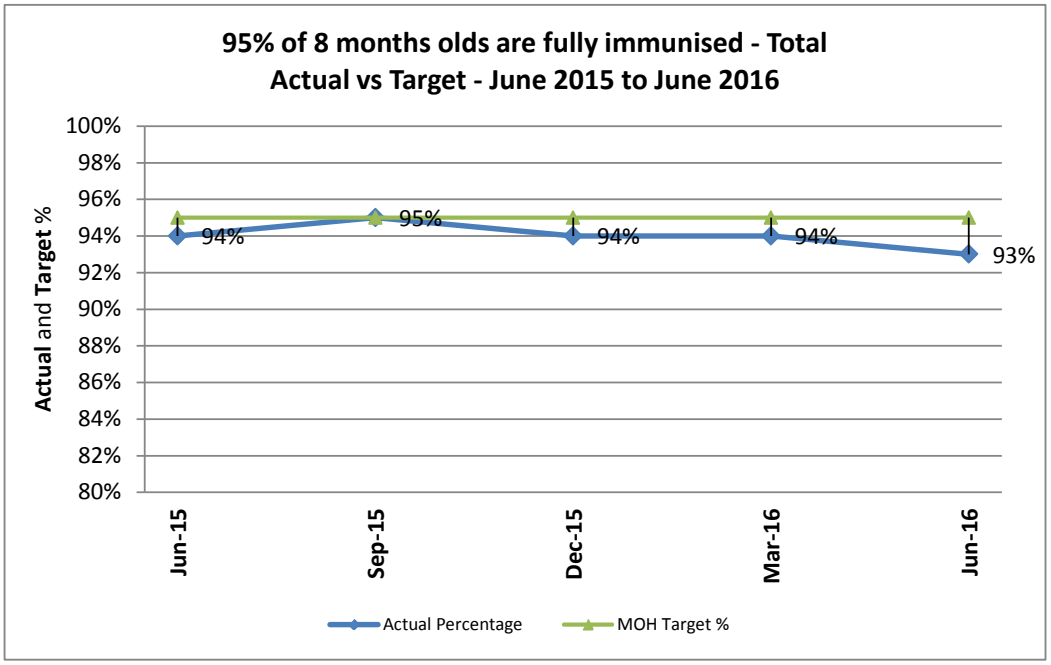
- We have a tranche of activities in place to improve the timeliness of access to, and provision of our services. These include understanding our pathways in more detail and working with clinicians to improve timeframes e.g. e-triage processes, moving to triage within 48 hours, using tumour stream groupings for clinic bookings, combining medical and radiation oncology clinics where this will suit patients better, and others.

Increased Immunisation

Target: 95 per cent of eight-month-olds will have their primary course of immunisation (six weeks, three months and five month immunisation events) on time by December 2014 and maintained to 2017.

The quarterly progress result includes children who turned eight months old during the three month period of the quarter and who were fully immunised at that stage.

Target Champion – Mike Shepherd



Current Target Performance

- ADHB's provisional coverage at 30 March 2016 is 93% which is 2% below the national health target of 95%. It is in line with the current national coverage rate of 92.7%. An equity gap remains for Maori (89%) and Others(84%). The target is exceeded for Pacific (96%) and Asian 97%. Coverage for NZE is 94.0%.
- The decline- opt/off rate increased this quarter to >3% which makes achieving the target more difficult.

Current/Planned Improvements

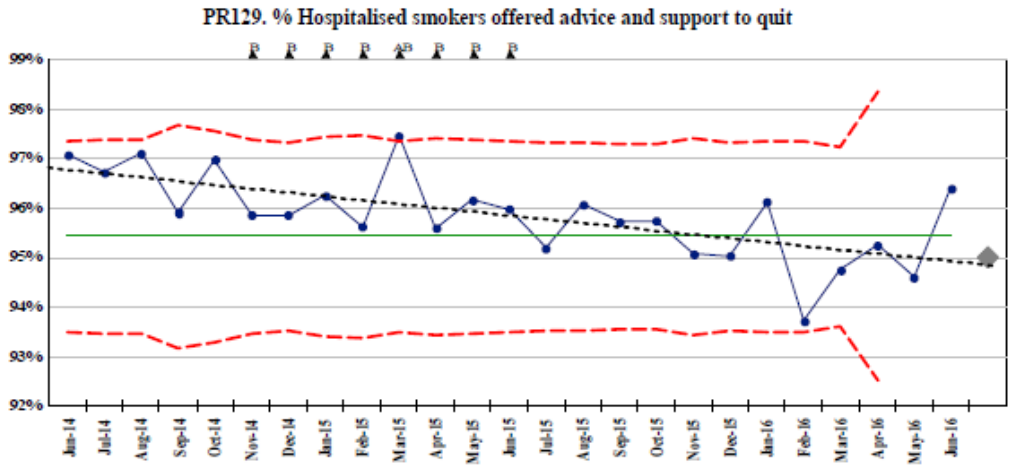
- An Immunisation reference group has been established in collaboration with Ngati Whatua, WCTO, Oral Health and DHB partners to share information and agree actions to support Maori whanau and tamariki who have overdue immunisations.
- The Six Month Milestone Plan current focus is on improving immunisation coverage to 85% at 6 months and new-born enrolment (NBE) processes to ensure all babies are enrolled with a GP by 3 months of age. A regional NBE Workshop was held in April to investigate and share improvement strategies. PHOs follow up on all children whose new born nomination is not actioned at the practice level within 3 days.
- The four Northern DHBs are developing a Business Case for NCHIP (National Child Health Information Platform).
- Education sessions are continuing for maternity services staff.
- Education sessions have commenced for Primary Care staff, including on Waiheke Island, and include sessions on working with vaccine hesitant parents.
- PICU vaccinators are offering opportunistic immunisation to eligible siblings of inpatients and the ADHB renal team are increasing immunisation services available on site to their clients. The Gateway programme are planning to provide opportunistic immunisation to their clients which include the most vulnerable and transient children.
- A summer studentship study has been completed which investigated Immunisation Practice for children admitted to Starship: and flow-on effect on primary care systems and immunisation status. Findings to be presented during 2016.

Better Help for Smokers to Quit

Target:

1. 95 per cent of hospitalised patients who smoke and are seen by a health practitioner in public hospitals, and 90 per cent of enrolled patients who smoke and are seen by a health practitioner in general practice, are offered brief advice and support to quit smoking.
2. Within the target a specialised identified group will include progress towards 90 per cent of pregnant women (who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer) are offered advice and support to quit.

Target Champions – Stephen Child, Margaret Dotchin, Karen Stevens



Current Target Performance

- As of 12 July 2016 we are at 96.8% at 73% coded which augers well for this month.

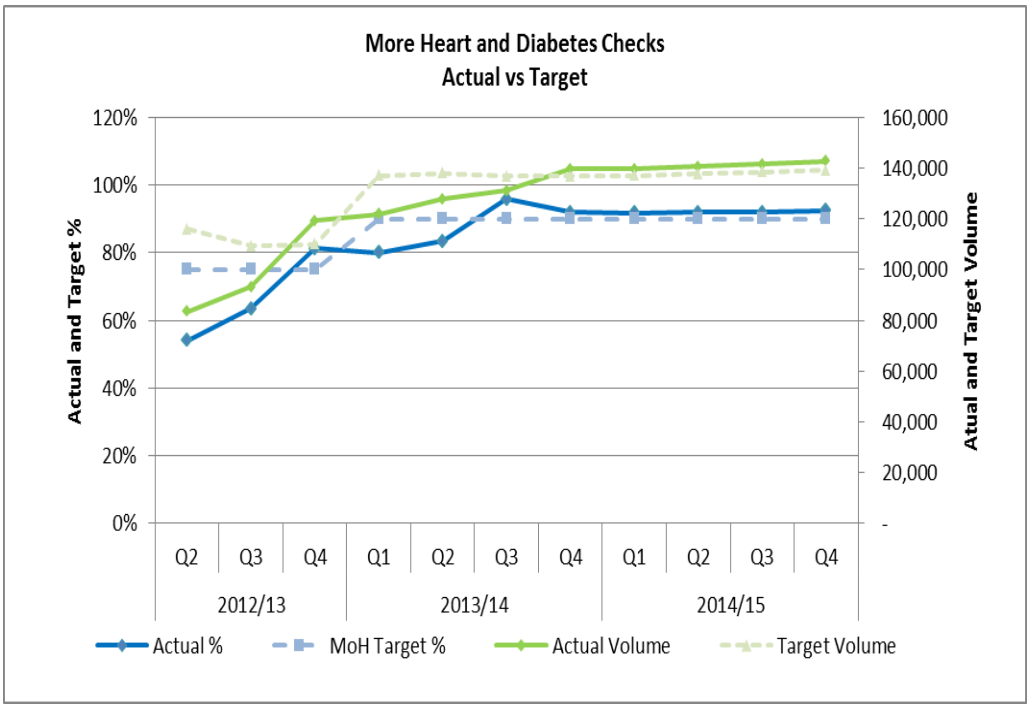
Current/Planned Improvements

- We are currently working with the new community stop smoking providers to ensure pathways for referral. Once confirmed we will be actively seeking referrals from all areas to pass on to these providers (ProCare; the Fono; Nagti Whatua AKP). We will also start rolling out the post discharge letter.
- We have started sending out the weekly ward posters in electronic format. This makes for quicker delivery and everyone can see what other wards are doing.
- In AED/APU we are ensuring that staff use the new NRT sticker for the medication chart and the nicotine inhalator – this is evidence that brief advice has been given.

More Heart and Diabetes Checks

Target: 90 per cent of the eligible population will have had their cardiovascular risk assessed in the last five years.

Target Champion – Jagpal Benipal



Current Target Performance

- Auckland DHB has met the More Heart and Diabetes Checks – National Health Target in Q3 2015/16. The results from the Ministry of Health show that Auckland DHB has achieved 92.2%. Auckland DHB has consistently met this target through the 2014/15 year (refer to the graph above).
- In Auckland DHB, 88.6% of the eligible Maori population and 90.6% of the eligible Pacific population has had a Heart and Diabetes Check.

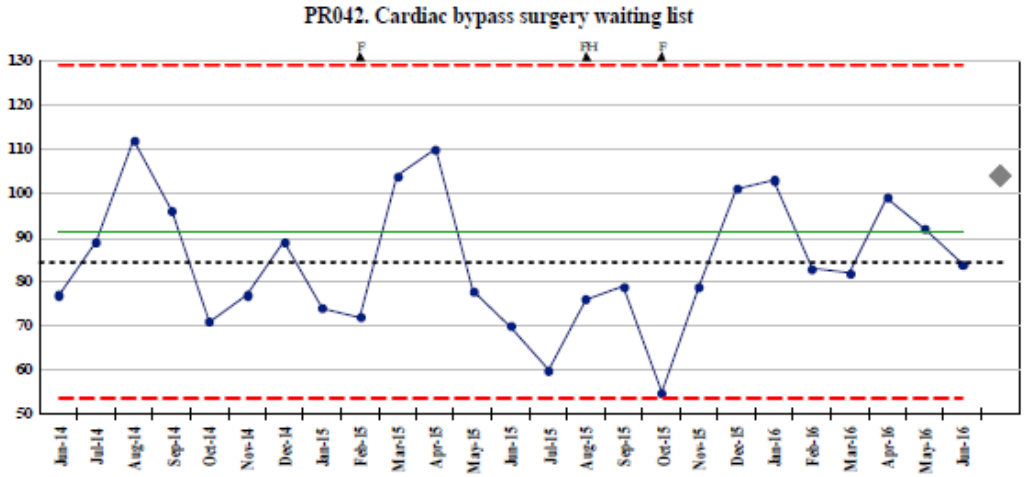
Current/Planned Improvements

- The PHOs will continue to work on maintaining and improving their performance.

Cardiac Bypass Surgery

Target: To enable timely access to cardiac bypass surgery, the wait list should be no greater than 104. To support the national cardiac bypass intervention target, 1038 bypasses should be completed in 2016/2017.

Target Champion – Dr Mark Edwards



Current Target Performance

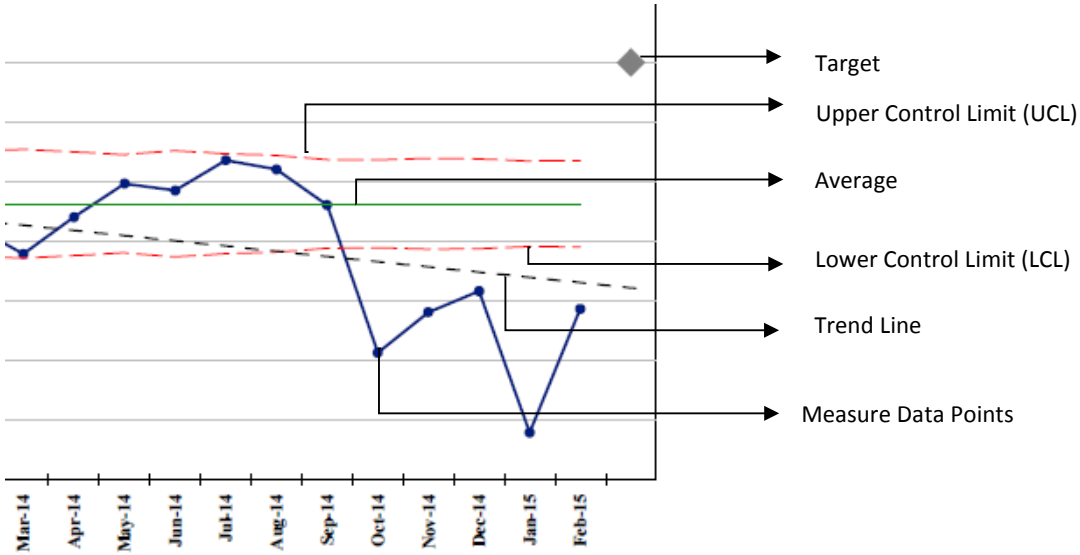
- During June the service delivered 79 eligible procedures against a plan of 85. The service had 85 new patients added to the waiting list which was over the planned number of 79.
- The service saw a decrease in the waitlist numbers from 92 in May to 84 for the month of June. This decrease was predominately due to sustained production and a reduction in cancellations.
- There were 5 ECMO patients throughout June, no transplant activity occurred during this period.
- At month end, there were 4 patients waiting in hospital, 78 waiting up to 90 days and 2 patients waiting between 90 and 120 days.
- Fortnightly teleconferencing with the MOH to update them on the service performance and production continues.
- The challenge for the service over the next months will be maintaining adequate production to manage the waitlist while managing winter ECMO pressure and acute work. Managing P1 patients while continuing to sustain P2 and P3 elective services will also be a focus. The service has remained ESPI2 and ESPI5 compliant.

Current/ Planned Improvements

- The ward review project has been implemented and patients are now being seen in ward 38 outpatients setting rather than on ward 42. The grid to capture all this work goes live at the beginning of August. Post project review will be completed.
- Consultation documentation has been completed for the House Officer roster change and the additional positon has been approved by NORTH and at service level.
- The consultation document for Ward 42 structure change is being completed. Models of care to be drafted for inclusion in the document.
- CVICU elective theatre guidelines flowchart has been reviewed. Following consultation and discussion with SCD this will be implemented to improve elective flow and facilitate earlier discharge from the CVICU when clinically appropriate.

Trend Information

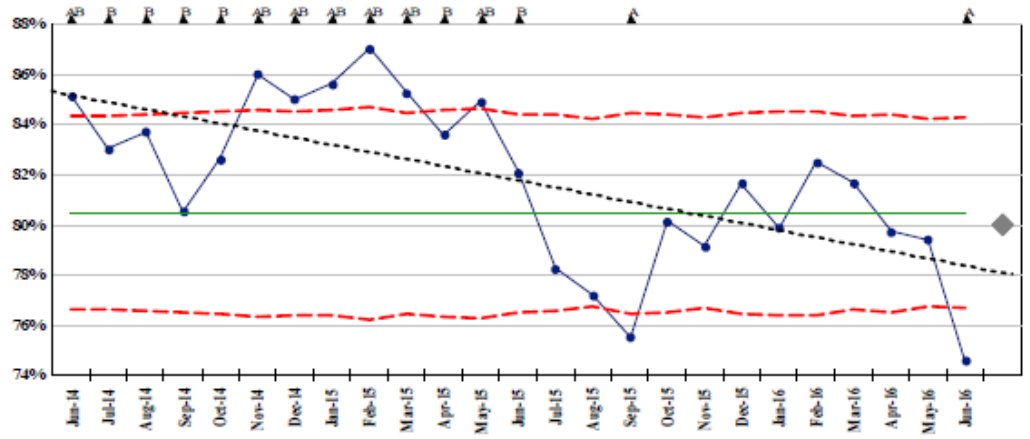
The following control charts plot process data in a time-ordered sequence to identify common cause and special cause variation.



- **Expected Variation Region**
  The area between the lower and upper control limits (LCL and UCL), where the process is expected to perform. This is also known as common cause variation and refers to occurrences that contribute to the natural variation in any process.
- **Unexpected Variation Region**
  The area beyond the control limits, also known as special cause variation. Special causes are unusual occurrences that are not normally (or intentionally) part of the process and create instability.

% AED patients seen within triage time - triage category 2 (10 minutes) (PR006)

The percentage of Triage 2 presentations who receive treatment within Australasian College of Emergency Medicine (ACEM) time guidelines



Current Target Performance

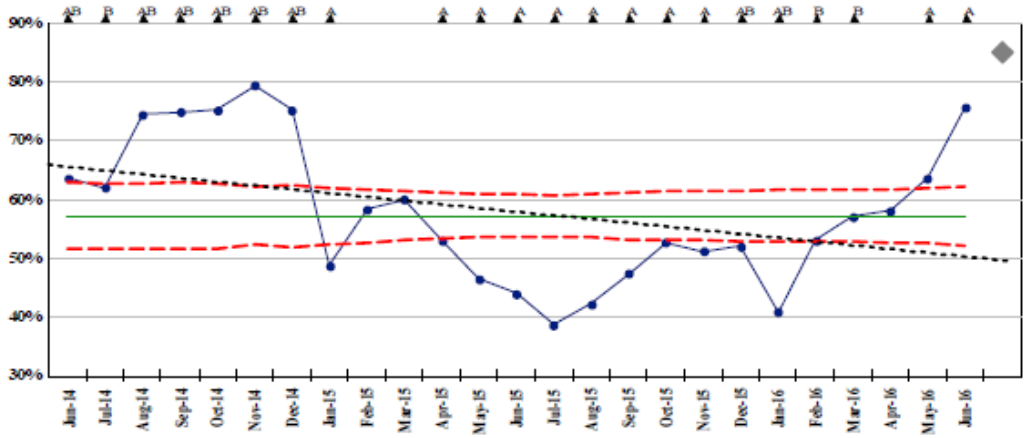
- The target is 80%.
- The drop to 74.6% was predicted and advised several months ago.
- Overall Triage 2 volumes are increasing at the same rate as AED presentations so the proportion of Triage 2 patients has not significantly increased.
- The mean sign-on time is still good at 8min but with the increased number of monitored beds (increased 10 from 6), it is harder for staff to visualise the new patient under 10min and complete electronic sign-on (including pathways).

Current/Planned Improvements

- 4 short stay beds were converted to monitored beds to provide space for the increasing number of triage 2 patients. This has reduced the number of patients waiting in corridors for a bed.
- Education continues for staff to manage high triage patients.
- Recruitment continues to fill staff positions.
- The layout of the Emergency Department is in the process of change with the development of an ambulatory care area and decision support unit, which will make space for the re-alignment of monitored beds to allow efficient allocation of staff.

% Outpatients & community referred MRI completed < 6 weeks (PR046)

The percentage of accepted Outpatient & Community referred MRI's completed within six weeks.



Current Target Performance

- The target is 85% - current performance 75.6%, improved from last month 64%.

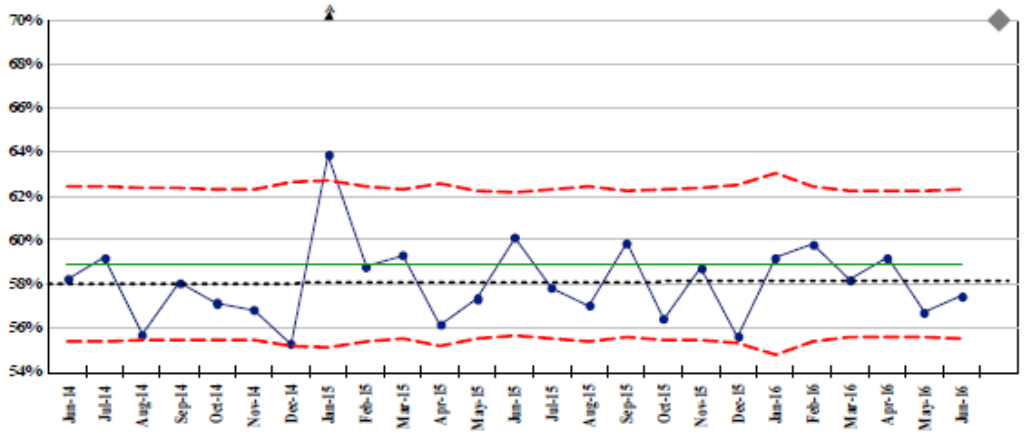
Current/Planned Improvements

- Adult MRI currently performing at 84.6%.
- Paediatric MRI currently performing at 50.4%.
- Hours of operation across all sites extended on a weekly basis, where staffing numbers can support this.
- Outsourcing to private providers will be discontinued from the end of July, the waitlist volumes and ministry compliance will be monitored to ensure any change in performance is acted on as soon as possible.
- Detailed weekly report now identifies all patients waiting longer than 5 weeks, previously the report identified patients waiting than 6 weeks. This will be changed to 4 weeks within the next month thereby allowing sufficient time to identify patients at risk of non-compliance and put plans in place to achieve compliance.
- Paediatric MRI waitlist is reducing month on month, the waitlist now has a total of 134 patients waiting compared with 213 in May.

- The majority of the non-compliant Paediatric patients are for procedures under GA. Funding has been approved for additional GA sessions which will be scheduled on Saturdays with an anticipated start date of 31 July.
- Continue to source additional GA sessions during normal working hours, by collaborating with Cardiology and CAMRI.
- Staff recruitment with 1 new member starting September (if not earlier).
- Proactive service level planning to ensure capacity meets demand on an ongoing basis.

% Day Surgery Rate (PR052)

The percentage of WIES funded elective surgical procedures that are daycases.



Current Target Performance

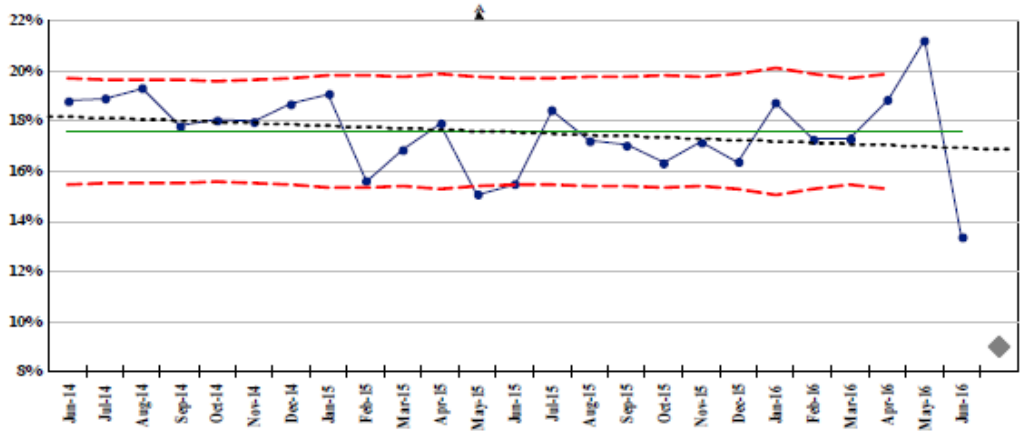
- Day cases reduced during May and have seen some recovery during June. This is largely driven by case mix and the impact of acute demand on current capacity as well as seasonal variation in acute activity.

Current/Planned Improvements

- Additional day case capacity is being implemented for Urology which will come on line in Q1 16/17 which will improve the current performance.
- The organisation is currently reviewing the process for the scheduling of local anaesthetic and sedation cases and the location for delivery.

% DNA rate for outpatient appointments – Maori (PR057)

The percentage of appointments booked for Maori where the patients Did Not Attend (DNA).



Current Target Performance

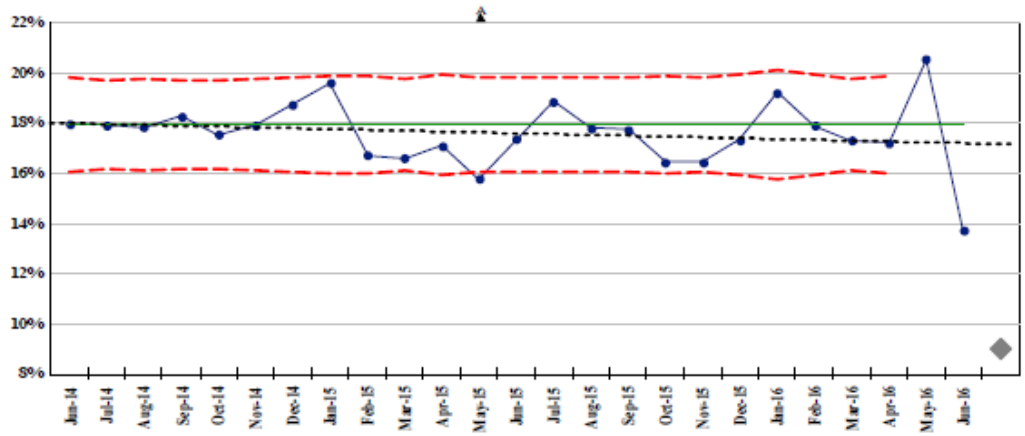
- The data shows a significant improvement in the DNA data of 2.7%, with improvements of over 4% in Cancer & Blood and Children's Health and Surgical from the February report.

Current/Planned Improvements

- We continue to focus in the cardiac space ie; ringing to remind, and support any new initiatives as a result of the proposed new DNA strategy which was presented and approved by the ELT's of ADHB and WDHB.

% DNA rate for outpatient appointments – Pacific (PR058)

The percentage of appointments booked for Pacific People where the patients Did Not Attend (DNA).



Current Target Performance

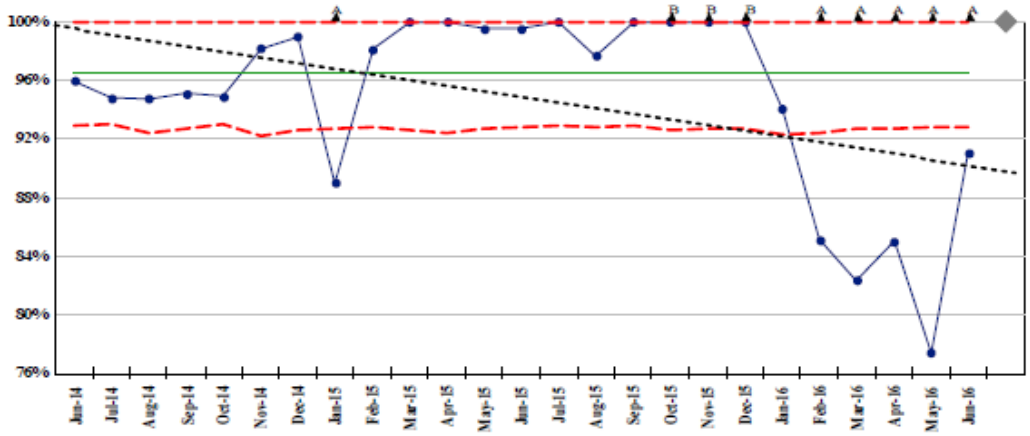
- The DNA rate reduced from the previous month from 21.02% to 18.03%.

Current/Planned Improvements

- The call backs continue for the Oncology clinics by the Tautai Fakataha team. This has been coordinated by the Advanced Social Worker for Cancer and Blood services.
- The after-hours call-backs for Diabetes outpatient continues from the call centre in Greenlane.

% Radiation oncology patients attending FSA within 4 weeks of referral – (PR064)

The percentage of patients attending Radiation Oncology First Specialist Assessment (FSA) within four weeks of referral



Current Target Performance

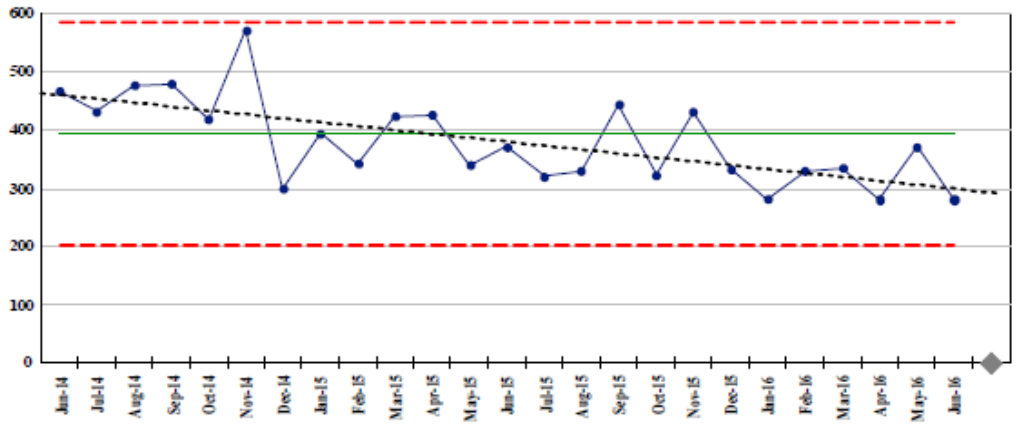
- The Service continues to work to match capacity to demand, with performance improving over the last four weeks.

Current/Planned Improvements

- The Service has applied additional fixed term SMO capacity to address high volume tumour stream pressures, with work continuing on the Rapid Access Clinic and protecting the appropriate number of FSAs for Faster Cancer Treatment patients. Triaging processes are being streamlined, and tumour streaming better effected through the use of teams rather than individual clinicians. A SCRUM process is to be initiated.

Number of CBU Outliers – Adult (PR173)

The number of patients with an assigned CBU (Clinical Business Unit) that is not the CBU of the ward the patient was admitted or transferred to.



Current Target Performance

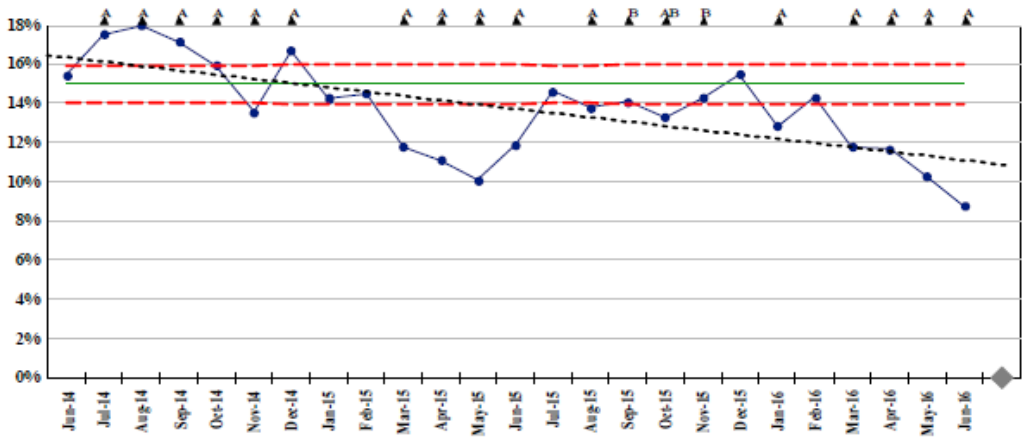
- General Medicine patient numbers have risen steadily over June and will be a factor in the Outlier report.

Current/Planned Improvements

- Use of Seasonal plan to place patients within areas of home CBU to reduce patient safety issues

% Patients cared for in a mixed gender room at midday – Adult (PR175)

The percentage of patients cared for in a mixed gender room based on census at midday – Adult.



Current Target Performance

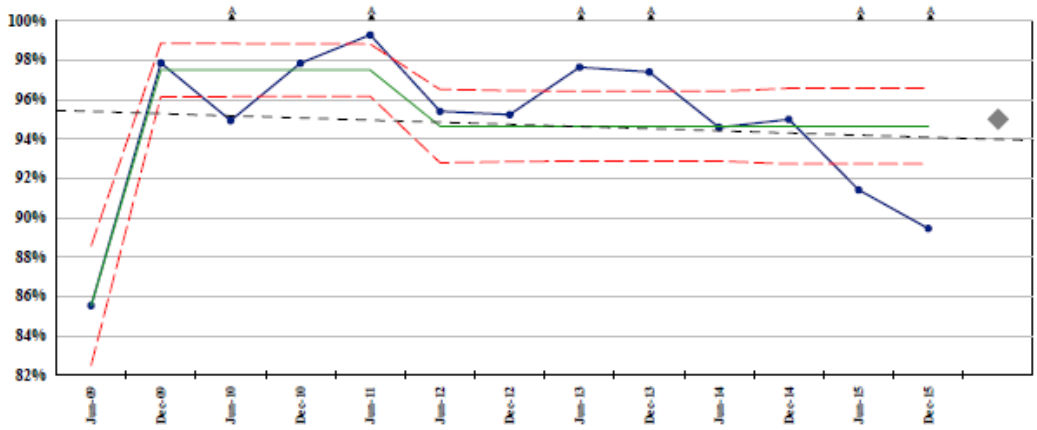
- No improvement in this area.

Current/Planned Improvements

- Continued daily review by Nurse Unit Managers and Charge Nurses.

Mental Health % long-term clients with relapse prevention plans in last 12 months (PR125)

The proportion of Long Term Service users with an up-to-date Relapse Prevention Plan



Current Target Performance

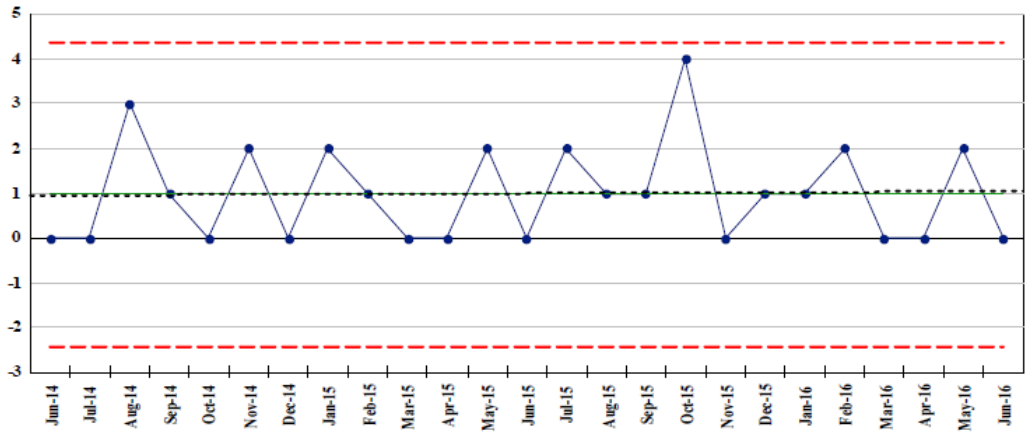
- Below target.

Current/Planned Improvements

- New Ministry reporting goals and processes around "wellness plans" will replace this relapse planning target from 1 July 2016. Services are currently transitioning to a range of new tools and processes to meet these requirements. Technical work has begun to capture and report on wellness planning data, but they are not yet fully developed and in place.

Mental Health Provider Arm Services: SAC1&2 (Inpatient & Non-Inpatient Suicides) (PR194)

A monthly count of suicides/suspected suicides advised to MH services and meeting the definition for SAC1 or SAC2



Current Target Performance

- Nil of note but reported to HAC as per request.

Current/Planned Improvements

- Ongoing monthly reporting to HAC by control chart as per request.

Resolution to exclude the public from the meeting

Recommendation

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

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
3. Confirmation of Confidential Minutes 22 June 2016	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence [Official Information Act 1982 s9(2)(ba)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4. Confidential Action Points	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence [Official Information Act 1982 s9(2)(ba)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5. 2016/17 Provider Business Plan	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations** To enable the Board to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations) [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.1 Faster Cancer Treatment	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage,	That the public conduct of the whole or the relevant part of the meeting would

	commercial activities [Official Information Act 1982 s9(2)(i)] **Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which if made available: i) would disclose a trade secret; or would be likely to unreasonably prejudice the commercial position of any person who supplied, or who is the subject of, such information [Official Information Act 1982 s9(2)(b)]	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 Cardiothoracic Surgery	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which if made available: i) would disclose a trade secret; or would be likely to unreasonably prejudice the commercial position of any person who supplied, or who is the subject of, such information [Official Information Act 1982 s9(2)(b)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.3 Acute Flow Performance	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which if made available: i) would disclose a trade secret; or would be likely to unreasonably prejudice the commercial position of any person who supplied, or who is the subject of, such information [Official Information Act 1982 s9(2)(b)]	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 Security for Safety Programme Report	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Confidence**	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

	The disclosure of information would not be in the public interest because of the greater need to protect information which if made available: i) would disclose a trade secret; or would be likely to unreasonably prejudice the commercial position of any person who supplied, or who is the subject of, such information [Official Information Act 1982 s9(2)(b)]	sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.5 Food Services Quality	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which if made available: ii) would disclose a trade secret; or would be likely to unreasonably prejudice the commercial position of any person who supplied, or who is the subject of, such information [Official Information Act 1982 s9(2)(b)]	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 Risk Register Reports	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** The disclosure of information would not be in the public interest because of the greater need to prevent the disclosure or use of official information for improper gain or advantage [Official Information Act 1982 s9(2)(k)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.1 Complaints	**Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence [Official Information Act 1982 s9(2)(ba)] **Privacy of Persons** To protect the privacy of natural persons, including that of deceased natural persons [Official Information Act s9(2)(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]
8.2 Compliments	**Obligation of Confidence** The disclosure of information would not	That the public conduct of the whole or the relevant part of the meeting would

	be in the public interest because of the greater need to protect information which is subject to an obligation of confidence [Official Information Act 1982 s9(2)(ba)] **Privacy of Persons** To protect the privacy of natural persons, including that of deceased natural persons [Official Information Act s9(2)(a)]	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]
8.3 Incident Management	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations** To enable the Board to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations) [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.4 Policies and Procedures	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [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]